Bridging The Gap:

The Changing Reproductive And Sexual Expectations Of Fijian Men

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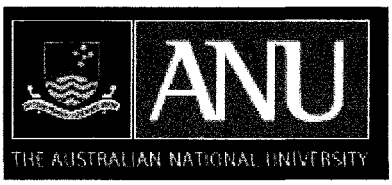
A thesis submitted for the degree of Doctor of Philosophy of the Australian National University



The Australian National University

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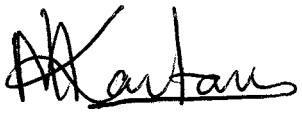
DECLARATION

Except where otherwise stated, this thesis is my own research work carried out from April 2000 to October 2003 as a PhD Scholar in Demography at the Australian National University.



Miliakere M Kaitani

October 2003

To my late mother
Alowesi Lailai VOLAU
and
To my loving husband and daughter
Semisi and Ana KAITANI.

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MAY GOD BLESS YOU ALL

ABSTRACT

Although much has recently been written on the reproductive health of men, there is relatively little research material on the reproductive and sexual behaviour of young men in Fiji and there has been no research to identify factors influencing behaviour. In this study an empirical investigation on men's sexual behaviour before and after European contact is examined to enable an understanding of the changing cultural expectations and values of sexuality. Social factors currently influencing reproductive health knowledge, attitudes and behaviour are also identified.

This study uses both quantitative and qualitative research methods including questionnaire interviews, in-depth interviews, focus group discussions, archival materials, informal interviews and participant observation to bridge this gap. Questionnaire interviews were statistically analysed using bi-variate and multivariate analyses identifying factors that influence reproductive and sexual behaviour. Different factors were found to influence different behaviour. The thesis identifies socio-demographic factors that influence sexual behaviour. These include the sources of information, education, age, religion and religiosity, area of childhood upbringing, parent's occupation, knowledge and attitudes to different sexual behaviours, and knowledge and attitudes to contraceptive use, use of available services, and risk behaviour.

The research findings shows that Fijian men in 2001 were aware that they play an important role in addressing the reproductive and sexual health issues of the community. However, they are seldom actively engaged in promoting reproductive health because culture dictates that women are responsible for reproductive health issues while men are the main source of income in the family. Traditional values have changed over time and these roles are at times modified or reversed. Western cultural practices brought to Fiji over the past 200 years have resulted in the mixing of culture and uncertainty about the appropriateness of competing values. Traditional institutions for the education of young people are fast being displaced and the traditional family system is crumbling. Alternative institutions have not emerged to offer adequate alternatives. This has resulted in young people being ill informed on sexual and reproductive behaviours. Knowledge and use of available services is very low. The condom is a commonly known contraceptive method but men are not aware of other methods. The

results show that contraceptive use is uncommon. Their knowledge is limited because they have a narrow range of sources of information on sexuality and they are misinformed about this taboo topic. The end result is a high incidence of teenage pregnancy and high incidence of STIs among the indigenous Fijian population.

Attitudes to sexual behaviour, including dating, premarital coitus, homosexuality, and commercial sex workers conform to society's expectations. Although these are not culturally acceptable they are becoming normal practice in society today. Religion influences social attitudes towards sexuality. The main influence is Christianity, introduced in the early nineteenth century. The research shows that knowledge and attitudes to reproductive health behaviour have little or no influence on behaviour but attitudes do influence engagement in risk taking behaviour.

In comparing the historical perspective on men's sexual behaviour to current behaviour, it is observed that the major changes in behavioural norms had already begun by the early twentieth century. Sexuality today is greatly influence by religion. There is a need to differentiate between the religious and cultural expectations of sexual and reproductive behaviours. The breakdown of the traditional institutions in society that look after sexual behaviour has led to young men having limited knowledge of sexual health, and also leads to increased risk behaviour. On the basis of this analysis, the thesis argues for institutional renewal to revive appropriate ways to educate men about safe and responsible sexuality. Educating young men about the risks of common sexual behaviours is highlighted as such education can influence behaviour for the better. The study concludes by exploring strategies that could be taken to encourage young men to engage in healthy reproductive behaviour.

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GLOSSARY:- FIJIAN TERMS AND MEANINGS

Term	**Meaning in English**
Boci	Uncircumcised penis/immature
bulubulu	Traditional ceremony for the burying of the hatch and asking for forgiveness.
bure	Fijian house
bure ni tagane	Men's house. This is a sleeping house for young men and all unmarried men.
bure ni sa	Men's house
ganena/veiganeni	brother and sister relationship
gauna	time
gauna e liu	past
gauna mai muri	future
iloloku	an offering to the dead soul
iyau	traditional items
kaivalagi	'European' or the 'white man'
liu or e liu	in front
malo	a piece of cloth that men wear to cover themselves. This is worn only when they a recognised as adults.
masi dakai	cleaning the gun, it also metaphorically means masturbating
muri	behind or back
tabua	whales tooth. It is a highly valued traditional item.
tavale/veitavaleni	cross cousins
tavi yadre/tuki yadre	slapping the forehead, it also metaphorically means masturbating
veidrotaki	elopement
veitabui	taboos that exists in a relationship
veitacini	brother to brother relationship, or a sister to sister relationship
waliwali	oiling one's self, also means masturbating
yaqona	kava, a traditional Fijian drink that is used during ceremonial functions. It is also a social drink today.
yavu sovu	finishing the soap, also implies masturbating

CHAPTER 1

INTRODUCTION AND SETTING THE RESEARCH AGENDA

1.1 INTRODUCTION

It is important to involve men in reproductive health programs since their role in decisions about sex, contraception, and childbearing often override the preferences of their female sexual partners. Men play an important role in the reproductive health of women (UNFPA 1995; Presser 1997). Isiugo-Abanihe (1994) argued that men's role in reproductive decision making derives from their social positions as they are generally regarded as protectors and providers for the family, and they make the majority of decisions about the family and society in general. However, comparatively little is known about the reproductive health behaviour of men because reproductive health research has been focused on women.

The emphasis on women derives from their biologically determined role as bearers of the physical and emotional strains of pregnancy and childrearing. Greene and Biddlecom (2000) agreed and stated that the focus on women could be because of women's primacy in fertility and contraceptive use. Reproduction however involves two individuals, a man and a woman, and their distinct and complementary roles must be understood in tandem in order to effectively address reproductive health issues.

The importance of men in reproductive health policy and planning surfaced after it was observed that in some developing countries, fertility control or family planning focusing exclusively on women was not effective in improving the reproductive health of the population. Many studies noted that men's objection to their wives' using modern contraception was an obstacle to contraceptive use (Fisek and Sumbuloglo 1978; Helzner 1996; Karra et al. 1997; Population Council 2000a; Population Council 2000b). With the emergence of HIV/AIDS in the early 1980s, men were further implicated in reproductive ill health through their role in the potentially infectious process of sexual intercourse, both heterosexually and homosexually. Two of the groups identified, as bearing the highest-risk in the early stages of the epidemic are male dominated groups: men who have sex with men and truck drivers. This indicated that men's influence in reproductive and sexual health must be examined in order to address reproductive issues.

Studies on the reproductive and sexual behaviour of men in Fiji are very rare. The reasons include the cultural taboo against discussing reproductive and sexual behaviour in public, and the perception that reproductive health is a women's issue because it is the woman who gets pregnant. The common perception was that men have not played an important role in reproductive health. This is also a cultural issue, as in Fijian custom it is the woman who is responsible for child rearing.

Society's cultural expectations are important in influencing reproductive behaviour; in-order to understand the influence of culture on reproductive outcome, men must be included in demographic research (Goldscheider and Kaufman 1996). This study aims to look at socio-cultural factors and personal characteristics that influence the reproductive and sexual health behaviour of men in Fiji; it examines the reproductive and sexual behaviour of adolescent and young adult Fijian males in urban Suva.

This chapter first outlines the purpose of this study; then the reproductive and sexual health issues of men in Fiji are discussed. The research questions are discussed in detail, and the different research methods and methodologies used to seek answers to the research questions are discussed. This is followed by a discussion of the aims, structure and objectives of this study.

1.2 PURPOSE OF THE STUDY

To understand the reproductive and sexual behaviour of women, we have to understand the reproductive and sexual behaviour of men. As stated earlier men have an important influence on the reproductive behaviour of women, but young men have received relatively little attention in human sexuality research in the world (Godina 1996; Greene and Biddlecom 2000; Okami 2001). Below is part of an interview with a sexual health consultant at a United Nations office in Fiji.

> *A lot is unknown about the sexual behaviour of men in the Pacific and in Fiji in particular. This needs to be known in order for preventative action to be implemented. .... This is largely related to sexual networking.... We must identify the factors that influence the behaviour, as it is the behaviour that makes the difference. What are the factors that promote risk-taking behaviours? What works and what do not work? We know very little about the base line background of the individuals. The behaviour influence is important but is complicated. (Max, WHO).*

This suggests that there is a need to conduct research on the reproductive and sexual behaviour of men in Fiji, because little in known about the importance of studying men's

reproductive and sexual health behaviour in Fiji. Sex is a difficult topic to talk about in Fiji and it is hard to get people to open up to the researcher and to give an idea of what is happening. It is generally assumed among Fijians that because of cultural taboos reproductive and sexual behaviour cannot be discussed in public.

Three studies have previously been conducted in Fiji, identifying the issues relating to the reproductive health behaviour of men. Chandra (2000) in 1999 examined the reproductive health behaviour of adolescents and young adults in Fiji using a multiple qualitative technique to collect the data. Kaitani (2000) examined the safe-sex knowledge and behaviour of Fijian men living in Suva; qualitative techniques were used to collect the data for the latter study. Plange in 2000 also conducted a study of men's reproductive behaviour in Fiji, was titled "Men as Partners" (Price 2002). The methods used included both qualitative and quantitative techniques.

The present study focuses on adolescent and young adult Fijian men. Both Chandra (2000) and Plange (Price 2002) examined all men in Fiji, while Kaitani (2000) studied indigenous Fijian men only. Chandra (2000) compared the sexual behaviour of adolescent and young adult males using qualitative methods. This thesis focuses on only one ethnic group in Fiji, and it also examines the socio-cultural factors that influence the reproductive and sexual behaviour of young adult men living in Suva.

1.3 FINDINGS FROM PREVIOUS STUDIES

The three studies mentioned above clearly indicate that there is a need for more studies of the reproductive behaviour of young men in Fiji. Kaitani (2000) notes that Fijian men are well informed about many aspects of reproductive health; Plange (Price 2002) concludes that men in Fiji are knowledgeable about reproductive and sexual health. Chandra (2000) however disagrees, arguing instead that adolescents in Fiji are poorly informed about reproductive health. Plange observes that many men are enthusiastic about knowing more about reproductive and sexual health, but add that sexual issues are not talked about by some adult and middle-aged men, and especially those in rural areas (Price 2002). Kaitani (2000) has found that Fijian men are well aware of the need for safe sex and of the services available to them, but they tend to make little use of the available services.

All three studies observe a growing concern about young people becoming sexually active at a very early age, and about the increase in unsafe sexual practices. Kaitani (2000) states that although Fijian men know of condom use as a safe sex method they other wise practise unsafe sex, while education has a significant influence on condom use. Chandra (2000) notes that men do not use condoms because they believe they are ineffective. Plange observes that men still do not appreciate condoms and argue that using condoms is not sexually pleasurable (Price 2002). All three studies noted that condom use is not very common among men in Fiji and unsafe sexual practice is increasing; this indicates that it is not the knowledge that is important but the understanding of the knowledge, for this can influence behaviour.

The three studies observe that coitus is practised extensively in Fijian society. Plange states that sex for pleasure is now common among men in Fiji (Price 2002); Chandra (2000) notes that although premarital sex is culturally unacceptable to both the Indo-Fijians and the Fijians, it is commonly practised in society. This indicates that cultural controls are becoming less effective in ensuring that the norms of society are observed.

Knowledge of Sexually transmitted infections (STI) and HIV/AIDS is common among men, but this seems to be limited to HIV/AIDS and gonorrhoea (commonly referred to as *Tona).* All three studies observe that most men lack detailed information on STIs and HIV/AIDS. Chandra (2000) and Plange (Price 2002) also note that men have limited knowledge of other reproductive health problems, such as prostate cancer and testicular cancer. There is therefore a need to understand why men are not well informed about these other sexual and reproductive problems.

1.4 RESEARCH QUESTIONS

Because of cultural expectations and the lack of information and knowledge of reproductive and sexual health, many men in Fiji are not aware of the importance of maintaining their reproductive and sexual health. Information on reproductive and sexual health is a non-issue in most Fijian communities and cannot be discussed in public: men are expected to know the healthy and accepted reproductive and sexual health behaviour although the way information is disseminated is not clear. Some information obtained from others in their peer groups, and traditionally from their elders, usually their grandparents.

The research questions in this thesis are classified into four parts. The first part addresses the knowledge of and attitude to reproductive and sexual behaviour: How is the information on reproductive and sexual health behaviour passed on to the younger generation? What are the main sources of information? What type of information do they receive? How does their knowledge of reproductive and sexual health influence their behaviour?

The second set of questions includes the available services and their uses: What are the services provided to men? How are these services provided? Do they reach all men or do they have 'unmet needs', such as service for youths and for unmarried men? The third part is based on identifying men's reproductive and sexual health behaviour and the socio-cultural and demographic factors that influence it: Why do men have different reproductive and sexual behaviours? What cultural factors influence these behaviours? What socio-economic factors? What demographic characteristics?

The final set of questions tries to identify the influence of the government and non-government institutions on reproductive and sexual behaviour: What government policies could influence and affect the reproductive and sexual behaviour of men? What policy approaches can be taken to improve the reproductive and sexual health behaviour of men in Fiji? How can NGOs and other organizations help?

1.5 AIMS AND OBJECTIVES

To involve young men in reproductive health it is important that their reproductive and sexual behaviour is understood. This includes 'dating' since it represents the context in which young people experience premarital sex. Empirical knowledge is essential to understand how to involve men in reproductive health programs. There is now a growing literature on men's reproductive and sexual behaviour globally (Godina 1996; Greene and Biddlecom 2000), but in Fiji only a handful of research-based studies have been conducted. Therefore there is a need for more investigation of this topic.

This thesis tries to contribute to a greater understanding of the reproductive and sexual behaviour of young Fijian men. It aims to identify the socio-cultural factors that influence young Fijian men's reproductive and sexual behaviour. This includes looking at reproductive and sexual health behaviour such as the frequency of sexual intercourse; premarital and extramarital affairs; marriage customs, patterns and practices; the use of available reproductive

health services and facilities; and men's sexual activities including homosexuality, visits to prostitutes, and masturbation.

This thesis also explores the role of the government and non-government organizations, religious frameworks and traditional leaders in encouraging society to address the importance of men's reproductive and sexual health behaviour. The expectation is that the government does little about reproductive health, while the non-government organizations are more effective in disseminating information and in implementing projects to help men see the importance of their reproductive health behaviour. It is hypothesised that Fijian men do not make use of the available services.

This study will also help to give insight into the differences in reproductive and sexual health behaviours of young Fijian men, and to assess the reproductive and sexual health problems faced by men in each group. It contributes to the evolution of an effective reproductive and sexual health program, focusing on men, in Fiji. This is important, as such a program is needed to reduce the spread of STIs. This study addresses the importance of the male contribution to reproductive health problems such as unwanted pregnancies and abortion, and the importance of safe motherhood; reproductive health problems, such as infertility and the use of contraception, that need to be acknowledge in the society.

The specific objectives of the thesis are addressed as follows: Objective 1 in Chapter 5, Objective 2 in Chapter 6-8, and Objective 3 in Chapter 9. Below are the outline of the objectives and the breakdown of specific objectives.

1.0. To provide a historical overview of men's reproductive and sexual behaviour
   - 1.1. To identify some of the sexual norms in Fijian society.
   - 1.2. To examine the historically enforced social controls on reproductive and sexual behaviours.
   - 1.3. To examine some of the rituals of society.
   - 1.4. To explore the changes in reproductive and sexual norms before and after European contact.

2.0 To explore the reproductive and sexual health knowledge, attitude and behaviour of young Fijian men and their use of the available services.

2.1 To examine the sources of knowledge and the types of information young men receives.

2.2 To explore young men's use of available services.

2.3 To examine the factors that influence young men's attitude to reproductive and sexual health behaviour.

2.4 To determine the socio-cultural and demographic factors that influence reproductive and sexual behaviour.

3.0 To identify the factors that influence young men's risk-taking behaviour.

3.1 To identify the risk-taking behaviour.

3.2 To examine factors that influence risk-taking behaviour

In this thesis 'dating' refers to an activity where a male and a female without a blood relationship go out together all alone. Coitus or sexual intercourse is defined as an act involving penile-vaginal penetration. Premarital coitus is not assumed to take place only through dating. Young men could also have coitus with paid partners (sex workers) or with a newly met unpaid partner. Premarital coitus also takes place as a result of forced sexual intercourse such as rape and 'convoy' (pack rape), as will be discussed in Chapter 9. The thesis focuses on Fijian young men and in the course of the thesis they are also referred to as adolescent male, young men, and young adult men. These terms are used interchangeably however when referring to all Fijian young adult and adult male the term men or Fijian men are used.

1.6 STRUCTURE OF THE THESIS

The focus and the scope of this thesis have been outlined in this chapter. Chapter 2 discusses the background of the study environment and some of the data on reproductive issues in Fiji. Chapter 3 gives an overview of literature on the reproductive and sexual behaviour of men. The fourth chapter discusses the research methods used to collect the data, to find answers to the research questions and to meet the objectives of the thesis. In the next five chapters the findings generated from the research to fulfil the objectives are discussed: Chapter 5 discusses the historic traditional reproductive and sexual behaviour: Chapter 6 the knowledge of reproductive health and the use of available services: Chapter 7 young Fijian men's attitudes to reproductive and sexual behaviour. Chapter 8 examines the factors that influence the reproductive and sexual behaviour of young men. Chapter 9 discusses risk-taking behaviour.

In the concluding chapter, a summary of the findings is presented with other related issues, and the recommendations are outlined.

CHAPTER 2

FIJI: THE SETTING- BACKGROUND OF THE STUDY ENVIRONMENT

2.1 INTRODUCTION

Fiji has a plural society: two major ethnic groups making up 94 per cent of the total population are Fijians and Indians, who have different demographic and socio-cultural norms and expectations. It is therefore important to understand the social systems of both groups. To identify the factors that contribute to adolescent reproductive and sexual health it is necessary to must understand the study area, and information on the geographic setting of Fiji. The chapter also provides an overview of the reproductive issues in the islands since the early 1990s; its main focus is to identify the issues of reproductive health in Fiji and to show why indigenous Fijian men play a key role in achieving good sexual health.

The chapter is organised in six sections: the first outlines the geographic background; the second describes the political and economic situation since Independence; the third section is a brief account of the population and social structure; the fourth section gives a description of the role of indigenous Fijian men in society; the fifth section gives an account on family planning in Fiji; the sixth describes the sexual behaviour of adolescent and young adult Fijian males and gives an overview of STI, teenage pregnancy and other reproductive health issues.

2.2 THE GEOGRAPHIC SETTING

Fiji is an archipelagic state lying in the heart of the Pacific Ocean (Figure 2.1), between longitudes 175 and 178 west and latitudes 15 and 22 south. The Pacific is divided into three groups: Polynesia, Melanesia, and Micronesia (as shown in Figure 2.1). Fiji belongs to the Melanesian group of countries that include Papua New Guinea, Vanuatu, and the Solomon Islands. Fiji is by global standards a microstate. The archipelago comprises about 330 islands (Figure 2.2), of which about one third are inhabited. Fiji's total land area is 18,333 square kilometres. Although Fiji has an extremely small land area, it encompasses a very large sea area of an estimated 1,290,000 square kilometres (Kearney 1980). This means that there is a good supply of marine resources available for exploitation.

Figure 2.1: Map of the Pacific

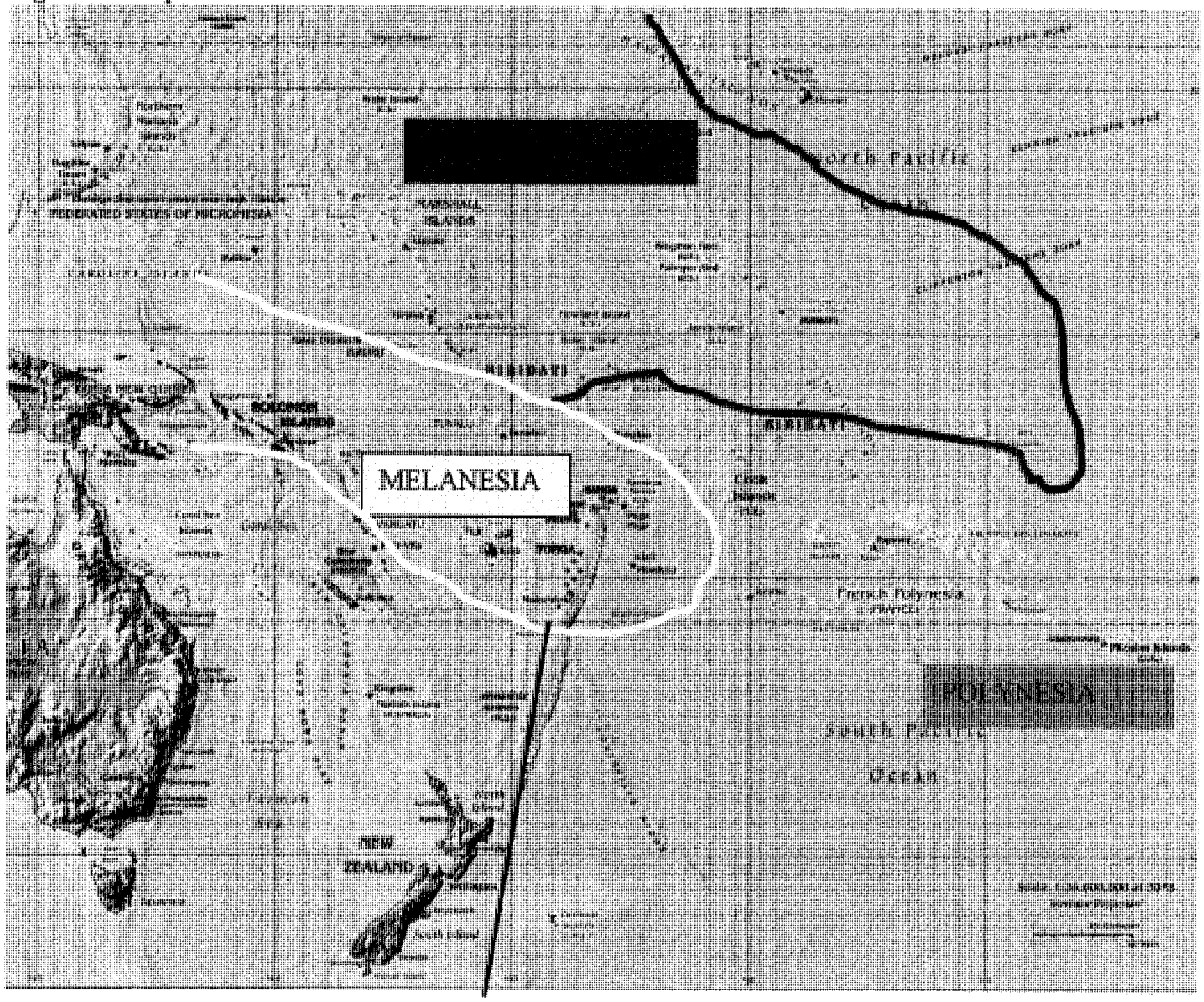
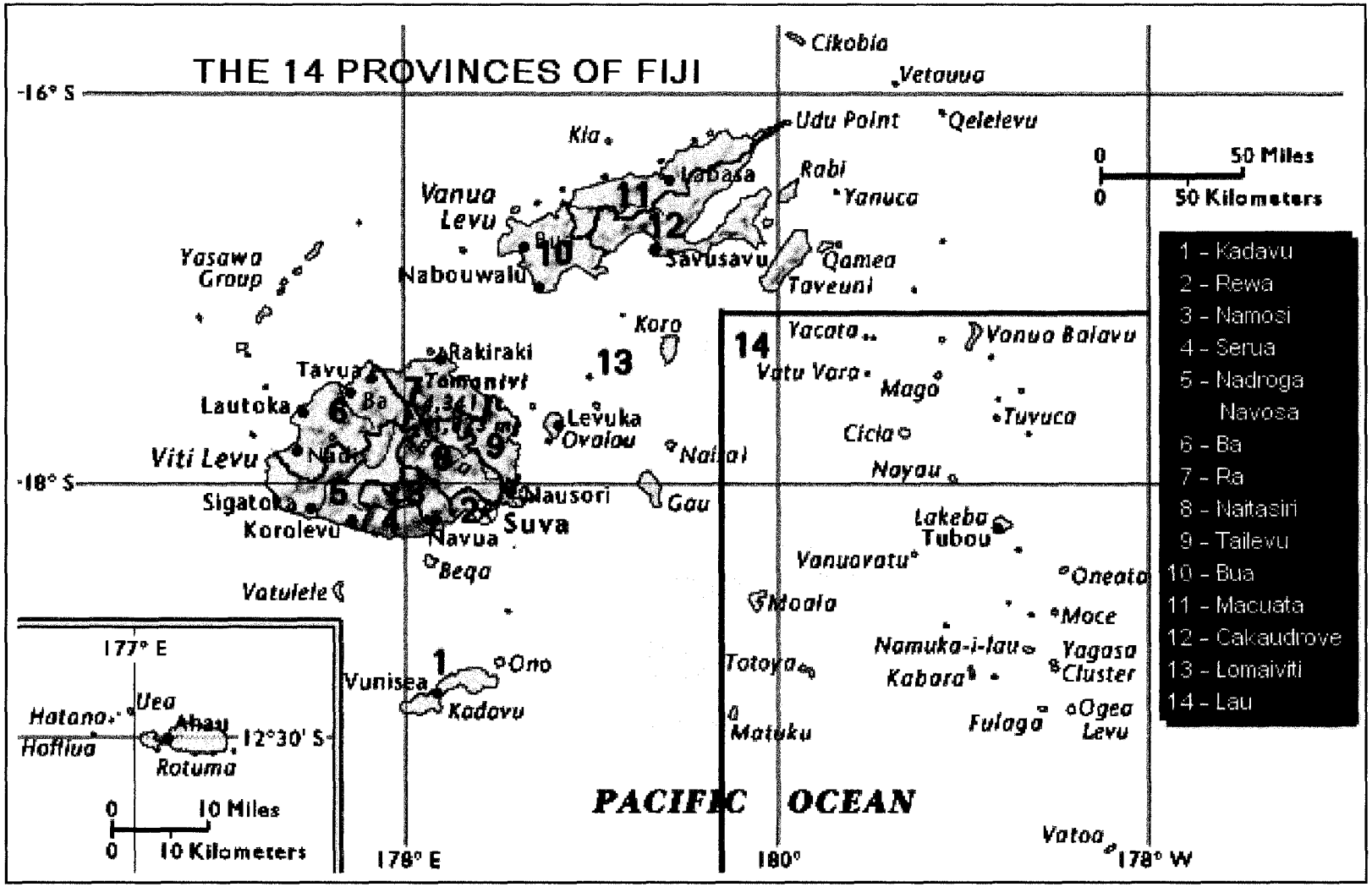


Figure 2.2 Map of Fiji and the Fijian Provinces



Fiji is a part of a high volcanic submarine mountain chain that spreads from Papua New Guinea through the Solomon Islands and Vanuatu to the small islands of Fiji at the Eastern tip. The larger islands are volcanic islands while the smaller islands are mostly coral or limestone outcrops. Leaders and planners worry that the greenhouse effect, resulting in a rise in the sea level, could engulf the peoples of the smaller low-lying islands. The two main islands are Viti Levu and Vanua Levu which together make up 87 per cent of the total land mass. All but one of the urban centres are located on the two main islands.

Fiji has a tropical South Seas maritime climate; natural disasters such as droughts, hurricane, and floods are common. According to the government an average of ten to twelve disasters affect the islands every decade (Ministry of Information 2001).

2.3 POPULATION

Fiji is a multiracial society: the two major races in Fiji are the indigenous Fijians (those of Melanesian origin) and the Indians (those of Indian origin). The 1996 Census of Population and Housing in Fiji stated that the population was 775,077 (Bureau of Statistics 1998b). The 1996 census showed that the Fijian population make up 51.1 per cent of the total population and the Indian proportion was 43.6 per cent. Other ethnic groups mainly comprise of other Pacific Islanders, Part-Europeans, and Chinese. The annual growth rate between the 1986 and 1996 censuses was 0.8 per cent (Ministry of Information 2001).

During the early colonial era, in 1879, the first group of Indians were brought into Fiji as indentured labourers to work in the sugar cane plantations. By 1946 the Indian population had attained numerical superiority over the indigenous Fijian people (Bureau of Statistics 1976). This has contributed to the political instability in the country since 1970. Fijian leaders were threatened by the idea that Indian leaders could take political power over the indigenous population and that the Indians could rule the country (Chung 1991).

Indian fertility declined long before Fijian fertility and it is still much lower than the Fijian fertility. In the 1930s and early 1940s Indian fertility was higher than that of the Fijians, but by the mid-1950s it had begun to decline. Fijian fertility declined after 1970. The differences between the total Fijian and Indian populations widened between 1944 and 1976; however, by the time of the 1986 census, the much faster growing Fijian population had almost caught

up with the Indian population (Bureau of Statistics 1989; Naroba 1990; Seniloli 1992). This was partly due to rapid fertility decline amongst the Indians and partly to out- migration of Indians. The Fijian population surpassed the Indian population in 1988. The major contributing factor was the 1987 political coup. One of the reasons for which was ethnic differences: it resulted in a sharp increase in the number of Indians emigrating (Kunabuli 1990). The 2000 coup resulted not only in a similar increase in out-migration of Indians but also in an increase in the out migration of skilled Fijian individuals.

The 1996 census showed that 46.4 percent of the total population resided in urban areas (Bureau of Statistics 1998a); This included 41.0 per cent of the Fijian population and 40.4 per cent of the ethnic Indians. More than 50 per cent of the total population were reported to be living in rural areas in the 1996 census. Fijians in rural areas mostly settle in village communities, while rural Indians were scattered across individual freehold plots or leased land. Fijians commonly live in extended family groups, which is a communal living style, while Indians tend to live in nuclear families (Chung 1991).

Urbanisation in Fiji has been rapid: The latest estimation from the Fiji Bureau of Statistics is that more than half of the total population are urban dwellers (*Daily Post* 2002). An estimated 22.5 per cent of the urban population are in the age group 15 to 24 years (*Daily Post* 2002). The two cities, Suva (the capital and main urban centre) and Lautoka as shown in Figure 2.2, and some towns are large, young and rapidly growing. Problems of urbanisation are clearly visible with a high crime rate, high unemployment, and increasing commercial sex workers (CSW) on the streets of Suva.

Fijians mostly move to the urban areas to look for jobs or for education. Most Indians move into the urban areas because there is uncertainty on the renewal of their leases. Land ownership in Fiji is through the village clan: all the members of the clan own the land and the it is subdivided to all the members to use for farming. The land is leased or rented out to outsiders for farming and other income generating avenues. Fijians lease land to Indians for sugar cane farming: farmers have moved to urban areas because their leases have expired.
Fiji overall has a relatively young population with about 53 per cent of the population age under 25 years of age (Secretariat of the Community 1999). The median age of the total

population is 21.2 years (Bureau of Statistics 1998a), but there is a difference in the median age of the two major ethnic groups: the Fijian population has a median of 20 years while the Indian population has a slightly older median age of 22.4 years. The difference reflects the high emigration of young Indians and the lower fertility of the Indian population as compared to the Fijian population.

The Fiji Bureau of Statistics (1998a) showed that the male population is 50.8 per cent of the total population. In 1996 the Fijian males made up over one-quater of the total population and the Indian males were over one fifth. The age distribution of the male population for the two main ethnic groups is given in Table 2.1. More than half of the male population are below the age of 25: the male population is a young population. The age distribution of the two major ethnic groups and total population is similar, but the Indians tend to have a slightly older population.

Table 2.1: Age distribution of male population by ethnicity, 1996 (%)

AGE (years)	ETHNICITY		
	Fijian	Indian	Total
under 15	38.6	32.9	35.8
15-19	10.4	11.6	10.9
20-24	8.5	8.9	8.7
25-29	7.6	8.1	7.9
30-34	7.4	8.6	7.8
35-39	6.6	8.0	7.2
40-44	5.1	6.3	5.7
45-49	4.3	5.1	4.7
50-54	3.4	3.9	3.6
55+	8.1	11.7	7.7
TOTAL[a]	50.7	43.6	100.00

Source: Fiji Bureau of Statistics: 1998a

Note: a: Other races are not included in the table therefore the two ethnic components do not add up to the total percentage.

The changing age structure, with a higher proportion of young adults entering the labour market, has resulted in a rising number of jobseekers. While more youth leave the formal education system, there are fewer jobs created to accommodate the increase in economically active population (UNICEF 1997); this has resulted in an increase in unemployment. In 1999 the unemployment rate was 7.6 per cent (Fiji Island Statistics Bureau 2003) and in 2000 the estimated unemployment rate was 12.1 per cent (Fiji Island Statistics Bureau 2003). The

latest statement by the Prime Minister was that the unemployment rate doubled in the last year, from 7 to 14 per cent. This has a great effect on adolescents and young adults, as a high proportion of those unemployed are the young.

2.4 POLITICAL STRUCTURE

Fiji became independent from Great Britain on 10 October 1970, following almost a century of colonial rule from Britain. Since colonisation there have been two political structures, the traditional political structure of the indigenous Fijians and the Western or modern governing structure introduced by the British government. The new system of government in Fiji was adopted from the British system with a bicameral parliament (Chandra 1990); the upper house is the Senate and the lower house is the House of Representatives. The House of Representatives members are elected by the public in a national election conducted every five years. This system has been in place in Fiji since the first constitution of independent Fiji in 1970.

The traditional political structure, although modified by the British, has three confederacies, the Kubuna, Burebasaga and Tovata confederacies, with each having one high chief paramount above all other chiefs in the confederacy. The three confederacies are made up of 14 provinces, and each province has a high chief, above all other chiefs in the province. Every province is divided into *tikina* and each *tikina* is made up of villages. Each village is made up of clans or *mataqali.* The above traditional political structure has cultural significance. The diversity of the Fijian traditional and cultural system begins at the *tikina* level.

The highest decision-making body of the Fijian political system is the Great Council of Chief. This is made up of all the high chiefs from the different confederacies with every province represented in the council. The Council has also had representatives in the Senate since the 1970 constitution. There is a paramount chief in every province and *tikina.* The village political structure has a village head or chief and every clan has a clan head, commonly the eldest male in the clan.

The Fijian political system is based on Fijian tradition and the Indians are not part of it except if elected to the modern democracy. The current political structure in Fiji is based on both the Western and the traditional political model. The House of Representatives consists of 70 members. Thirty-seven members of the House are elected from among persons registered on the roll of voters as Fijians; 27 members are elected from among persons who are registered on the roll of voters as Indians. One member of the House is elected from amongst persons who are registered on the roll of voters as Rotumans. Five members of the House are elected from among persons who are registered on the roll of voters who are neither Fijians, Indians nor Rotumans (General Electors Roll). The Senate consists of 34 members appointed by the President in accordance with Section 55 of the Fiji Constitution Of these 24 Fijians are appointed by the President on the advice of the Bose Levu Vakaturaga (Great Council of Chiefs), one Rotuman is appointed by the President on the advice of the Council of Rotuma. The President in his own deliberate judgement from the community appoints nine members of the Senate.

Since 1987, seventeen years after Independence, Fiji has experienced an unstable political environment. The country has had three political coups since 1987, each resulting in the overthrow of the government of the day. The first coup led by Sitiveni Rabuka took place in May 1987, and was followed by another involving the same coup leader in September the same year. The coup was the result of dissatisfaction about political leadership among indigenous Fijians. The military was the main body involved in the coup; about 90 per cent of the military force is made up of indigenous Fijian men. Young Fijian militant men were actively involved in the coup, ensuring that law and order was maintained and that the objectives of the coup were carried out. To the indigenous Fijians the military were seen as heroes, enabling the Fijians to regain political dominance in their homeland over the Indians.

The result was the adoption of a new constitution in 1992. This was not internationally accepted because it was seen as racially discriminating, favouring the indigenous Fijians. As a result of international opposition, a new constitution was adopted in 1997 (Ministry of Information 2001), only to result in the overthrowing of the government of the day in the May 2000 coup. International opposition included expulsion from the Commonwealth, later rejoined. The new constitution was not acceptable to many nationalistic indigenous leaders

and as a result a variety of mainstream male movements openly advocated the need to safeguard indigenous people. They argued that this was not clearly outlined in the 1997 constitution and demanded amendments to safeguard the interests of the indigenous population.

2.5 ECONOMIC STATUS

Indians are generally economically better off than indigenous Fijians. They control one of the mainstays of Fiji's economy, sugar, as they dominate sugar cane farming. The Indian community also dominates the commercial sector. Fijians, although they are the landowners, lease their land to Indian farmers, and get very little return from the land. The economic status of the two ethnic groups is indicated in Table 2.2 below, showing the labour force participation of the population age 15 and over from the two ethnic groups. Male participation in the monetary economy is high for Indian males compared to Fijian males. Table 2.2 shows that Indian females are less engaged in the labour force than Fijian females.

Fiji is still an agriculture-based economy with heavy reliance on a single crop, sugar cane. There was a significant change in the structure of the economy during the 1990s with the growth in the manufacturing sector as a share of the GDP while the share of agriculture, forestry and fisheries contracted. The garment and sugar industries have been the main contributors to growth in the manufacturing sector whilst tourism was the main contributor in the wholesale and retail sector. Sugar continues to be a major exports commodity, accounting for around 21 per cent of total exports in the period 1998-2001 (Fiji Government 2002). The May 2000 crisis resulted in the plummeting of tourist arrivals from over 400,000 in 1999 to 249,000 in 2000 but the industry recovered in 2001 with a total visitor arrival of 348,000 (Fiji Government 2002). The political uncertainty contributes to substantial fluctuations in earnings from tourism and sugar, and to the emigration of skilled workers.

Compared to Indians, who are mostly wage earners and living on cash-crop farming, Fijian males are more likely to be subsistence farmers or unemployed. This is a source of envy and displacement for the Fijians. The actual and perceived economic disparity between indigenous and other communities has been a cause of concern in Fiji.

Table 2.2: Labor force participation of Fijians and Indians in Fiji, by sex, 1996.

Type of activity	Fijian		Indian	
	Male	Female	Male	Female
Money economy	58.0	23.7	75.0	17.5
Subsistence	16.4	21.7	2.5	8.6
Unemployed	4.6	3.5	2.9	2.6
Not in labour force	21.1	51.1	19.5	71.3

Source: Bureau of Statistics, 1998a.

Fiji's economic problems began in the 1980s after the introduction of structural adjustment policies. The two political coups in 1987 and 2000 damaged the growth potential of the struggling economy. Political instability and the reform process have not improved the economy.

2.6 EDUCATION

Fiji's population is well educated with almost universal excess to primary and secondary education. About one-quarter of the entire population is of school-going age; primary and lower secondary education is free but not compulsory. The 1996 census recorded that 98 per cent of children between 6 and 14 years of age are attending school. However the increasing dropout rate among Fijians is a great concern.

There is also a high degree of community participation in the delivery of education services. This strengthens the system that needs to be maintained, including religion and community organizations; local communities and organizations operate most schools, with assistance from the government. The Ministry of Education operates only 2 per cent of the primary schools, 8 per cent of secondary schools, 7 per cent of vocational and technical education schools, and two of the four teacher training colleges (Ministry of Information 2001).

Fijian education has been a government concern for the last two decades. Fijian children make up the largest proportion of school dropouts; many children are compelled to leave at the completion of class 8 because they fail in the secondary entrance examinations, or they do not proceed to secondary level mainly because of the cost (UNICEF 1997). To improve the academic achievement of ethnic Fijians, the government has provided more scholarships and better education facilities. Those who drop out may still have opportunities for a good living if they live in rural areas and have access to land, but a growing proportion do not, particularly in towns, for inadequate education is a contributing factor in unemployment, poverty, and crime.

2.7 RELIGION

Religion and rituals have always been crucial in the Pacific and Fiji is no exception. The local religious beliefs and practices underlie conversions to Christianity. Christianity and Hinduism are the two major religions in Fiji: indigenous Fijians are mostly Christians while Indians are largely Hindus and Muslims. The 1996 census recorded that 58 per cent of the Fiji's total population were Christians, and 99 per cent of the Fijian population are Christians, making up 87 per cent of the total Christian population. Indians are predominantly Hindus, making up 34 per cent of the total population, and Muslims, making up 7 per cent (Bureau of Statistics 1998b). Among Christians, Methodists constitute the largest group, 32 per cent of the total national population and 66.5 per cent of the total Fijian population. There is a high degree of religiosity in Fiji amongst both groups. There is an overwhelming religious tolerance and good will in Fiji, both among sects and within religions and among the different religious groups.

As the first Christian church to be established in Fiji in the middle 1830s, Methodism has been regarded as the *lotu ni noda qase*, 'the religion of our ancestors'. Methodism is almost completely identified with indigenous tradition; this gives it a strong sense of historical connection with indigenous culture and moral values. Catholicism, the second largest of the Christian denominations does not have the same degree of connection with culture, but it uses Fijian traditional symbolism and values extensively in its worship practices and doctrines.

2.8 REPRODUCTIVE CULTURAL AND SOCIAL ROLES

The cultural and social roles of Fijian men differ according to their province of origin. In the western and central division, women are expected to do most of the work for the family including the gathering of food and gardening (Burns 1963; Ravuvu 1983), while in the eastern division, particularly in the Lau province women are protected from physically strenuous work (Thompson 1940; Sahlins 1962). In the Lau group a married woman's responsibility is to look after the children and prepare the food for the family while men go out and gather the food and firewood. In other parts of Fiji women gather food and do farm labour, and at the same time must look after the welfare of the family (Sahlins 1962; Ravuvu 1983; Seniloli 1992; Veramo 1995; UNICEF 1997). However, owing to intermarriage between people of different provinces, these differences are disappearing.

Men are regarded as the main decision-makers in most Fijian communities; they head the households and the villages. In a Fijian family, fathers spent little time in the house because

social, communal, and religious expectations take higher priority than family tasks and obligations. Men usually spend the whole day on the farm and the evening drinking *yaqona,* kava (Veramo 1995). They only come to know of their children's behaviour by speaking to their wives. Fathers are the decision-makers in the family and culturally expected to discipline both their children and their wives (Emberson-Bain and Slatter 1995; UNICEF 1997; Cederbaum 1998; Price 2002).

During adolescence Fijian males are greatly influenced by their peer group (UNICEF 1997; Michaels and Giami 1999; Kaitani 2000; Nzioka 2001). The peer groups encourage sexual virility and see it as important. Among the peer groups, stories of negative yet sensational behaviour, which often appeal to those who feel they may be missing out on something, are exchanged, and stories of sexual conquests are swapped. The result is that Fijian youths have the desire for fantasy to turn to reality. This contributes to the high incidence of clandestine premarital relationships in the Fijian community. Smoking and drinking alcohol are taken for granted among young men and only those who are immature have never tried these temptations. Parents often reduce control over children at late adolescence, when peer group influence is at its peak, so there is impetus and scope for experimentation.

Gender roles in the Fijian community are clearly defined by traditional and cultural norms and expectations of the society. Men are the heads of the family and as in most other cultures, the decision makers. Women are expected to do the domestic duties for the family and to look after the children. Gender roles are further discussed in Chapter 5.

2.9 REPRODUCTIVE AND SEXUAL HEALTH BEHAVIOUR

Reproductive health behaviour includes use of family planning, and treatment and prevention of STI, and infertility. Reproductive health implies that all people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when, and how often to do so (UNFPA 1995). The government, through the Ministry of Health, addresses issues of reproductive health in Fiji.

2.9.1 Fertility

There is a striking contrast between the Fijian and Indian patterns of fertility. Table 2.3 shows the fertility trends of the two ethnic groups between 1956 and 1996. The Fijian total fertility rate (TFR) increased between 1956 and 1966, but in 1976 TFR had declined. A similar but more pronounced decline occurred in the fertility rate of the Indian population, with a slight

decline between 1956 and 1966 and a rapid decline after 1976. The fertility rate for Indians has now declined to almost replacement level.

Table 2.3: Total Fertility Rate by Ethnic Groups, 1956-1996

Years	Ethnicity		
	Fijian	Indian	Total
1956	4.60	6.20	-----
1966	5.58	5.51	5.48
1976	4.26	3.47	4.10
1986	4.19	2.94	3.51
1996	3.90	2.45	3.26

Sources: - 1956-1976, Naroba, 1990
- 1986-1996, Fiji Bureau of Statistics, 1998a.

The profound decline in among the Indians between 1956 and 1976 has been attributed to their quick acceptance of contraception, increase in the age at first marriage among Indian women, and improved levels of education (Bureau of Statistics 1976; Naroba 1990). The Fijian and Indian populations have different fertility levels and patterns caused by the difference in cultural and social behaviour and the changes in behaviour over time.

In Fiji it is assumed that exposure to child bearing commences at the time of entry into a more stable sexual union, and marriage has a direct bearing on reproductive performance. From1966 a shift towards later marriage was observed among the Indians while Fijians already tended to marry at a later age. The shift to later age at first marriage contributes to the reduced fertility, since exposure to childbearing has a direct association with marriage.

Family planning in Fiji was very effective in reducing fertility over the past four decades ((Hull and Hull 1973; Bureau of Statistics 1976; Bavadra and Kierski 1980; Gubhaju and Navunisaravi 1990; Laquian and Naroba 1990; Seniloli 1990; Seniloli 1992; Seniloli 1996; Bureau of Statistics 1998a). In the 1970s sharp disparities existed in the contraceptive use of the two major ethnic groups in Fiji (Bureau of Statistics 1976; Laquian and Naroba 1990; Seniloli 1990). Seniloli (1996) observed that the impact of family planning on fertility has been far less in the indigenous population than among the Indians. The greater use of family planning services by Indian women results from the encouragement and support they receive from their partners to use modern contraception (Seniloli 1992).

Traditionally, the fertility of Fijian women was limited by many cultural practices including the tendency to marry (after the age of 20), and a long period of sexual abstinence during pregnancy (4-6 months) and after childbirth (10 months) while the mother is breast-feeding. However with modernisation, Fijian women today have higher fertility than Indian women because of a shorter period of breastfeeding, and a shorter period of postpartum abstinence, an average of three months (Bureau of Statistics 1976).

The fertility differences noted above are ascribed to ethnicity, which is effectively a proxy for socio-cultural and economic differences. The cultural differences and the differences in economic status and education attainment of the two ethnic groups are well distinguished. In general Indians are economically better off better educated than Fijians. The socio-cultural and economic differences between the two ethnic groups have major implications for family planning, and contraceptive use in Fiji.

2.10 FAMILY PLANNING IN FIJI

Voluntary fertility regulation became socially and officially accepted in Fiji in the early 1960s. In the 1960s and early 1970s the family planning program in Fiji was described as one of the most successful in developing countries (Bavadra and Kierski 1980; Laquian and Naroba 1990). After four decades of family planning in Fiji, there has been little narrowing of ethnic differentials in patterns of contraceptive use. The long plateau in the trend of family planning protection rate by ethnic Fijians suggests their apathy and resistance to modern methods of contraception (Seniloli 1990). Fiji Indians on the other hand increased their use of modern of contraceptives (Roizen et al. 1992). This was clearly reflected in the declining TFR of the two ethnic groups since 1966, with their rates of decrease in TFR differing greatly. It must also be noted that male participation in family planning in Fiji is largely limited to condom use, with some small acceptance of vasectomy, and a small proportion using the rhythm and withdrawal methods.

The Fiji Fertility Survey of 1974 showed that knowledge of some form of contraception was nearly universal among women in Fiji (Bureau of Statistics 1976). However family planning was not popular among ethnic Fijians, and there was a lack of acceptance of contraceptive use among ethnic Fijians compared to Indians. Bavadra and Kierski (1980) stated three reasons: a belief that land was still abundant, the fear of political dominance by Indians, and a fear amongst ethnic Fijian men that their wives would have extramarital relationships.

In 1974 Indians reported a much higher use of condoms than Fijians (Bureau of Statistics 1976). Cleland (1975) also observed this difference in the 1973 Suva survey. The 1986 Ministry of Health data indicated that there were sharp ethnic differences in the use of condoms for contraception, with use most common among ethnic Indians. Seniloli (1996) in a study on the reproductive health of women, found that less than 10 per cent of Fijian women in the survey indicated that their husbands had used condoms, compared with 22 per cent of Indian wives.

Laquian and Naroba (1990) stated that the socio-economic differences between Fijian and Indians had major implications for family planning use, which studies had shown was related to higher income, higher education, and greater exposure to media, gainful employment of women, urban residence, and greater access to modern medical services. In Fiji, Indians generally exhibit these socio-economic characteristics, and Fijians do not.

The Family Planning Unit in Fiji was established in 1962; one of its objectives was to promote the use of male contraceptives. This objective, put into practice by distributing free condoms (Hull and Hull 1973), was not a great success, as women were still the main focus in family planning program. Clift (1997) stated that traditional family planning programs and reproductive health services neglected the potential role that men can play in contributing to their family's well being. However, the promotion of male involvement, male responsibility, and men's participation in reproductive health gained ground in the 1990s. As family planning services have usually been available only at the Maternal and Child Health (MCH) clinics, this presents a barrier for men to use the clinic (Seniloli 1990). Since it is generally assumed that the MHC clinic is for women and children only. A similar finding in Bangladesh showed that the exclusive focus on maternal and child health has led to the total exclusion of men as recipients of reproductive health care (Hawkes 1998).

Sex and sexual health are sensitive issues in Fiji. These topics are traditionally not acceptable for discussion and it is against the culture of the two ethnic societies to have open discussions about such things. Secondly, most service providers are women and discussion of issues of reproductive health between the sexes is culturally taboo for both ethnic groups (Laquian and Naroba 1990), making it difficult for men to discuss the issues with any woman, regardless of their status in society. However with the increased awareness of AIDS, men and women in Fiji

are becoming more aware to the myths and barriers of sex education, and are focusing on the importance of sexual health. Studies have indicated that with the increased awareness of AIDS, sexual health has become an important focus of health education (Shephard 1996; Lee 1999; Moore 1999).

Social and cultural expectations are important in determining how gender roles in the society influence sexual behaviour. Shepard (1996) stated that the traditional cultural model of men in most societies is transmitted by parents and peers to make males eschew outward signs of weakness, drink alcoholic beverages together, seek sexual experience, and engage in instinctive, uncontrollable, and aggressive sex behaviour. Men who openly challenge traditional male roles risk the social marginalisation that follows being suspected of homosexuality.

Men are the main decision-makers in most societies. Studies have indicated that men often make decisions that are crucial to women's reproductive health (Abrams et al. 1990; Drennan 1998; AVSC International 1998; Robey et al. 1998). Bavadra and Kierski (1980) supported this statement, claiming that Fijian men as the decision-makers were reluctant to accept family planning. However a study by Seniloli (1992) showed that Fijian men have a positive view of the use of contraception when they realise the economic cost of having children. Indian men also generally have positive views of family planning; at times however, they have negative attitudes but are influenced by their parents and older extended family members to support their wives in contraceptive use. Seniloli (1992) noted that Fijian and Indian men in the study had different reasons for their positive and negative views of family planning. Most Fijian men associate the use of contraceptives with health problems while for Indian husbands the cost of having large families override all other factors including the negative effects of contraceptives.

Family planning has been in effect in Fiji for more than four decades. It was not until the early 1960s that voluntary fertility regulation became socially and officially accepted in society. One of the major reasons behind the social and official acceptance was the recommendation from the Burns Commission that contraceptives must be freely available to married women and that the government should provide the service (Hull and Hull 1973).

Since the early 1960s the Ministry of Health has been responsible for providing family planning services. The Maternal and Child Health (MCH) clinic in the Ministry of Health

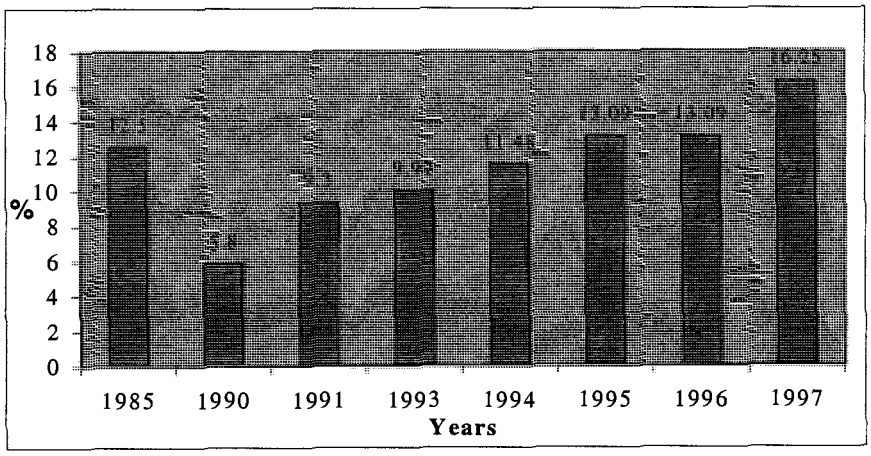
addresses family planning needs in Fiji. The services provided through the family planning service today have expanded from offering free contraceptives and counselling for women to including counselling for both partners and giving free contraceptives to men. However the community perception that the MCH clinic is for women and children only has resulted in a very low proportion of men using the service.

Apart from the free contraceptives available at the hospitals, health clinics, reproductive health clinics and other sections of the Ministry of Health, some contraceptive methods are also available from the retail shops and from NGOs including the AIDs Task Force, and the Reproductive and Family Health Association of Fiji (RFHAF).

2.10.1 Condom Use.

Condom use in Fiji is not very common. However, because of its association with the prevention of AIDS, the proportion of users as a percentage of Family Planning Acceptors is increasing. Figure 2.3 shows the increase in proportion of Family Planning Acceptors using condoms since 1990. Condom uses in most of these cases is referred to as a contraceptive method and not as safe sex preventive method against STIs.

Figure 2.3: Percentage of Family Planning Acceptors using Condoms, 1985 – 1997



Source: Ministry of Health Annual Tabulation 1997.

Data on condom users are not readily available because condoms can be obtained from many different sources. It is only the condoms that are obtained from family planning clinics that are accounted for by the government, while those bought from the commercial centres are not accounted for, so the proportion of reported acceptors or users is lower than that of actual users. This is a clear indication of under-reporting of condom use, but it is difficult to obtain

data on commercially bought condoms. The proportion of users, as reported by the MOH, decreased between 1985 and 1990, it has increased ever since, but unprotected sex is common in Fiji. A Ministry of Health survey conducted in 1989 found that less than 10 per cent of men in Fiji had protected sex (Barr 1995). A survey of men as partners in reproductive behaviour in 2000 noted that many men in Fiji still do not appreciate the condom as a family planning method (Price 2002).

2.11 SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted diseases are usually caused by sexual contact such as coitus. It is also possible for some STIs to be transmitted through other routes such as blood transfusion. Although most STIs have been curable by appropriate chemotherapeutic agents for over forty years they have continued to be a public health problem.

One of the major problems in Fiji today is the increasing incidence of STI, which like HIV results from unprotected sexual intercourse. A survey on re-infected patients at the Suva STI clinic noted that 88 per cent of the individuals knew that condoms prevent STI but only 5 per cent used condoms in their last sexual encounter (Hotchin et al. 1995). This indicates that although there is adequate knowledge of the preventive measures, this has little effect on the subsequent behaviour of the individual as although more than 80 per cent of the young men new that using condoms prevents STI infection less than 10 percent were using condoms at the time of the survey.

Incidence of STIs has long been recorded in Fiji, since the early colonial era in the late nineteenth century. Today the Ministry of Health has a unit that addresses STIs; till the early 1990s the clinic for the unit was called the STI clinic. In the mid-1990s the name was changed to the Reproductive Health Unit; included in it is a special counselling program for those who visit the unit for treatment and advice. This is a more 'user-friendlier' name and does not restrict the clinic to those needing treatment for STIs.

Table 2.4 shows that the two most commonly reported STIs in Fiji between 1993 and 1997 were gonorrhoea and syphilis. The very high percentage of infections reported by ethnic Fijians is clearly shown: 93 per cent of the cases of gonorrhoea reported in 1993 were Fijian, while in 1997 this declined to 89 per cent. Of the total cases of syphilis reported in 1993, 88 per cent were Fijians and in 1997 this had increased to 93 per cent. However it must be noted

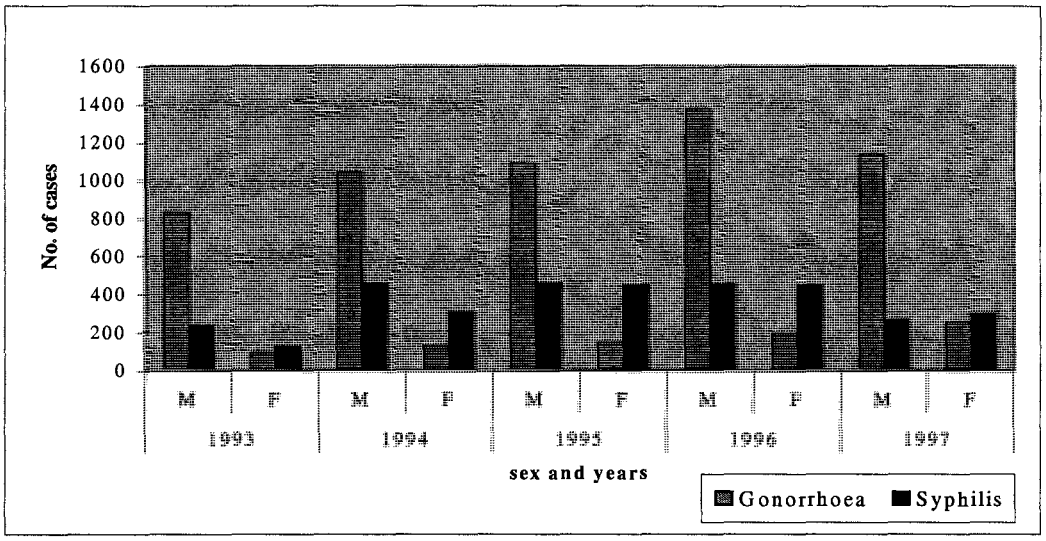
that these exclude cases reported to private doctors and those treated using traditional medicines. Indians are known to make better use of private doctors than do Fijians, and for a sensitive and confidential matter like STIs, Indians mostly prefer private doctors to public hospitals and health clinics, where sustaining the confidentiality of such matters is almost impossible. There are other services not reported so this is a clear indication of under-reporting of the incidence of STIs in Fiji, as these are only the cases reported to the Ministry of Health.

Table 2.4: Incidence of Infection with Gonorrhoea and Syphilis in Fiji, 1993-1997, by Ethnicity (Percentages)

	1993		1994		1995		1996		1997	
	Gon.[a]	Syp.[b]	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.
Fijian	93.4	87.7	92.7	93.7	88.0	92.5	87.5	91.7	88.7	93.0
Indian	3.5	7.0	5.3	3.0	8.5	4.6	9.2	5.3	7.7	3.8
Others	3.1	5.3	2.0	3.3	3.6	2.9	3.3	2.9	3.4	3.2
Total	100	100	100	100	100	100	100	100	100	100

Source: Ministry of Health Annual Tabulation 1997.
Note: a – Gonorrhoea, b - Syphilis

Figure 2.4: Incidence of Infection of Gonorrhoea and Syphilis in Fiji, 1993-1997 by Sex



Source: Ministry of Health Annual Tabulation 1997.

As shown in Figure 2.4 the reported incidence of male infections was much higher than that of female infections; this could indicate under-reporting of the incidence of STI among females. Ninety per cent of reported infections were to males, and this was reduced to 82 per cent in 1997. This has been the trend since 1993. Reported cases were mostly males because the symptoms are physically visible after a short period of being infected and so they go for

treatment while for women the symptoms become visible after a longer time span. These infected male do not inform their partners and encourage them to go for check up.

Table 2.5: Incidence of Infection of Gonorrhea and Syphilis in Fiji, 1993-1997, by Age (percentage)

AGE	1993		1994		1995		1996		1997	
	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.	Gon.	Syp.
<15	0	0	0.3	0.8	0.2	2.4	0.6	2.7	0.5	5.2
15-19	20.0	15.0	17.3	11.6	17.2	10.9	17.2	9.24	15.0	5.0
20-24	35.1	36.0	38.3	34.0	44.5	34.1	40.8	32.6	39.1	29.7
25-29	23.6	24	16.7	27.1	21.7	24.1	21.5	25.9	22.6	23.8
30-34	11.8	14.0	5.4	14.2	8.2	10.0	8.8	11.2	10.3	18.1
35-39	5.7	5.1	1.4	4.5	2.8	5.3	3.8	6.7	4.7	6.3
40-44	1.8	2.0	1.0	1.7	0.5	2.3	1.1	1.8	1.2	2.5
45-49	0.2	2.0	0.4	0.6	0.1	1.6	0.4	2.2	0.5	1.6
50+	0.3	1.4	0.5	1.3	0.2	2.7	0.3	3.5	0.4	2.9
NS	1.5	1.1	18.7	4.2	4.6	6.6	5.6	4.1	5.6	4.8
Total	100	100	100.	100	100	100	100	100	100	100

Source: Ministry of Health Annual Tabulation 1997.
NS: Not Stated

Table 2.5 shows that between 1993 and 1997 most of the cases of both gonorrhoea and those reported syphilis were between the ages of 15 and 29 years. Men are at high risk of being infected with STIs, as the reported incidence of female infections in Fiji is very low. There is little tracing of the partners of the infected male reporting the incidence of STI infections. More than 50 per cent of the reported cases of both gonorrhoea and syphilis between 1993 and 1997 were to those aged 20-29.

2.12 HIV/AIDS

Officially reported cases of HIV/AIDS in Fiji have increased from four in 1989 to 111 in December 2002; first case was reported in 1988. In August 2003 there were 119 reported cases, a rise of 18 cases since December 2002. The escalation in HIV/AIDS in the last 14 years has strengthened the need to implement preventive and control strategies; in the 2003 budget the government allocated funds for a preventive program (Fiji Government 2003).

The spread of the HIV virus in Fiji has not been limited to any particular group of people, but certain people have so far suffered more. The most common mode of infection is through heterosexual intercourse. Those infected with and affected by the virus have mostly been from groups that, before HIV arrived, were already marginalised and discriminated against: - the poor, women, homosexual men, and prostitutes. In Fiji, those who are infected are likely to

have their rights as human beings, violated simply because they carry the virus. Their right to privacy is denied by their HIV status being made public knowledge without their consent.

While Fiji seems to have been relatively unaffected by HIV/AIDS, with 119 reported cases of HIV to date, the actual number is possibly many times higher, and the country remains vulnerable to HIV for a number of reasons. Until recently, both the public and the government of Fiji have seen HIV almost purely as a health issue, and the discussion about HIV and ways in which to combat the virus has developed from this narrow view.

It was not till 1997, in Fiji's five years development strategies that HIV/AIDS was referred to as a development issue (Ministry of Planning 1997). The Ministry of Health is the government department responsible for AIDS-related matters in Fiji: the AIDS Task Force of Fiji, as a part of the Ministry of Health, was set up in 1996. With the help of UNDP, UNFPA, UNAIDS, WHO, SPC, and other organisations, the newly formed AIDS Task Force has tried to extending the public's awareness of HIV/AIDS through the media, visiting schools, talking to different interest groups and the use of pamphlets and posters.

AIDS is a growing concern and a vigorous campaign is being undertaken in association with NGOs in Fiji. An intensive education program has been mounted to prevent sexually transmitted diseases, through the promotion of safe sex and by increasing public awareness. A medium term plan funded by WHO is currently being implemented to prevent the spread of HIV infection. A survey of 50 homosexual men in the capital city, Suva, showed that despite greater awareness about how AIDS is transmitted and easy access to condoms, a significant number continue to practise unprotected sex (Waqa 1998). This means that knowledge does not necessarily link to behaviour, so other approaches must be made to help change this behaviour. The government, NGOs, international agencies, and community leaders could work together as several social, cultural and economic factors make Fiji communities vulnerable to contracting the virus. It must be made known to the nation that AIDS is not only a threat to life but to the development prospects of the nation.

2.13 SUMMARY

Democratic rule since Independence was interrupted by two military coups in 1987 caused by the concern of the indigenous community about of a government perceived as dominated by the Indian community. A 1990 constitution favouring the indigenous Fijians led to heavy

emigration of the Indian population. The population loss resulted in economic difficulty but ensured that the Melanesians became the majority. The constitutional amendments enacted in 1997 made the constitution more equitable, resulting in the election of a new government in 1999, with a government led by an Indian; but the coup in May 2000 ushered in a prolonged period of political turmoil. An election in August 2001 resulted in the formation of a Fijian dominated government.

It is clear that reproductive health behaviour in Fiji has changed over time. The decline in the fertility rate is attributed to the increase in contraceptive use in Fiji. There is however also an increase in reported cases of STIs. This indicates that unsafe sex and risk behaviour are two of the major issue of reproductive health in Fiji. More young men than women were reported to have STIs. Therefore it is important to educate young men on safe sex and to identify the factors that influence their reproductive and sexual behaviour. Though identifying the factors that influence behaviour, programs can by formulated and implemented to improve young men's reproductive and sexual behaviour.

CHAPTER 3

GLOBAL PERSPECTIVE

3.1 INTRODUCTION

Male participation is important in addressing reproductive health. Catley-Carlson (1998) argued that reproductive health should include all those aspects of behaviour that could affect men's ability to engage in a healthy and enjoyable sexual relationship, with or without the intention of procreation. Men must ensure that a woman carries out a pregnancy to term and gives birth in good health, both for the mother and the child.

Only in the last two decades have men have been included as an important element of Reproductive Health programmes. The 1994 International Conference on Population Development (ICPD) recognised the importance of men and stressed the need for men to be more aware of matters relating to their reproductive health behaviour.

> "Special effort should be made to emphasize men's shared responsibility and promote their active involvement in reproductive behaviour..... Male responsibilities in family life must be included in the education of children from the earliest ages (UN 1995).

At the dawn of the new century, adolescent sexuality remains a topic of concern to adults throughout the world. Male involvement in reproductive and sexual health starts with adolescence. This is in recognition of the evidence-based fact that men begin their sexual experimentation early (Kraft et al. 1990; Rosenthal et al. 1999) and with insufficient information to protect either themselves or their partners (Ip et al. 2001). In studying reproductive health it is important to be gender-specific rather than generalising across both parties. Both partners should be encouraged to make joint decision-making on reproductive behaviour. Efforts to reach male (and female) youths[1] should begin at an early age, ideally before or at the beginning of their sexual activities.

The acknowledgement of men's role in fertility and family planning has expanded rapidly since the early 1990s (Becker 1996). Greene and Biddlecom (2000) outlined pressure from feminists to recognise men's responsibilities in child-rearing, second the failure to explain

1. Adolescents, youths, and young men are used interchangeably in this thesis. They address the same group, that is, those aged 15-24.

why changing fertility patterns do not follow the classic demographic transition theory of fertility, and third the central role men play in preventing STDs and HIV/AIDS. Webb (Webb 2000) observed that in Zambia men appear to be a more vulnerable group that needing attention in reproductive and sexual health policies, that is, male reproductive health is important in its own right.

This chapter presents an overview of studies of adolescent male reproductive and sexual behaviour. Some literatures looking at both males and females as a group are also referenced in this thesis. It was earlier discussed that it is important to observe sexual behaviour on a gender basis, as the two groups (adolescent males and females) have distinct behaviours that need to be understood in contrasting one to the other. In the literature review I focus particularly on young men's reproductive and sexual behaviour. The review covers both theoretical and empirical studies published between 1990 and 2003[2]. Studies published before 1990 are also cited in this chapter, this is to substantiate some of the arguments put forward in the review and to give an historical perspective.

The chapter is divided into seven sections. The first section discussed the shift in focus on reproductive and sexual health in the last three decades, from the 1970s to the new millennium. The second gives an overview of young men's knowledge and attitude to reproductive and sexual behaviour. To understand the type of knowledge that young men received, one must also identify the source of information. This is also discussed in part two. The third section discusses their reproductive and sexual behaviour of young men including family planning, sexual initiation and the reproductive and sexual behaviour of young men. The fourth, examines reproductive health behaviour focusing on family planning and safe sex. The fifth gives an overview of young men's sexual risk behaviours including casual sex and having multiple partners. The sixth discusses reproductive and sexual health issues including STI and teenage pregnancies. The final section discussed the obstacles to policies on reproductive and sexual health.

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2. The studies surveyed adolescent samples of different sizes and age groups. Adolescents interviewed were between aged 12-24. Some studies focused on those aged 15-19, other 12-19 or 15-24. Some include both males and females. Some observed a small community while others researched at the national level.

3.2 REPRODUCTIVE HEALTH FOCUS: FROM FEMALES TO MALES

Comparatively little is known about the reproductive health behaviour of men because reproductive health services have mainly focused on women. In order to understand the reproductive and sexual behaviour of men one must also observe the behaviours and concerns of women. Unfortunately most researches on women focussed on reproductive outcomes because demographers were interested in fertility levels rather than the reproductive behaviours shaping these outcomes. Greene and Biddlecom (2000) highlight this view stating that the focus on women derives from women's primacy in fertility and contraceptive use.

It could be argued that a focus on reproductive outcome is essential even when you are concerned about male health issues. Demographic transition theory explained the decline in fertility in terms of socio-economic and cultural factors (Kirk 1996). Notestine emphasised the importance of the changes in social institutions as factors producing fertility decline, while giving less attention to "cultural" change (Lucas 1994). Lesthaeghe (1983) and Caldwell (1976) however provided strong evidence for the importance of cultural modification in shaping behaviour. Bulatao and Lee (1983) followed Easterlin in describing the integrated force of economic and sociological theories of fertility. In all these elaboration of classical transition theory the reproductive health behaviours of women were of prime focus of attention with little consideration on the way changing male roles were central to the institutional, social, cultural and economic changes that were seen to reshape the process of reproduction.

Davis and Blake (1957) suggested that the process of reproduction involved three steps. These steps are, first intercourse, secondly conception, and finally gestation and parturition determined fertility levels. They identified eleven intermediate variables that are influenced by cultural and socio-economic factors to shape fertility. The factors that reflect the reproductive and sexual behaviour of men include:

1 Age at first marriage. It assumed that coitus is a function of marriage.

2 The exposure to intercourse outside marriage such as pre-marital and extra-marital affairs.

3 The frequency of intercourse and abstinence, such as postpartum abstinence.

4 Spousal separation, this could be voluntary or involuntary.

5 The use of contraception.

6 Infertility.

The Davis and Blake (1957) framework was open to consideration of both male and female behaviours unlike the later Bongaarts (1982) approach which centred fertility framework on intermediate variables defined in terms of the impact of women's behaviour and situation.

However little research has been done on reproductive health related behaviours of men, except in the ways male participation in family planning[3] and transmission of sexually transmitted diseases[4] may affect their female partners. The reproductive and sexual health needs of men began to receive some attention in the early 1980s. The 1981 International Conference on Family Planning held in Jakarta, Indonesia, affirmed that men have the same reproductive rights as women. In a review of the writings on reproductive and sexual behaviour prior to ICPD Dixon-Muller (1993) stated that the literature placed emphasis on adolescent girls but little attention to young adult males. There is now an increasing interest in men's view on their reproductive functions and sexual lives. Most work in the last decade consider the role man play and their influence on women's reproductive decisions, their attitudes about sexual and reproductive health, and their knowledge of their own and their partner's reproductive system (International 1998). Shepard (1996) noted that some studies analyse men's participation and responsibility in reproductive health including family planning and sexual health, while others present an update on men's involvement in reproductive health

In the 1970s the global interest in reproductive and sexual health was focussed on family planning. Controlling fertility was the emphasis of the day and women were the main focus of interest in the seventies. Family planning and contraceptive methods were introduced and were focus on women. It was assumed that by targeting women's reproductive and sexual behaviour, fertility levels could be reduced. Family planning NGOs were established. This coincided with the baby boom period reinforcing the need to reduce fertility. The reproductive behaviour of women was the focus of study to academics and policy makers.

The 1980s however brought a new perspective to reproductive and sexual health with a growing attention to gender issues. It was argued that to be successful in population control nations must promote gender equality and equity.

The concept of gender equality and equity is focused on women's status in society, as many culture and social hierarchies perceive women to be inferior or of a lower status than men. To ensure that responsibilities are shared and that there is not gender discrimination advocates of gender equality and gender equity lobbied for women's status in society to be improved as it will improve the reproductive and sexual health of women.

In the 1990s the primary focus of debate on reproductive and sexual health centred on the moral quagmire of adolescent behaviour. The concerns centred on the need to control teenage pregnancy and STI. With the introduction of HIV/AIDS in the late 1980s, the problem of not finding a cure to HIV, and the reasons stated earlier by Greene and Biddlecom (2000), the focus by the beginning of the new century changed to male involvement in reproductive and sexual health. Men are observed as risk takers and the best way to prevent HIV infection, apart from abstinence, is to use a condom during coitus. As use of the female condom is not universal, the two reasons above and men being an important individual in decision making on contraceptive use, the twenty first century sees men as the new focus on reproductive and sexual health.

Men deserve more attention in reproductive health care for their own sake, for women's sake and for the health of their families and communities. From this perspective, men are potential partners in and advocates for good reproductive health rather than bystanders, barriers, or adversaries. Reproductive health care providers customarily pay little attention to men except for the diagnosis and treatment of STDs (Greene et al. 1995; Tambi 1996). This is also the case in Fiji, where the Family Planning Unit emphasises the importance of contraceptive use by women, while Reproductive Health Unit address the problems of STIs and has a high proportion of Fijian male clients. In summary male involvement is an important element of reproductive health.

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3. Male participation in family planning is discussed in the later part of this chapter.
4. Sexually transmitted disease is discussed in the later part of the chapter.

3.3 KNOWLEDGE AND ATTITUDE

Knowledge and attitude are important in determining the behaviour of an individual. Many studies have been conducted on the reproductive and sexual behaviour knowledge, attitude, and practices (Schofield 1965; Hunt 1974; Oswald and Pforr 1992; Kang and Zador 1993; Moore and Rosenthal 1993; Johnson et al. 1994; Klanger et al. 1994; Leigh et al. 1994; Welling et al. 1994; Hotchin et al. 1995; Utomo 1997; Matasha et al. 1998; Kaitani 2000; Kapamadzija et al. 2000; Ip et al. 2001). Most of these studies noted that sexual attitudes and practice contradict, that is although most individuals disapprove of premarital sex a large proportion of unmarried people are involved in sexual relationships. Some of the factors that influence knowledge of reproductive and sexual behaviour are education qualification; area of residence; parent's education; religion; and the social environment an individual is brought up in.

This section of the literature review is a background of the analysis contained in Chapters Six and Seven. Chapter six examines and discuss the findings on young men's knowledge of reproductive and sexual health behaviours. Chapter Seven examined young men's attitude to reproductive and sexual health. The literature discusses findings from other countries on knowledge and attitude to reproductive and sexual health. This could be compared to the finding of the current research.

3.3.1 Source of Information

The source of information of sexual knowledge is an important tool in promoting reproductive health. Some studies have identified different sources of information on reproductive and sexual health behaviours. The different or potential sources of information stated in previous studies include information obtained from peer group members (Kinsman et al. 1998; Rosenthal et al. 1999), the parents (Gordon and Synder 1986; Taris and Semin 1996), the formal education system or schooling, other kin, and mass media (Muller and Powers 1990; Hassan and Creatsas 2000; Kapamadzija et al. 2000; Meekers and Ahmed 2000). Other less direct influences include religion, legal system, and cultural traditions (Dowsett and Aggleton 1999).

Among adolescent males, mass media and peer communication are noted to be the main sources of information (Fishbein et al. 1994; Rosenthal and Smith 1995; Council 2000;

Kaitani 2000; Kapamadzija et al. 2000). Mass media information sources include magazines, televisions, movies, and books. However, studies have shown that this information is not always accurate and may even be harmful. Sexual information in particular is often erroneous, unduly glamorised, and is believed in gender stereotypical ways that degrade women.

The role of the media in shaping young people's sexual attitudes has been well documented (Abrams et al. 1990; Cullari and Mikus 1990; Rosenthal and Smith 1995; Rosenthal and Smith 1997; Rosenthal et al. 1999). Rosenthal (Rosenthal et al. 1999) stated that sexually targeted media such as sexually explicit materials and radio talk shows which deal solely with sexual issues are likely to have a greater impact on young people's sexual behaviours and beliefs than media which produce non-sexually related materials.

Moore and Erickson (1993) noted that adolescents report their friends[5] as being more important than their parents in providing sex education. Young men share their experiences with their peers and discuss their problems with each other. Generally information obtained from peers includes sexual adventures, sexual experiences and myths. Such myths are easily obtained from the mass media and elaborated by other peers (Kinsman et al. 1998; DiIorio C 2001; Nzioka 2001).

Formal instruction in schools is an important source of accurate reproductive and sexual health information to young men. Mauldon and Luker (1996) observed that sex education programs in school resulted in increased knowledge of contraceptive methods among American adolescents. However formalised curricula for sexuality education are much less common in developing countries than in Western countries, and they are typically not implemented at a national level in developing countries (Dunne et al. 1993; Matasha et al. 1998; Kapamadzija et al. 2000). In developed countries, such as Australia (Dunne et al. 1993), the curriculum for sex education is structured to begin at primary school level, that is before puberty. While in most developing countries it is mostly taught to young men in their final two years of high school, at college level (Kapamadzija et al. 2000).

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5. Friend and peers are used interchangeably through out this thesis.

It is generally assumed that education is a remedy for many of society's problem and how young people manage their sexuality is no exception. Although there had been a lot of opposition to having sexuality education in the school, developed countries have taught sexuality education since the 1960s. There has been a shift is education focus in the United States from sexuality and contraceptive use to safe sex and abstinence(Wilson 2000). Lindberg et.al. (2000) stated that adolescent male who dropped out of school receive less information on sexuality.

There is often strong religious and political opposition to sexuality education out of fear that it will encourage sexual activity (Dixon-Muller 1993; Kaitani 2000; Meekers and Ahmed 2000). Data indicates however that sexuality education does not encourage young people to engage in sex. Knowledge obtained in the United States includes messages to encourage sexual abstinence and promote the use of condoms and contraceptives by those who are sexually active (Mauldon and Luker 1996; Lindberg et al. 2000). This is an important step in promoting safer sexual behaviour. Visser and Vanbilsen (1994) stated that in many Western countries sex education appears to have no impact on sexual behaviour.

The role of parents in reproductive and sexual health education has been a controversial issue for years. Communication between teens and parents are difficult (Hassan and Creatsas 2000). It appears that the role of parents with regard to the reproductive and sexual health education of their children is of limited importance. Adolescents do not see as parents as good educators. It was reported that only 15 per cent of the respondents in the sample were satisfied of their parents acting as educators (Gordon and Synder 1986; Taris and Semin 1996).

Parents usually play a minor role in educating their children about sexuality; friends are found considerably more important (Muller and Powers 1990; Romer et al. 1999; DiIorio C 2001; Odimegwu et al. 2002)). However while their significance as educators is unimportant, the parental influence as a socialising agent may be more substantial (Taris and Semin 1996). Children learn more from their parents through observations that is by observing their parent's own reproductive behaviour, and being exposed to the values they teach and display. Rosenthal et.al. (2001) stated that when sex communication is frequent, American

parents exhibit positive style of communication both about sex and in general. When sex communication is infrequent, parents are more likely to engage in negative style of communication. Very few parents are truly comfortable discussing reproductive and sexual health behaviours (Muller and Powers 1990; Dixon-Muller 1993; Taris and Semin 1996; Romer et al. 1999). There is a conflict between the need to inform kids about sex and parent's disapproval of kids' sexual activities.

There has been a global growing debate on who is responsible for providing reproductive health information to adolescents and young adults. Western culture along with its religious influence has developed a different approach to that found in many non-Christian traditional societies. Meeker and Ahmed (2000) noted that in pre-colonial Botswana, this information was provided by means of the initiation ceremonies, but today these no longer exists and adolescents must obtain sexuality knowledge from other sources. One key sources is the formal education system. Males in Botswana were observed to be most responsive to information obtained from schools, and lesser extend from parents, peers, and the media and they become more responsive to these information as they grow older (Meekers and Ahmed 2000).

In summary the traditional sources of information displaced by Western cultural institutions are often available, but attenuated in modern developing societies. They offered institutional frames for more effective sexuality education. Traditional and western sources of information could be combined to improve the impact on individual knowledge and safe sex behaviour. This integration of knowledge sources will be considered below. The different sources of information today include friends, the media, parents, and the schools.

3.3.2 Knowledge of reproductive and sexual behaviour

To be able to practice safe reproductive and sexual health behaviours one must first be knowledgeable about the characteristics of healthy sexual behaviour. Different studies have identified different factors that influence an individual's practical knowledge when exposed to different sources of sexuality information.

Adolescents generally have a limited knowledge of health behaviours irrespective of where the information comes from. Students have a low level of knowledge of the determinants and consequences of adolescent marriage, pregnancy, and adolescent sexual activity (Ip et al. 2001). A study of homeless children in the Solomon Islands noted that young people had little knowledge of sexuality despite the fact that they were often sexually active (Gatu 2000).

There are different ways to disseminate knowledge through a society, however open discussion of sexuality is a taboo in many societies (Davies 1982). Sex is an essential element of many, very deeply held, concerns within cultures, like incest taboo, family valuation of chastity, marital arrangement for economic gains, and so forth. In such a fraught contest for social attention, this is a major obstacle to any attempt to educate people on ways to pursue safe and pleasurable sex lives.

As stated earlier male adolescents gain most of their knowledge on sexual life and contraception from magazines, TV, and friends. Kapamadzija et.al. (2000) stated that this information in usually inappropriate and can be simply incorrect. Proper sexual education is therefore of great importance to overcome the ill effects of dominant informal learning (Kapamadzija et al. 2000).

Many educational programs have resulted in greater knowledge but only a few have actually delayed the initiation of sex, increased condom use or contraceptive use and reduced unprotected sex among youths. This finding is supported by Morton et.al. (1996) who noted that education intervention increases students' knowledge of HIV/AIDS, and that this is only the first step to changing health behaviour. For instance, Durand (1995) noted that in the Northern Mariana Islands awareness of HIV/AIDS was high (98%) but there was still a high rate of misconception about what HIV is and how it spreads. In a similar dynamic studies have found that young men have awareness knowledge of many sexual health issues but lack the detailed practical knowledge to guarantee their health (Moberg and Piper 1998; Gatu 2000). Studies have shown that when male adolescents are aware of sexuality issues they crave education on these subjects and they want it from experts (Faulkenberry et al. 1987; Muller and Powers 1990; Werdelin et al. 1992; Morton et al. 1996; Gatu 2000; Kapamadzija et al. 2000; Ip et al. 2001). Muller and Powers (1990) noted that in comparing

the accuracy of knowledge between males and females in the USA, females have a high level of sexual knowledge than did males.

Knowledge about sexuality, reproduction and contraception could be acquired before or after sexual experience. Hassan and Cretsas (2000) stated that knowledge is often acquired after sexual activity has begun. This is because perceived of age at first sexual experience is much higher than the actual age. In many less developing counties school systems sex education as a curriculum is taught to students aged 17 years and above, however most studied have shown that young men are sexually active by the age of 15 years. In Western countries the experience is different. Linberg et.al. (2000) observed between 1988 and 1995 that the age of initial instruction on sexual health in the United States decreased from 14 to 13 years.

Although adolescent males have little knowledge of reproductive and sexual health behaviours some studies have shown that knowledge of reproductive health is increasing. A Survey of high school students showed that knowledge of HIV/AIDS was highest and students however lack knowledge on some sexual health areas (Moberg and Piper 1998). This shows that although education intervention does increase students knowledge of HIV/AIDS, there is still room for improvement as this is the first step to changing behaviour (Morton et al. 1996).

It is assumed that sexual experience comes with knowledge so those with early experience do little to improve their knowledge of reproductive and sexual health behaviour. Childhood experiences also influence knowledge of reproductive and sexual behaviour. Caceres et.al. (2000) observed that in Peru young men who had suffered physical sexual coerce reported less sexual knowledge than other men not coerced.

3.3.3 Myths of sexual behaviour

There are many myths of sexual behaviour in every society. A myth is commonly conceived to be analogous to falsehood. It often contains false and/or negative information. Myth is defined as a recurring theme or character type that incorporates information about cultural

standards (Dainton 1993). Myths therefore represent a way of viewing the world that embodies a culture's beliefs, regardless of whether these beliefs are accurate.

In many countries sexual myths are in co-operated as part of the traditional culture. These could be in the form of folklore and stories. Sexual myths are legion in many countries in the world and are influenced by the same cultural heritage. Myths regarding male sexuality have been particularly tenacious because men have traditionally not talked about their sexual feelings and experiences honestly and openly with each other (Woodward 1963; Zilbergeld 1992b). Our culture has perpetuated these myths and makes it difficult for men to admit to any lack of knowledge or experience, and this has lead to a feeling of isolation and inadequacy for many.

As stated earlier myths are normally passed on through peers. They tend to influence behaviour and encourage sexual risk behaviour. Two of the most common myths are "the size of the penis matters" and "men are always ready and willing to have sex". These are knowledge are obtained from friends, peers, and mass media. Another commonly known reproductive health behaviour myth is that using a condom does not give sexual pleasure to the two individuals involved. Hansen (Hansen 2001) stated that myths influence the individual's decision to use condoms or not. Sexual decisions based on myths can have serious consequences. Knowing the facts about sexuality is important as without accurate information it is difficult to make responsible sexual decisions and to act with sexual integrity.

3.3.4 Attitudes toward reproductive and sexual behaviour

Men's attitudes and beliefs about reproductive and sexual behaviour and their decision and responsibility concerning conception, contraception, and contraceptive methods use have been analysed in different studies. Factors identified as determinants of young men's attitude to reproductive health include the education, age, religion and religiosity, and sexual experience. It was observed in the United States that education is noted for providing a positive attitude towards contraceptive use (Visser and Vanbilsen 1994). Ip et al. (2001) stated that in China high school students, both males and females, had a positive attitude towards the importance of the family and the importance of birth control while those with

primary education were less likely to have such attitudes. The formal education system influences both attitudes and beliefs. In Botswana it was observed that teachers have a great influence on the reproductive attitudes or beliefs of adolescent males (Meekers and Ahmed 2000). It is their quality of teaching and the teachers' attitude to what they teach in reproductive issues that influence the above.

The socio-economic setting of young men influence their attitude to reproductive and sexual behaviour, Schatz and Dzvimbo (2001) agreed with the above statement and noted that in Zimbabwe they observed that the socio-economic setting and the source of information have a significant influence on the attitude of young men. A student of Chinese adolescents noted that Chinese male student indicated a positive attitude towards the importance of the family and the importance of birth control. This positive attitude could be due to the social influence and the importance of fertility control is the society and could also be due to education status.

Attitudes are also shaped by interaction with peers. Peer influence examined today are confined largely to perceptions of peer behaviour and beliefs (Rosenthal et al. 1999). Nahom et.al (2001) stated that a young man's perception about the sexual behaviour of his peers influenced his attitude towards his own sexual behaviour. Ku et al. (1998) noted in the United States young men's attitude to premarital sex have a strong and consistent association with sexual activities. Young people who believe that their peers are sexually active are more likely to report being so themselves (Dunne et al. 1993; Rosenthal et al. 1999).

Religion has a significant relationship with attitude to reproductive and sexual behaviour. Ku et al. (1998) agree that religiosity is associated with less permissive sexual attitudes and belief and that religious belief may be strongly linked to conservative sexual values. Grey and Swain (1996) observed that among Irish students there is a significantly negative correlation between religious attitude and the attitude to promiscuous sexual behaviour of Irish. This does not suggest that all Irish are promiscuous.

Dixon-Muller (1993) noted that one of the factors that is important in shaping attitude to reproductive and sexual behaviour is the condition surrounding sexual initiation. Murray et

al. (1998) agreed stating that a positive attitude towards sexuality and early parenthood is associated with early sexual debut and students with more liberal attitudes towards sex are more likely to have had sexual intercourse. This indicates that young men's attitude could shape their choices related to sexual behaviour. Grey and Swain (1996) noted that in the United States the personal attitude and perceptions of young men shape their sexual and contraceptive decision.

Knowledge of reproductive and sexual health behaviour has little influence on the actual behaviour of an individual. Studies have noted that although young men know about HIV/AIDS, they are knowledgeable about how it spread and what preventative measures can be taken. This does little to influence their behaviour. However attitude and behaviour on reproductive and sexual behaviour have a strong association. Ku et al. (1998b) in a study young metropolitan males in the United States of America observed that attitude is strongly associated with sexual behaviour. More conservative sexual attitude is a predictor of decreased sexual activity among adolescent males.

It cannot be ascertained whether the attitudinal shift led to the behavioural trends, or whether the reverse is true. Studies have shown that young men who disapprove of premarital sex were less likely to engage in those behaviours however those who were sexually active were unlikely to express disapproval (Ku et al. 1998). Thus attitude on premarital sex predicts behaviour and behaviour also predict attitudinal changes. Brazzell and Acock (1988) noted that Azjen and Fishbein's theory of reasons action state that attitude directly influence behavioural intentions and that attitude of significant others directly affects behavioural intentions.

Strangely, knowledge of risk behaviour has been found to have little influence on the attitudes and behaviour of young men. Johnson et al. (1999) stated that there is a minimal impact in the knowledge of sexual intercourse and STIs on the sexual attitudes among adolescents in the USA. Friedland et al. (1991) noted that although young men in South Africa were knowledgeable about AIDS there is still a negative attitude toward condom use and over 80 per cent of the sexually active did not perceive themselves to be at risk of contacting AIDS. Grey and Swain (1996) stated that Irish males hold more promiscuous

attitudes and they endorse less responsible attitudes to birth control than the females. Presumably their attitudes on contraception are parallelled by attitudes toward prevention of STI that are not protective of either partner.

Attitudes surrounding sexuality carry a profound meaning and affect the quality of life in fundamental ways. Ku et al. (1998) stated that one of the reasons for the change in the sexual behaviour of adolescents in the United States could be the shift in attitudes about sex and pregnancy. Casual sex has become less acceptable in the American society. This reflects the change in broader societal norms about sexual behaviour. Similarly in Nigeria it was observed that programs implemented to change men's attitude about population matters, has motivated them and hence their wives to produce smaller families (Isiugo-Abanihe 1994). However male chauvinist attitudes are likely to lead to more children than are more egalitarian thinking because chauvinists exercise greater control over their wives' reproductive and sexual behaviour.

3.4 REPRODUCTIVE AND SEXUAL BEHAVIOUR

It is generally assumed that an increased amount of knowledge would produce changes in reproductive behaviour. However recent research findings showed that this is not always the case (Werdelin et al. 1992; Grunseit et al. 1994; Utomo 1997). Some of the determinants of reproductive behaviour include age at marriage, the impact of education, the ethnic factor, unequal expectations, the value of virginity and gender, and the economic and social consequences of the behaviour (UNESCO 2000). The feeling of pressure to have sex differ by gender and by sexual experience status (Nahom et al. 2001). Traditional norms regarding sexual behaviour have been altered by Western influences including Christian religions, mass education, mass media, and modern family legislation (Meekers and Ahmed 2000).

This section gives background information on and literature on previous research findings to Chapter Eight. The literature is background information on reproductive and sexual behaviour. Analysis from the survey will be discussed ion the Chapter Eights and compared to the findings from this Chapter.

Literature attributed early sexual activity in part to diminished parental control over the sexual behaviour of unmarried adolescents (Meekers and Ahmed 2000). The level of education affects sexual experience. In Botswana the analysis show that males from higher socio-economic background attract girls easily. Economic wealth attracts girls as this is a symbol of future economic security. The traditional norm prescribing premarital abstinences is no longer adhered to. Male influence by school, health sector, media, or by peers are more likely to be sexually experienced. The above points are discussed in the later parts of this chapter.

3.5 PREMARITAL SEX AND COITAL EXPERIENCE

Factors that encourage sexual experimentation includes curiosity, need for love, and peer pressure, while factors that discourages these behaviour were fear of pregnancy and sexually transmissible diseases (Cullari and Mikus 1990). The media, peers, and siblings are expected to promote Western values regarding romantic love and sexual permissiveness. In most countries, as in Botswana and Fiji one modern courtship behaviour is calling on a girl (Meekers and Ahmed 2000).

Although there has been much research on adolescent sexual activity, the focus has been centred on coital behaviour (Udry 1990; Kinsman et al. 1998; Anderson and Sorensen 1999) and contraceptive practices (Marsigilo and Mott 1986; Mosher and Bachrach 1987; Mauldon and Luker 1996).Few studies however, have focused on the sexual activities adolescents (including young men) engage in prior coital initiation (Meyer-Bahlburg et al. 1999; Schwartz 1999). The dearth of information on precoital sexual activity creates a gap in our understanding of adolescent sexual behaviour. Although much is known about young men's coital practices, little is known about the extent of their experiences with behaviours such as masturbation, kissing, caressing, and oral-genital stimulation prior to their initial coitus. Schuster et al. (1996); and Schwartz (1999) pointed out that although precoital sexual activity may be of little concern with regards to unplanned pregnancy, the potential for spreading STI through oral-genital activity certainly exist. Schwartz (1999) observed that although some adolescents are yet to be engaged in coitus, they are already engaged in high risk sexual behaviour.

Social acceptance of cohabitation is itself an index of an erosion of marriage norms and this pattern is widespread in all Western societies (Bumpass 1990; Rossi 1997). Most societies today, like America, Korea, Japan, no longer believe in marriage and having children (Rossi 1997). Meeker and Ahmed (2000) stated that youths who are not able to find lovers are disrespected by their peers. Letamo (1993) agreed stating that some young men end up in the streets and form gangsters with similar interest. Studies have shown that boys are more likely to plan to have sex before marriage. Boys are less likely to refuse sex with long term dating partners. Boys are intent to have sex before they finish high school (Epstein et al. 1994). Meeker and Ahmed (2000) noted that due to Western influence, traditional control on premarital sexual behaviour have weaken. Young people meet in schools, trading shops, at dances, on the streets and other recreation areas. Single parents have less control over their sexual behaviour.

More young people are engaging in heterosexual intercourse towards the middle and end of adolescence. In 1999 a study conducted by the Centre for Disease Control and Prevention in the United States of America noted that 52 per cent of males in grades 9 to 12 reported engaging in intercourse (Delamater and Friedrich 2002). By the age of 18 years 90 per cent have had some kind of sexual activity (Kapamadzija et al. 2000). A study in Tanzania showed that 80 per cent of boys in primary schools and 89 per cent in secondary schools stated that they were already sexually active. The lifetime rate of condom use was 30 per cent. Discussion about sex was restricted almost exclusively to peers (Matasha et al. 1998).

The age at which first sexual intercourse takes place within a population is an important statistics (Gruinseit and Richters 2000). Rosenthal and Smith (Rosenthal and Smith 1997) noted that higher the rate of STD infections have been associated with earlier age of initiation of sexual intercourse, while greater use of condoms (Stigum et al. 1987; Kraft et al. 1990) and contraception (Zelnik and Shah 1983; Faulkenberry et al. 1987; Mosher and Bachrach 1987) were both associated with later coital initiation.

Ip et.al (2001)observed that among Chinese secondary students in Hong Kong, male students had a higher level of agreement with premarital intercourse and the use of pressure and force in sexual activity, as compared to the females. A study in Nigeria showed that

more that one third of the adolescents interviewed had sexual intercourse in the month proceeding the survey (Odimegwu et al. 2002).

The socialization of youths have also partly become the responsibility of the education system (Letamo 1993; Meekers and Ahmed 2000). There was concern that providing family life education in schools may perpetuate the problem. Schools have been able to control premarital sexual activity.

Education status and education attainments influence premarital sex and coital experiences. The two main forces of education are the formal school system and the parents as an agent of sex and family life education. Odimegwu et al. (2002) observed that in Nigeria adolescents with whom parents have discussed family life issues were less likely to be sexually active than those with who parents had never discussed family life issues. Adolescents who have family life education from parents are less likely to be sexually active. Paul et al. (2000) in a New Zealand study observed that individual and school factors appear to be more important than family composition or socio-economic status in the decision to have sexual intercourse before the age of 16. Meekers and Ahmed (2000) noted that among Botswana males having secondary education strongly increases the odds of being sexually active, presumably because such males make attractive partners.

A study of African American adolescents living in high poverty urban settings showed that children who reported high level of parental monitoring were less likely to report initiating sex at pre-adolescent and they report a lower rate of sexual initiation as they aged. Children who reported to have greater monitoring and communication concerning sexual risks were less likely to have engaged in anal sex. Interventions with parents and other guardians to increase monitoring and communication about sexual risk seem to be promising health promotion strategies for adolescents in high risk settings (Romer et al. 1999).

Young men are practicing behaviour that they recognise as risk-behaviour for HIV/AIDS (Morton et al. 1996). Women are more cautious in sexual partner selection than men (Rossi 1997). Some studies have shown that men are reported to be more willing to engage in sex with a new partner (Wilson 1981; Hatfield and Sprecher 1986; Wilson 1987; Rossi 1997).

Boys must be provided with a different model of masculinity, based on shared responsibility instead of dominance. Increasingly men are adopting new models of masculinity that includes being a responsible, caring husband and father (UNFPA 2003).

Religion influences premarital sex and coital experience. Most religion does not encourage premarital sex. This includes Christianity and the Muslim religion. In Botswana, due to the influence of Christianity, the traditional initiation ceremonies have been abandoned thereby creating a gap in family life education (Meekers and Ahmed 2000). Even the most religious young people in Botswana do not regard it as wrong to have premarital sexual relations, provided that they can avoid conception.

3.5.1 Sexual initiation

The initiation of sexual intercourse is a milestone in the physical and psychological development of men and women in all societies, and both the timing of this event and the context in which it occurs can have long-term consequences for the individual. Moreover, first intercourse marks the beginning of young people's possible exposure to the risk of contracting STI. The desire to achieve the transition to adulthood at an earlier age than their peers constitutes a powerful incentive for young people to become sexually active (Rosenthal et al. 1999). There is suggestion that the initiation of sexual activity is related to teenagers' perception of their transition to adulthood (Scott-Jones and White 1990; Rosenthal et al. 1999), which Udry (1990) termed the "strain towards maturity". Early intercourse has been shown to be related to pressure for early autonomy by adolescents (Rosenthal and Smith 1997).

Studies in many western countries reveal that a large number of teenagers have had sexual intercourse that they do so at an earlier age than previous generations, and they engage in wider variety of sexual practices than earlier generations (Rosenthal et al. 1990; Kraft 1991; Meschke and Silbereisen 1997; Rosenthal et al. 1999). Studies in Scandanavia (Werdelin et al. 1992; Klanger et al. 1994), the United States (Laumann et al. 1994b), and Britain (Johnson et al. 1994), indicated that the majority of teenagers become sexually active between the ages of 15 and 19. Recent Australian survey showed similar findings (Rodden et al. 1996).

Sexual initiation was not a random or unexpected event. Kinsman et.al. (1998) agrees with the behavioural change theories of adolescent behaviour, that the intentions are predictive of subsequent behaviours (Ajzen 1985; Fishbein et al. 1994; Kinsman et al. 1998). Social influences, particularly peer norms, seem to be important determinants of sexual initiation (Costa et al. 1995; Kinsman et al. 1998).

Table 3.1: Median age of first coitus by country, according to gender

Region, country, and survey year	*Type of survey*	*Female median age at first coitus*	*Males median age at first coitus*
Sub Sahara Africa			
Ghana (1993)	DHS	16.9	18.4
Mali (1995-1996	DHS	15.8	18.7
Tanzania (1996)	DHS	17.4	17.8
Zimbabwe (1994)	DHS	18.8	18.7
Asia			
Philippines (1994)	National	na	na
Thailand (1994)	National	na	19.0
Latin America & Caribbean			
Brazil (1996)	DHS	18.6	16.2
Costa Rica (1991)	YARHS	19.4	17.4
Dominican Republic (1996)	DHS	18.7	17.1
Haiti (1994-1995)	DHS	18.7	17.8
Jamaica (1994)	YARHS	16.9	15.4
Peru (1996)	DHS	19.6	17.4
Developed countries			
Great Britain (1991)	National	17.4	17.2
United States (1995)	National	17.2	16.1

Source: Adapted from Susheela Sing et.al. (Singh et al. 2000).
Note : na = not applicable because fewer than 50 per cent had become sexually active.

The likelihood of first intercourse rises with age and in most countries, as shown in Table 3.1 except for sub Saharan Africa males have their first sexual experience substantially earlier than females (Murray et al. 1998). The average age of sexual initiation among males in Serbia was 15.6 years (Kapamadzija et al. 2000). Kinsman et.al. (1998) stated that early sexual intercourse is not an unplanned experience for many teens. The decision about sexual initiation is strongly bound to social context with peers playing an important role in creating a sense of normative behaviour. The changes in social acceptability of early sexual behaviour has influenced the lowering of age at first intercourse (Paul et al. 2000). Men also claimed and reported that their first sexual experience (sexual initiation) came about because they were 'ready' or they were 'curious' about sex. A secular drop in the age of physical sexual

maturity reflected by declines in the age of menarche for girls and puberty in boys, in turn has affected the age of sexual initiation (Rossi 1997).

Kinsman et.al. (1998) state that the normative predictor of intentions and initiation of intercourse is the perception about the peers' sexual behaviour if most of their peer are having sex, they are likely to report intending to initiate and are also more likely to initiate themselves. The time of sexual initiation based on differences in race or ethnicity has been a focus of different studies. Young adolescents' intentions to initiate are strongly bound to their social context with peer playing an important role in creating a sense of normative behaviour. The most important component of peer influence is the young adolescents' perception about the prevalence of sexual intercourse among peers (Kinsman et al. 1998). Fewer than one-third of the men claimed they were in love with their first sexual partners (Laumann et al. 1994b; Rossi 1997).

Models of sexual initiation tend to draw on both biological and psychological components, although the emphasis may vary. Biological explanation suggests that the timing of puberty has a significant influence on initiation of sexual intercourse for boys, but for girls social control plays a more important role than puberty timing (Udry 1990; Rosenthal et al. 1999). Biological factors cannot provide complete explanation of sexual phenomena for psychological (Jessor and Jessor 1975) and sociological (Delamater 1987) predictors have effects on coital activity. The age at first intercourse is taken as an indicator of psychological and physical maturation in a population (de La Rochebrochard 2000). Sociological explanation, using the theory of reasoned action (Fishbein 1975) is a predictor of sexual initiation where an individual's decision to have first intercourse could be influenced by his attitude and but normative belief that his peer are sexually active.

Education and church attendance were significantly predictors of later coital initiation (Marsigilo and Mott 1986; Johnson et al. 1994; Laumann et al. 1994b). Researches have observed that young people who are frequent churchgoers and who believe in the importance of religion are less likely to report being sexually active than their less religious peers(Dunne et al. 1993; Rosenthal et al. 1999). Studies have also observed that sex

education in schools does not lead to earlier, or more extensive, sexual activity but may delay onset of sexual initiation (Kirby et al. 1994; Rosenthal et al. 1999).

Findings from 23 published peer-review studies of school- based education programs in the United States reported that some programs did delay the initiation of intercourse (Mauldon and Luker 1996). Gruinseit and Richters (Gruinseit and Richters 2000) stated that if sex education is to occur before sexual initiation it needs to be offered in primary schools and the first year of high school (11-13 years). Lindberg et.al. (2000) observe that the earlier ages of sexual initiation among American males than among females may explain in part the significantly lower levels of reproductive health education prior to first intercourse among males.

Religion beliefs are more strongly linked to conservative sexual values. Ku (1998) stated that like other studies (Thomson and Camburn 1989) observed that young men in the United States religiosity is associated with less-permissive sexual attitudes and behaviour. Some religious beliefs may have become more strongly linked to conservative sexual values. In the 1990s conservative Christian groups encouraged teenagers to pledge abstinence until marriage and many teenagers were reported to have taken up the virginity pledge. This is in line with the health belief model when in the late 1980s and the early 1990 individuals perceived susceptibility to be at risk of HIV.

Studies have shown that socio-economic factors are significant determinants of sexual initiation. Social influences on early onset of sexual activity include demographic categories such as race, gender, class, education, and family structure (Hofferth and Hayes 1987; Scott-Jones and White 1990; Moore and Rosenthal 1993). Other researchers have examined aspects of social context such as family environment, peer relations, schools, religion, and media influence. Youths living in a single parent household in American are at increased risk of early initiation of sexual intercourse (Rosenthal et al. 1999).

Traditional gender roles and dating scripts place men as the dominating, aggressive initiator in sexual contact. Traditional sexual scripts explain men as the initiator and the aggressor during heterosexual contact. However a number of studies have documented women as

initiating sex with them when they are minors, by getting them drunk or by threatening to end their relationship (O'Sullivan and Byers 1993; Anderson 1996; Anderson and Sorensen 1999). Anderson and Sorensen (1999) observed in a study of American adolescents that women initiate sex with men when they are minors, by making them drunk, or threatening to end their relationship. This behaviour is not conforming to traditional social norm. However conformity to traditional gender roles may lead women to perceive men as always ready for sex (Anderson and Aymami 1993). It is also normal for women to initiate sex at times and this does happen all the time.

Relationships exist between early sexual initiation and social activities. These activities may open up the possibility of meeting potential sexual partners (Rosenthal et al. 1999). Early experiences of sexual intercourse are tied up with behaviour defined as adult activities that present the problematic contradiction of adolescents trying to minimise behaviour that is approved for adults but forbidden for children. Therefore the desire to achieve the transition to adulthood at an earlier age than their peers constitutes a powerful incentive for young people to become sexually active (Rosenthal et al. 1999).

Studies have identified a number of independent predictors of sexual initiation. These include socio-economic status, found to be universally associated with age of first intercourse in the USA in the 1950s and 1960s (Kinsley et al. 1948; Schofield 1965; Paul et al. 2000). Other predictors of early onset of sexual activity include broad demographic categories such as race, gender, class, education, and family structure (Scott-Jones and White 1990; Moore and Rosenthal 1993; Rosenthal et al. 1999). Other researchers have examined aspects of the social context, such as family environment, peer relations, school, religion, and media influence (Rosenthal et al. 1999).

In the United States it was found that parent- child connectedness (family attachment) was associated with a later age of sexual initiation (Paul et al. 2000). Poor communication, lack of support, and low levels of parental monitoring have been shown to predict early onset of teenage sexual intercourse (Meschke and Silbereisen 1997). By contrast close relationship with parents is associated with later onset (Weinstein and Thornton 1989).

Results tend to disconfirm the notion that close parent-child relationship lead to later sexual initiation. It was observed that a stronger parental desire to maintain a good relationship with their adolescent children, is associated with earlier sexual initiation by the child (Taris and Semin 1996). Some studies have shown that disturbed families could lead to early sexual maturation, producing early sexual initiation and subsequently early childbearing (Udry and Campbell 1994; Rossi 1997).

Rosenthal et.al. (1999) stated that in addition to family and friendship networks, key social institutions that have received attention are schools, religion, and the media. As stated earlier young people who are frequent churchgoers and who believe in the importance of religion are less likely to report being sexually active than their less religious peers (Hofferth and Hayes 1987; Dunne et al. 1993; Rosenthal et al. 1999). Both religious affiliation and commitment have been found to be inversely associated with early sexual initiation (Goodson et al. 1997). Murray et.al. (1998) observed that religiousness have been shown to delay first premarital intercourse in Chile.

Perception of sexual behaviour norms surrounding smoking, use of alcohol, and illicit drugs have all yielded strong associations with early onset of sexual intercourse (Moore and Rosenthal 1993; Rosenthal et al. 1999). Relation have been established between early sexual activity and alcohol consumption, smoking behaviour delinquency and use of illicit drugs (Kraft 1991; Rosenthal et al. 1999). Rosenthal noted that data support earlier findings of an association between early initiation of sexual intercourse and use of drugs. The data also support the earlier finding that young people with less traditional attitudes to gender roles are likely to incorporate sexual activity in their behavioural repertoire (Rosenthal et al. 1999).

There is a growing concern about the risks associated with adolescent sexuality. Early initiation of sexual activity is a concern because of increased risk of STI, including HIV/AIDS, and unwanted pregnancy as first intercourse marks the beginning of young men's possible exposure to the risk of contacting STI (Singh et al. 2000). Rwenge (2000) stated that one of the reasons for the above is because adolescents engage in more frequent sex and have a long period of sexual activity before them. Besharov and Gardiner (1997) stated that adolescents tend to be reckless in their behaviour, and unprotected sex is just one

of a host of risky behaviours in which they engage in. Some adolescents are exploited or coerced into having sex and thus have little control over contraception. Rosenthal et al. (Rosenthal et al. 1999) observed there is an association between early initiation of sexual intercourse and use of drugs, including alcohol, cigarettes and illicit drugs. The 1995 Botswana Adolescent Reproductive Health Survey suggested that adolescent males and females alike become sexually active at an earlier age and have multiple sex partners (Meekers and Ahmed 2000). The study stated that the early sexual initiation implies that reproductive health programs should target youth age 13 or younger.

There is evidence that earlier onset of sexual intercourse is associated with comparatively low levels of contraceptive use and a high degree of sexual risk-taking behaviour among teenage men. Ku et.al. (1992) reported that 22 per cent of sexually active American teenage men had not used condoms in the previous three years and 43 per cent had only used them on occasion. There is evidence that is risk-taking behaviour may be of greater significance at first sex. Forrest and Singh (990) reported that more than half of females engaging in first sex had relied on the males to use condom (47%) or withdrawal (8%).

3.6 MASTURBATION

The dictionary definition of masturbation is, it is the stimulation of the genital by means other than intercourse. Voss et al. (1987) defined masturbation as a process of self-touching that becomes more focused on the genitals and breasts and has goals of causing sexual excitement. Masturbation in itself was not an unusual behaviour but to masturbate either obsessively, without pleasure or in a way that causes pain was very unusual (Lindbald 1995). Masturbation is commonly referred to as a process of sexually stimulating oneself, self-pleasuring, self-stimulation. Different societies have different interpretations of the process of masturbation. Perceptions of masturbation also changed overtime.

Masturbation is one of the most common sexual acts. Little children masturbate until parents forbid them to (Zilbergeld 1992a; Leitenberg et al. 1993; Lindbald 1995). In America most boys masturbate at puberty and most continue throughout life (Kinsley et al. 1948; Zilbergeld 1992a; Leitenberg et al. 1993; Lindbald 1995). In a study on commercial sex between men in three of Australia's major cities, Peterson et.al. (2000) observed that

masturbation was the most common sex act of male sex workers that took place during the encounter.

Kinsey et.al. (1948) stated that masturbation was second to coitus as the most important source of male orgasm, and it continues into adulthood. It can therefore be concluded that masturbation cannot result in physical deterioration, and it was an erotic notion of choice second only to coitus. The study also noted that masturbation was more common among the rich than among the poor.

More in most societies today are give more varied repertoire of acceptable sexual practice such as masturbation. Masturbation in a certain way can help overcome sexual problems such as erection difficulties and rapid ejaculation. Clark and Wiederman (2000) stated that partners who are separated from each other for some special reasons should as work, encourage each other to masturbate rather than seek sexual pleasure from someone else.

Masturbation was not an accepted behaviour in the 19th and early 20th century. The medical field greatly contributed to the early negative attitude towards masturbation. It was regarded as a "disease" in the medical field. In the mid 19th century many illness including polio and chronic diseases assumed to be caused by masturbation. Horrocks (1997) stated that even in the early psychoanalytic movement it was seen as injurious to mental health. Masturbation was feared and it was generally assumed that of all sexual behaviour, nothing compared to masturbation was that harmful. It was said to be "unnatural sex' (Wallerstein 1980).

In the mid 20th century there were contradicting views by medical profession on whether masturbation was a disease or not. It was than believed that the necessary handling of the penis encourages masturbation. Even in the 1960s adolescents contributed masturbation to illness including pimples, insanity, stooped shoulder, weakness, loss of manly vigour, etc. However eventually analysts argued that learning to masturbate is a necessary and health part of a child's development. As autonym, the definition and elaboration of oneself occurs in the self-experience of masturbation.

Studies have shown that there is a gender difference in masturbation of adolescents and adults. Males are more likely to engage in masturbatory activity and to do so with greater frequency (Leitenberg et al. 1993; Oliver and Hyde 1993; Laumann et al. 1994a). A gender difference in masturbation has been observed in the United States and in some other countries as well (Leitenberg et al. 1993). A higher percentage of males reported that they have masturbated as compared to females and for those who have masturbated, showing that the frequency of masturbation is higher for males as compared to females (Kinsley et al. 1948; Hunt 1974)]. There is no evidence of a society where masturbation rate is higher and more frequent for females than males (Leitenberg et al. 1993). However Lindblad (1995) noted that masturbation among preschoolers have no gender differences. . This supports what might be supposed from development theories (De-jong 1989).

Many religious activities discourage masturbation (Patton 1986; Clark and Wiederman. 2000). Studies have shown that women may react more negatively to masturbation due to religious beliefs on such behaviour, as they tend to be more religious than men (Low and Handal 1995; Miller and Hoffmann 1995; Francis and Wilcox 1996; Clark and Wiederman. 2000). Most religion till today see masturbation as a sin and label it as 'unnatural sex' (Wallerstein 1980). The Jews see masturbation as a 'reprehensive sin' or 'capital sin'. Until today religious people warn their children not to masturbate. This indicated that the negative perception towards masturbation still exist in most societies.

The 1960s' view of masturbation by Medical professions changed. The psychiatric dictionary (1960) stated

> *"It is recognised that all children masturbate during the infantile period, most do during adolescent and some do during the latency period. Masturbation then, can be considered psychologically normal during childhood and is a major avenue for the discharge of instinctual tension. Under present cultural condition, masturbation can also be considered psychologically normal during adolescence, and to some extent even in adulthood....."*

This contributed to the change in attitude towards masturbation in most Western societies. Psychoanalytic movements today argue that learning to masturbate is a necessary and health part of a child's development.

Different societies have difference views of masturbation. In some societies both mother and father masturbate their children. The Hopi, Siriono, Kazak, and Alorese parents

masturbate or fondle the genitals of their own children (Seymour-Smith 1975). Most societies today still associated masturbation with uncomfortable and disapproval, unfortunate and unnecessary guilt. It is done in secrecy. Although a normal and natural processes most feel ashamed or guilty about it. The social perceptive of masturbation is that it is an immature process. Society perceives that a real man would be able to find a partner to have sex with rather than being left to his own device. If he already has a partner than why on earth would he want to have sex by himself (Zilbergeld 1992a).

Sexual norms continue to change and many changes involve the increasing acceptance of personal exploration of one's own sexuality through masturbation. Studies have stated that masturbation is not a disease as interpreted in the 19th and early 20th century. It was also argued that early masturbation experience as neither beneficial nor harmful to sexual adjustment in young adulthood (Clark and Wiederman. 2000).

In summary masturbation is in reproductive health. Individuals must be encouraged to realise that masturbating is not and religious leaders, and other social groups must learn to understudy that masturbation is clean and that both men and women masturbate. The changing sexual norm could now result in masturbation becoming acceptable in most societies.

3.7 REPRODUCTIVE AND SEXUAL HEALTH BEHAVIOUR

Another perspective on male sexual health is examining behaviour beyond the individual level and focusing on the social and political policies that have been developed to provoke or manage changes in behaviour. An example of this is the 1994 ICPD. The ICPD (UN 1995) defined reproductive health as

> *"... a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes."*

Reproductive health behaviour includes behaviour related to marriage, family planning practices, breastfeeding, and childcare. These are all behaviours contributing to reproductive health. It includes the use of family planning, treatment of STI, infertility, and the prevention of STI.

3.7.1 Family planning- contraceptive and condom use

Men's attitudes about contraceptive use constitutes one of the most documented topic is the study of men's reproductive and sexual behaviour. Many studies explore the meaning and use or non-use of condoms by men. It was observed that although men are acquainted with contraceptive methods (mainly the condoms and the pill), there is still a gap between knowledge of these methods and another wide gap between simple use, and knowledgeable correct use (Greene and Biddlecom 2000; Kaitani 2000; Karra, Stark, and Wolf 1997; Johnson, Rozmus, and Edmission 1999).

Five currently available contraceptive methods are available for use by men or require men's active participation. They are condoms (male and female), vasectomy, natural family planning (rhythm), withdrawal and abstinence. Some advantages of these methods are, condoms protect against sexually transmitted diseases; vasectomy is safe and highly effective; and rhythm and withdrawal are hormone-free and readily available at no monetary cost to the user. These last two methods also promote communication and co-operation between partners. However none of these methods is perfect, meaning 100 percent safe and effective. Contraceptive and safe sex education for adolescents has been shown to be effective, in preventing pregnancy and transmission of diseases particularly if given before first intercourse (Grunseit et al. 1994) that is in early adolescent or before puberty.

Involving men in family planning and contraceptive use can improve the reproductive health of both partners. When men are provided with information about reproductive health issues, they are more likely to support their partners' family planning decisions (Ndong I, et.al., 1998). This could promote men's involvement in preventing HIV/AIDS and other forms of STDs, and high-risk pregnancy (Hawkes, 1998).

Family planning programs exist in almost every country in the world today. Green, Cohen, and Ghouayel (1995) stated that the three global rationales of family planning programs are as follows:

1. The demographic rationale stating that reducing fertility rates and slowing population growth benefit developing nations.

2. The health rationale which focus on mitigating the adverse health consequences of high fertility for mothers and children
3. The human right rationale that rests on the premises that individuals and couples have a right to control reproductive decision including family size and the timing of birth.

Family planning programs slow population growth by enabling couples to plan the number and spacing of their children. Family planning programs include the provision of contraceptive methods; provision of maternal and child health care services; counselling services; and information dissemination. The many way the family planning programs gets services and information to people include health clinics and hospitals, communities and neighbours, commercial outlets like pharmacies and grocery stores, mass media campaigns, one-on-one communications and sex education programs in schools and communities Growing concern over teenage pregnancy and STI including HIV/AIDS has led to the expansion of the services provided in family planning programs (Shelton 1999). Programs are mostly country based and different family planning programs are implemented in different countries. The one child policy in China implemented to reduce population growth is unique to the country.

Traditionally family planning and reproductive health programs were only focused on women as the primary beneficiaries of service provision because it is the women who become pregnant, most contraceptive methods are designed for women and reproductive health services can be conveniently offered as part of maternal and child health services (Robey and Drennan 1998). Men have been considered 'silent partners" (Edwards 1994). However both the 1994 ICPD in Cairo and the 1995 Fourth World Conference on Women in Beijing endorsed the in-cooperation of reproductive health services that include men. Consensus statements from both conferences call for better ways to reach men with reproductive health and family planning services. Some family planning programmes have overlooked men because they assume that men are indifferent or even opposed to family planning (Mason and Taj, 1987; Green, et.al., 1995; Danforth, 1995). Studies have shown that educating men on family planning can improve contraceptive uses among couples (Fisek and Sumbuloglu, 1978; Helzner, 1996.). A study in Southern India indicated that men's involvement in family planning and decision making could also be motivated by external

factors such as desire for the improved economic status of a smaller family (Karra, et.al, 1997).

Male involvement in family planning are often rooted in negative assumptions as men are viewed as gatekeepers, potential obstructionists who if involved in decision making will defeat women's effort to regulate fertility. However recent surveys have indicated that men are more interested in and supportive of family planning than has been assumed (Edwards 1994; Miller and Hoffmann 1995; Council 1996; Ezeh et al. 1996; Karra et al. 1997). With the effectiveness of reaching men with family planning services, a study in Kenya has reported that men make greater current use of modern contraceptives than women (Miller and Hoffmann 1995). This indicates that if men are provided with information about reproductive health issues they are more likely to support their partners' family planning decisions. A study on the Kilifi district in Kenya observed that involving men in family planning, both as the distributor and as the target for the services resulted in greater use of family planning and increase interspousal communication (Council 1996).

Research suggests that in many regions men viewed family planning favourably and can have a strong influence on the use of contraception. For example, research in Kenya suggested that contraception is two to three times more likely to be used when husbands rather than wives want to cease childbearing (Dodoo, 1998). However, Ezeh et.al (1996) observed from the Demographic and Health Survey (DHS) of 17 different countries, between 1985 and 1992, in Asia and Africa are:

1. Men's approval for and intentions to use family planning are similar to women; men and women have similar reproductive preferences and attitudes towards family planning;
2. Men are no more opposed to family planning than women;
3. In many countries men are as supportive of condom use as women.

Karra (1997) also observed that in South India some men readily accepted condom use and vasectomy, even though they may not have liked some of the specific characteristics of these methods.

The stereotypic man is seen as uncooperative and uninterested in family planning and reproductive health but new surveys have found that many men know and approve of family planning and are interested in their reproductive health (Ezeh et al. 1996; Robey and Drennan 1998). It must be noted however, that although some men do prevent women from using contraception (AVSC International 1998; Ezeh et al. 1996; Robey and Drennan 1998), spread STI to their female partners (Basen-Engquist and Parcel 1992; Joffe and Radius 1993; DiIorio et al. 2001), or act in other harmful ways, most men do not. It is therefore important to understand what determines the reproductive health behaviours of men, in-order to address the issues relating to their reproductive health behaviours.

Social norm shape the behaviour and attitude of young people about appropriate sexual activity. Studies consistently show that condom use is rejected as much by men as by women and that the majority of men refuse to use condoms for various reasons including fear of losing an erection, impeding direct contact with the woman, diminishing pleasure, and limiting the masculinity of the male. In comparing male contraceptive use in Latin America, Asia and Africa, it was observed that male contraceptive methods (vasectomy, condoms, withdrawal, and abstinence) are less commonly used in Latin America than in Asia and Africa (AVSC International 1998). Research results show that male contraceptive methods (vasectomy, condom, withdrawal, and abstinence) are less commonly used in the United States than in Asia and Africa (Barker 1996).

Periodic abstinence and withdrawal, also known as coitus interruptus are other commonly used male methods of contraceptive. In a recent review of literature Rogow and Horowitz (1995) lamented the lack of research on determinants of the practice of coitus interruptus. This may be related to its being a male method and a traditional method therefore generating less interest among policymakers than other kinds of contraceptives. Withdrawal is one of the most widely used temporary methods worldwide and it has been used as a contraceptive method since biblical times. Population International estimated that in 1991 38 million couples, representing 13 per cent of all users of temporary methods globally, rely on withdrawal to prevent pregnancy (Rogow and Horowitz 1995). Okun (1997) noted that withdrawal is practice by a significant proportion of Jewish married couples in Israel. Two countries that have also reported high rates of prevalence are Turkey (Goldberg and Toros

1994) and the Philippines (Reports 1986). Therefore the withdrawal method could be a good method of contraception and teenage pregnancy prevention.

Over the years different models have been drawn upon to predict safer sex behaviours. Among them, the Theory of Reasoned Action (TRA) (Fishbein 1975; Ajzen 1985) has displayed the greatest power in predicting safer sex behaviours such as condom use (Basen-Engquist and Parcel 1992; Fisher et al. 1995; Bryan et al. 1996). The theory assumes that HIV/AIDS prevention behaviours such as condom use are functions of behavioural intentions that are, in turn, a function of attitudes, subjective norms, and perceived behavioural control intentions concerning those behaviours. Wong and Tang (Wong and Tang 2001) observed that the theory was most applicable in understanding the Chinese college students' intention to use condoms in future casual sexual encounters. However current condom use and intentions to use condoms in future regular sexual activities were less applicable, knowledge attitudes and vulnerability to sexual risks were not linked to current condom use and intentions to use condoms in future. Similar findings were also noted in previous studies with Western college samples (Fisher et al. 1995). Many authors however suggest that knowledge alone may be insufficient to change adolescent behaviour in regard to condoms (Spingarn 1995).

Past research work have observed that adolescents who hold positive outcome expectancies or positive attitudes about condoms are more likely to use condoms (Basen-Engquist and Parcel 1992; Magura et al. 1994; DiIorio et al. 2001). As with other countries, however, condom use in France has climbed in recent years, and is especially common at first intercourse (Toulemon and Leridon 1998). In a study of adolescents age 13 to 15 years DiIorio et al. (DiIorio et al. 2001) observed that social outcome expectancies were important in explaining condom use. It was observed that if the partner has a favourable attitude towards using condom they were more likely to use condom consistently.

Several researchers have observed that adolescents who expressed higher levels of self-efficacy to use condoms or talk to their partners about using condoms were more likely to intend to use condoms (Basen-Engquist and Parcel 1992; Basen-Engquist et al. 1997) or actually use condoms (Basen-Engquist and Parcel 1992; Joffe and Radius 1993; DiIorio et al.

2001). Studies have also found that attitudes about condoms are associated with their use among adolescents (Richard and Van-der-Pligt 1991; Basen-Engquist et al. 1997). However other researchers found self-efficacy was not a consistent correlate of condom use (Richard and Van-der-Pligt 1991; Basen-Engquist et al. 1997). Basen-Engquist et al. (Richard and Van-der-Pligt 1991; Basen-Engquist et al. 1997) observed that young men who reported consistent condom use perceived their friends to have favourable views on using condoms.

Researcher stated that factors that can influence intentions to engage in sexual behaviour and use condom differ by gender and by sexual experience status (Nahom et al. 2001). However other studies consistently show that condom use is rejected as much by men as by women and that the majority of men refuse to use them for various reasons including fear of losing an erection, impeding direct contact with the women, diminishing pleasure, and limiting the masculinity of male. Condoms are used more commonly as prophylactics not as contraceptives (Nahom et al. 2001). Adolescents with experience of sexual intercourse rate condoms more negatively than do those without such experience (Oswald and Pforr 1992).

Intention to use condom could be positively determined by knowledge that condom use reduces the risk of AIDS and by decision-making skills (Epstein et al. 1994). Lifetime condom use among students in Tanzania was reported to be 30 per cent. Although this is a high rate of condom use 33 per cent of the boys reported to have had past experience of sexually transmitted diseases (STDs) (Matasha et al. 1998). However studies have shown that condom use at last intercourse could be unrelated to perception of risk and concern about AIDS (Leigh et al. 1994).

Communication was also positively related to initiation of condom use and consistent condom use (Romer et al. 1999). Although males were willing to engage in safe sex talk if their female partners raised the topic, they rarely initiated such discussions. Alcohol use, previous sexual experiences, knowledge about reproduction and contraception, conversations with friends and the media were intervening conditions for safe sex conversations. Some believed that discussing safer sex practices indicated a lack of trust. Many demonstrated trust in their partners by engaging in high-risk sexual behaviours (Lock et al. 1998).

Studies have observed that condom use among adolescents and young adults is not very common. Students in Sweden consider that they only have a lower risk of contracting a sexually transmitted diseases (STD), condom use is very low and this has implications for the students' potential to contact an STD (Tyden et al. 1991). Condoms were reported to be used by Nigerian boys only for the prevention of unwanted pregnancy (Jinadu and Odesanmi 1993). In Germany adolescents were asked about condoms they additionally emphasis their effect of reducing feeling and pleasure (Oswald and Pforr 1992).

3.8 RISK BEHAVIOURS

When sexually active, young men may be exposed to reproductive health risks (Meekers and Ahmed 2000) if they do not wear condoms and/or have multiple partners. A number of behavioural and social characteristics of adolescents are thought to determine their high-risk status. This includes the on set of sexual activity during teen years (Delamater 1990); the probability of multiple partnerships (Heins 1992); the general non use or inconsistent use of condom (Moore and Rosenthal 1991); and the reported tendency of adolescents to perceive themselves to be both physically and psychologically invulnerable which in turn, is related to the conduct of a variety of risky behaviour (Moore and Rosenthal 1991). In this era of AIDS and other STI knowledge of the behaviour of the population is essential to prevent the spread of the infection. Sexual orientation, type of sexual contact, number of sexual partners, and frequency of sex has been cited as risk factors for the transmission of these diseases (Delamater 1990; Friedman 1994; Heins 1992; Moore and Rosenthal 1991).

Risk reproductive and sexual behaviour findings from the field are analysed in Chapter Nine of this thesis. The literature is background knowledge of factors that influence risk behaviour in other countries. Lessons can be learnt from other countries and other research findings in addressing risk behaviours. This section of the literature review discusses the risk behaviours that are also discussed in Chapter Nine.

The World Health Organization (WHO) and UNICEF have, since the last decade, placed top priority to HIV prevention among adolescents (Luna and Rotheram-Borus 1992). Some

men engage in sexual activities that involve risks to their physical health, such STI and HIV infections, and unwanted or teenage pregnancy. Examples of such activities include engaging in vaginal or anal intercourse without using condoms, engaging in sexual activities with casual partners, and engaging in sex with multiple partners. Since 1985 there has been substantial publicity about these risks (Delamater and Friedrich 2002).

The influence of social and community norms and contextual factors has a far greater influence on the behaviour of students, than the school-based social influence program (Moberg and Piper 1998). A study have shown that in communicating with the sexual partners about sexual risk behaviours, young men were willing to discuss safe sex once the conversation was initiated by their partner who raised the topic, but they rarely initiate such discussions (Lock et al. 1998).

Change in population growth and distribution, the rise of telecommunications and internet service, the increase in international travel and a decline in the family size, as well as a general earlier start of menarche and later age of marriage are contributing to an increase in unprotected sexual relationship before marriage. This combined with risks from early marriages, result in too early or unwanted pregnancy and childbirth, induced abortion in hazardous circumstances and sexually transmitted diseases, including HIV infections leading to AIDS (Friedman 1994).

3.8.1 Circumcision

Male circumcision, sometimes referred to as male genital mutilation, is widely practiced. Globally approximately 25 percent of men are circumcised for religious, cultural, medical, or parental choice (Moses et al. 1998; Goldman 1999; Kim et al. 1999). The concentration of circumcised men is in the United States, Canada, Southeast Asia (Indonesia, Malaysia, Philippines), countries in the Middle East, other countries with Muslim population, countries where circumcision is a traditional custom, and large portions of Africa (Moses et al. 1998; Updegrove 2001).

Although theories abound, no one knows when, where, how, or why male circumcision began (Wallerstein 1980). Anthropologists cannot agree on the origin of circumcision. While

some believed that it might have originated independently with in several different cultures as it has been practiced in the Near East, most of tribal Africa, among Muslims in Indian and Southeast Asia, and among Aboriginal Australians and New Guinea tribes. However, studies have shown that circumcision has been practiced for in some countries for a long time, showing that it is a traditional expectation (Updegrove 2001). Mummies 6000 years old have been reported to show evidence of circumcision (Woodward 1963). The oldest recorded circumcisions are found in the Bible in Genesis 17:10 to perpetuate circumcision as a sign of covenant between man and God.

While there is great variation in the way cutting is carried out in male circumcision, little has been published distinguishing different degrees of tissues removed. It is generally defined as the removal of the foreskin. However in parts of East Africa not all the foreskin is removed and among some other African groups it remains and is cut in strips (Caldwell et al. 1997). In social and medical literature male circumcision is regarded as being more superficial and consequently less dangerous than female circumcision, though this generalisation refers to the more extreme cutting of females found in Africa (Caldwell et.al 1997).

Most male circumcision is practised for religious reasons, largely in Muslim and Jewish Communities (Wallerstein 1980; Milos 1992; Caldwell et al. 1997). In Judaism, circumcision is a sign of religious identity. Jewish males are circumcised eight days after birth (Wallerstein 1980; Dunsmuir and Gordon 1999). Muslims practice circumcision as it signifies spiritual purification. They are not unanimous about the age at which circumcision should be carried out (Dunsmuir and Gordon 1999; Rizvi et al. 1999). Procedures range from seven days after birth to after adolescent, and concentrate on ages of 3 – 7 years and generally intended to be carried out before marriage. Knudsen (Knudsen 1994)found among circumcising people in Ghana that it is the cutting that binds them to the spiritual world. Circumcision is however, absent from Hindu-Buddhist and Confucian religion and Christian churches have no specific doctrine about it, though it is discussed in a number of books of the New Testament.

Early in the 20th century, all English-speaking countries began to practice newborn circumcision. Since the 1950s the incidence the procedure has diminished in Canada and Australia and in England it has been almost totally abandoned. Studies have shown that in

America a different trend has been followed, where circumcision appears as part of the medical culture, with 80 percent of newborns in 1990, being circumcised (Wiswell and Hachey 1993; Moses et al. 1998).

Male circumcision is also a product of traditional cultural norms and the rituals are basic to traditional societies and in many societies to adulthood. In many communities, particularly in Africa, male circumcision is observed as a rite of passage into manhood and is most often done at puberty or between the ages of 10 and 20 years. Australian Aborigines also practice male circumcision as a cultural recognition for a rite passage to manhood and adulthood.

Circumcision was introduced into the United States in the late 19th century. American medical providers accepted claims that it was an effective treatment for such "diseases as masturbation, headache, insanity, epilepsy, and paralysis (Fleiss and Hodge 1996; Houben 1999). In addition circumcision was believed to improve hygiene and prevent STD's. Globally the circumcision rate peaked in the 1970s, when 80-90 percent of male neonatal in the United States were circumcised (Moses et al. 1990; Updegrove 2001).

In some societies, as in Some Asian countries, male circumcision is a newly introduced concept and has become widely accepted as it is associated with increased sexual pleasure. In South Korea it is a recently acquired culture, brought in by the Americans after 1945. The procedure is accepted as a rite of passage and is practiced during adolescence with about 90 percent of South Korean adolescents below the age of 20 years being circumcised (Kim et al. 1999). This indicated that male circumcision has become a social norm in the society.

In societies where male circumcision is common the uncircumcised are at risk of being alienated from society. In some African societies, the uncircumcised have difficulty finding marriage partner to marry (Knudsen 1994). Some American parents assume that it is a social expectation that their infant should be circumcised at birth. To avoid potential ridicule later they circumcise their infants at birth. Circumcision is also believed to enhance sexual performance and reproductive potential (Caldwell et al. 1997).

Medical reasons most commonly cited as reasons for male circumcision are prevention of phimosis, paraphimosis, and balanoposthitis ; and decrease the risk of developing cancer of the penis, urinary tract infections (UTIs), sexually transmitted diseases (STDs) and HIV (To et al. 1998; Holman and Stuessi 1999). Upgrove (2001) stated that sufficient research exists showing that circumcision decreases the incidence of urinary tract infections (UTI). In 1999 the American Academy of Paediatrics issued a statement that although circumcision is a painful procedure, it does convey protection against UTI, penile cancer and various STDs.

Interest in male circumcision has recently increased because of the demonstration that circumcised males are probably at lower risk of HIV/AIDS (Bongaarts et al. 1989; Moses et al. 1990; Caldwell et al. 1997). With the increase awareness and spread of HIV/AIDs, circumcision was seen as a preventive measure. This was first noted in the mid 19th century when Hutchinson (Hutchinson 1885) proposed that the removal of the foreskin reduced the susceptibility of men to sexually transmitted infections (STIs). Fink (1986) during the early HIV pandemic suggested that the risk of HIV infection could be reduced through male circumcision. Numerous studies have confirmed these argument (Fink 1986; Caldwell and Caldwell 1996; Moses et al. 1998; Halperin et al. 1999; Auvert et al. 2001). Two ecological studies in sub-Sahara Africa have demonstrated that regional HIV prevalence was associated with patterns of male circumcision (Bongaarts et al. 1989; Moses et al. 1990; Bailey et al. 2001). However, Bailey et al. (2001) argued that randomised controlled trials are needed to definitely prove the concept before circumcision should be given serious consideration as a HIV prevention measure. Caldwell and Caldwell (1993) observed that the close association between AIDS and circumcision is related to the original reason for adopting circumcision, possibly to reduce STIs among the populations with the highest levels.

3.8.2 Casual Sex and Multiple partners

Engage in casual sex and having multiple partners are sexual risk taking behaviours. Casual sex is in other words called one-night stands and no string attached sex. Sonenstein (1973) labelled adolescents who frequently change their sexual partner as sexual adventurers. These are individuals having multiple partners. Everyone who is a risk taker is at risk of having HIV/AIDS and STI. Meekers and Ahmed (2000) stated that irregular sexual partners increase the risk of contacting STI.

Women reported fewer casual sex than men (Laumann et al. 1994b; Rossi 1997). The 1990 Youth Risk Behaviour Survey findings establish that many adolescents have had several partners. Study in Botswana showed that many adolescent males have multiple sex partners (Meekers and Ahmed 2000). A study in Nigeria noted that more than 50 per cent of young men stated that they have had more than one sexual partner in the last twelve months prior to the survey (Jinadu and Odesanmi 1993). In Namibia it was observed that casual sex and having multiple partners is still an issue although the country has a high HIV/AIDS prevalence rate (Bongaarts et.al. 1989; Caldwell and Caldwell 1996).

Although there is a growing literature on adolescents having multiple partners there are few studies that examine factors associated with having multiple partners. One perception is the work by Ku et.al (1992) on 15-19 year old males in the United States and found that older males aged 20-24 years, those from more affluent families and those whose mothers gave birth as teenagers had more heterosexual partners in the past year. Evangelical and born-again Christians had fewer partners than other Christians in the survey. There was also evident that young men are less likely to have multiple partners if they are more knowledgeable about AIDS (Anderson et al. 1990; Ku et al. 1992). Luster and Small (1994) in a study in the United States identified frequent alcohol consumption, low level of parental support, and a history of sexual abuse as some factors that are associated with sexual risk taking among male.

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6. 'married' is a term used by commercial sex worker to identify a category of their different types of clients.

3.8.3 Commercial Sex Worker

Prostitution or becoming a commercial sex worker (CSW) does not arise simply out of men's sexual desires or deviant women's willingness to offer sex for money but because of underlying structural conditions and concrete social organizations of sexual exchange. Sex workers, both female and male, define commercial sex as work (Browne and Minichiello 1995) . This enable them to separate work from and personal sex, defining work sex as 'not real sex'. Globally many culture do not accept commercial sex work. In Thailand commercial sex is illegal but is tolerated and is a source of revenue for many people (Caldwell 1995). However commercial sex is legalised in some parts of the world, such as Nevada (Browne and Minichiello 1995), in the United State and Canberra in Australia. Commercial sex work is legalised as a way a of preventing exploitation and ensuring safe sex. Commercial sex workers have been identified as a high-risk group since the discovery of the epidemic HIV/AIDS. The risk is associated with engaging in casual sex and having multiple partners.

Browne and Minichiello (1995) stated that sex workers categorise their clients according to their perceptions of them, which includes *'marrieds'*[6], *'easy trade', 'undesirable', 'sugar daddies', and 'heaven trade'. 'Married'* are those who expect little from sex workers beyond the sexual act. *"Easy trade"* are clients who are caring, gentlemanly, *"undesirables"* are clients who mistreat sex workers and sex workers would not prefer to service, including rough, violent, patronizing, dirty and disrespectful clients. *"Sugar daddies"* are older men who temporarily support a sex worker. Finally, *"heaven trade"* is a special encounter with a client based on a desire for a meaningful relationship and a potential for a happy future.

Some societies encourage first sexual intercourse with prostitutes because young women are not available, this was a traditional practiced in Nigeria but is no longer practical today (Orubuloye et al. 1992; Owuamanam 1995). Nigeria today, like most countries globally do not encourage young men to have first sexual intercourse experience with commercial sex workers (Orubuloye et al. 1991). Commercial sex worker are mostly young women and gay men. In Nigeria a substantial number of commercial sex workers are separated or divorced (Caldwell 1995). Akinnawo (1995) identified socio-economic factors including financial handicap, divorce or separation from husband, unemployment, and peer influence to be major factors encouraging the growth of the sex industry.

Commercial sex workers engage in casual sex and have multiple partners and researches on sex workers observed that condom use is common. In Thailand it was observed that men increasingly use condom during sexual encounters with prostitutes (Havanon et al. 1993; Hollander 1996). In the state of Nevada in the United States, Remez (1996) stated that female sex workers consistently use condoms. However condom use depends on the type of client. In an interview with male sex workers in Melbourne, Browne and Minichello (1995) observed that practising safe sex depends on the type of clients, as sex worker could either take control of the situation or the client is in control of the situation. This means that the client can offer to pay more or is told to pay more if condom is not used. Although engaging in commercial sex is well known to be high-risk for HIV/AIDS/STI many men either do not use condoms at all or use them irregularly (Havanon et al. 1993). Mahler (1997) agreed and stated that in Latin American context, a subgroup of men who have many casual partners or who frequent prostitutes do not typically use condoms.

3.9 ISSUES OF REPRODUCTIVE HEALTH – MALE INVOLVEMENT

The need to include men in reproductive health programs and to develop creative strategies to reach men is becoming increasingly urgent in the face of the growing worldwide spread of STI, including HIV infection. The major issues of reproductive and sexual behaviour discussed in this thesis is sexually transmitted infect including HIV/AIDS. This is a global issue as there is no cure for HIV/AIDS. A man's sexual practices may not only put himself but also his partner at risk of STI. Two other issues discussed in the chapter are sexual assault and teenage pregnancy. A man's view on fertility and family planning can influence his partner's attitude and her access to the service, thereby determining the timing and the number of pregnancies that she may have. An important need for young men is the basic knowledge of reproductive health issues. However in areas where premarital sex is traditionally taboo, such knowledge is very limited to young men.

3.9.1 Sexually Transmitted Infections

According to WHO, 333 million new cases of STIs occur worldwide each year and at least one third of these cases occur in people under age 25 (WHO/UNFPA/UNICEF 1999). A vast majority of these STI cases, including HIV/AIDS occur in the developing world, particularly in sub-Saharan Africa. STIs is a reproductive health issue to young men because

nearly half of all HIV infections occur to young men and women younger than 25 years, and data have indicated that up to 60 per cent of all new infections are among 15-24 year olds (UNAIDS/WHO 2002). Statistics clearly indicate that men play a critical role in spreading HIV/AIDS/STI. Youths are at risk of STI including HIV for many reasons, including the lack of knowledge about STI; not perceiving themselves to be at risk; lack of access to exposure; biological factors; economic factors; and social factors including the lack of skill or power to negotiate condom use and being forced into a relationship (McCauley and Salter 1995; Senderowitz 1995; WHO/UNFPA/UNICEF 1999; Best 2000).

Studies have noted that early sexual activity may lead to exposure to sexually transmitted diseases, including HIV/AIDS. The practice of unsafe sex, having multiple partners and having casual sex are three risk behaviours that can result in the transmitting of HIV/AIDS/STI. Researches have documented a high prevalence of STI among sex workers in developing countries. With limited knowledge of STIs and HIV/AIDS there is limited protection. Epstein (1994) stated that the discovery of relevant knowledge of AIDS was associated with lower intentions to engage in sexual behaviour in the future. Most sexually active young men know little about STIs or how to prevent them (McCauley and Salter 1995).

Even when young men do not know about STIs, inexperience or denial as well as cultural pressure can make them take unnecessary risks. A study of Latin American young men in Brazil, Ecuador, and Chile showed that almost all the young men surveyed reported that they had heard of HIV/AIDS. About 80 per cent knew that a person can be infected with HIV but show no symptoms. Despite this knowledge most did not think that they faces much risk for HIV infection, even though they were sexually active (Morris 1994).

Sexually transmitted infections include HIV/AIDS. Statistics indicate that men play a critical role in spreading STI and HIV/AIDS. Men are likely to have more sexual partners than women, thus men are at greater risk of becoming infected (Barker 2000). Men are twice more likely as women to infect their partners. A husband's extramarital relationships now carry the risk that not only he may become infected but that he may bring home infection that could also kill his wife. The converse is also true, though less frequently so (UNFPA

2003). The effect of men's attitude and behaviours with respect to women's health is perhaps most evident in STI prevention and treatment. Increasing condom use and changing high-risk sexual behaviour are primary STI prevention strategies. This is a step towards changing men's behaviour in a way that directly affects their own health as well as the health of their partners and wives. In India a study of married and monogamous women at STI clinics found a high rate of HIV and other STD in this apparently low-risk group (Althaus 1998). A strong predictor for HIV infection among these women was having a husband who had been diagnosed with a STI.

STI such as gonorrhoea and Chlamydia can cause infertility in men and women if left untreated. However women are often blamed for infertility when in fact the man may be infertile (WHO 1991; Danforth and Green 1996). WHO estimated that 8 to 22 per cent of infertility worldwide is due to male causes (WHO 1998). Treating men's STIs early and correctly diagnosing fertility problems would help reduce the social stigma and abuse some women receive when they do not conceive (Danforth and Green 1996).

3.9.2 Sexual Assault

Sexual assault is a broad-based term that encompasses a wide range of sexual victimization, including rape. Sexual coercion is defined as the physical or verbal pressure to engage in sex. This range from sexual abuse- in which a child is forced to perform sexual acts by an adult, or rape, in which physical force is used, to ignoring someone when he or she express a desire to stop (Caceres et al. 2000). Sexual coercion has taken on added importance in the era of HIV/AIDS. There is a relationship between sexual coercion and HIV/AIDS, it is associated with risk (Caceres et al. 2000).

The past 20 years have brought a significant increase in the general knowledge about adolescent offenders and sexual offenders and the potential harm they can cause to victims. Sexual offending is likely caused by multiple causation and interactive factors (O'Shaughnessy 2002). Studies have shown that those who experienced sexual abuse during childhood or adolescences were more likely to engage in HIV risk-behaviours during adulthood. Caceres et.al. (2000) notes that experiencing heterosexual initiation as coercive appears to be a marker for a riskier sexual career for both genders and for future

homosexual behaviour in men. Coerced heterosexual initiation also reported more lifetime sexually transmitted diseases and a lower age at first sex than those not reporting coercion.

Although there is little reported incidence of sexual assaults to males as compared to females, this does not imply that the incidence of sexual to male is lower than that of the females. One major reason for the lower level of reported incidence of sexual assault to male is because of the masculinity concept that men are suppose to be the instigators of sexual activities, men are the dominating individual and are suppose to enjoy sexual activities. When reporting sexual assaults these men would be frowned in society. There is therefore limited research available on men who reported having been sexually coerced. Jinich et.al (1998) however observed that there is a high levels of childhood sexual abuse among homosexual men.

Recent evidence indicates that many sexual offenders were themselves molested and that the lack of family support about that molestation is an important risk factor for sexual offending (Paradise 2001). With the lack of family support the individuals could be withdrawn or blame others for their weakness. A study in South Africa showed that sexual violence exists where men dictate the conditions and timing of sex through the use of violence and through the circulation of certain constructions of love, intercourses and entitlements to which the teenage girls were expected to submit. Violence to some were a show of love (Wood et al. 1998).

Child sexual abuse is a type of sexual assault that is frequently unreported and unacknowledged, making it difficult to measure its prevalence. Studies have shown that it is widespread throughout the world with girls more likely to be abused than boys (Finkelhor 1994; Heise et al. 1999). Most perpetrators are men and are known to their victims. They frequently are family members, friends, or older men in position of authority (Leach 2001; Jewkes et al. 2002). Consequences include physical injuries, STI and HIV/AIDS, pregnancy, sexual dysfunction, depression, and other psychological and social problems. Child abuse is also associated with risk-taking behaviour later in life, such as unprotected sex, and multiple sexual partners (Boyer and Fine 1992; Fergusson et al. 1997). The harmful consequences are

reported more frequently by women than men and are more likely to occur when it involves force, penetrative, incest, or repeated incidents (Kendall-Tackett et al. 1993.).

3.9.3 Teenage Pregnancies

Teenage pregnancy and childbearing have received widespread attention in recent years. Involving men in reproductive health is crucial in enabling women to avoid unwanted pregnancies. Unplanned pregnancy rates vary dramatically across the globe. The rate of teenage pregnancy and birth in the United States is so much higher than any other developed country (Delbanco et al. 1997; Gohel et al. 1997).

The characteristics of a teenage woman's partners appear to play a role in non-marital teenage pregnancy and its outcome. Previous research have shown that young men living in areas with substandard social and economic resources are more likely than those from more advantaged backgrounds to say that they have fathered a child, or that their partner has been pregnant (Hanson et al. 1989; Marsiglio 1993). Environmental factors also influence attitude and behaviour towards pregnancy. According to a cohort study conducted at a San Diego primary care clinic Rosenberg (2001) observed that men who are exposed to abuse or domestic violence in childhood are significantly more likely than others to be involved in a teenage pregnancy.

Researchers have examined men's role in non-marital teenage pregnancy and its resolution. Studies have explored the effects of young men's family background, education and other characteristics on whether they become a father or impregnate a partner (Hanson et al. 1989; Ku et al. 1993; Thornberry et al. 1997; Zavodny 2001). However adolescent males do not cause all teenage pregnancies and little is known about older sexual partners of teenage women (Darroch et al. 1999). Some men may not know that their partner became pregnant if the pregnancy was terminated. Some studies examined both male and female partners' background characteristics. Age differences was observed to influence pregnancy rates and pregnancy outcome (Darroch et al. 1999; Zavodny 2001). A man's willingness to accept paternity and the men's reaction to a young woman's pregnancy can influence a woman's decision to abort (Webb 2000).

Vundule et.al. (2001) stated that there is a limited understanding of the factors that place particular adolescents at risk of teenage pregnancy. Teenage pregnancy among black adolescents in Cape Town were found to be associated with frequent sex, forced sexual initiation, not owning a TV, not living in a brick house, talking openly about sex with the boyfriend, not using reliable contraceptives protection, large household size, not living with biological father, and perceiving most friends to be pregnant.

Some of the reasons for teenage pregnancy could be attributed to the declining traditional norms that prevent premarital pregnancy, development, and Westernisation. Different attitudes and beliefs about sexual activity may also affect the prevalence of unplanned pregnancy globally. Cultural norms and religious values are often reflected in and reinforced by government laws and regulations, as well as by medical, educational and media policies and practices (Zavodny 2001).

3.10 SUMMARY

Men's participation in reproductive health is a promising strategy for addressing some of the most pressing reproductive health problems. Men can help slow the spread of HIV/AIDS and other STI; prevent unintended pregnancies and reduce unmet need for family planning and stop abusing women (Green et al. 1995; United Nations 1995; Byrne 1997). New surveys on young men are providing valuable information about this often under-served group, however more research is need on how to reach youth most in need (United Nations 1995; Hughes and McCauley 1998; Wegner et al. 1998). Like the older married men, young unmarried men and boys need information account contraception, STI including HIV/AIDS, sexuality, pregnancy, and other reproductive health issues. Many also need more access to reproductive health care including family planning.

Young men have a lot to learn before they can become responsible sex partners. Globally many young unmarried men are having sexual relations but know little about the consequences. Some studies have shown that few young men understand fertility or the menstrual cycle (Morris 1994; Gorgen et al. 1998). Many young men mistakenly think that pregnancy cannot occur if the female partner is a virgin (Gorgen et al. 1998) and that a woman can only became pregnant if sexual coitus takes place during menstruation (Morris

1994). Many young men do not know about modern contraceptives or where to get information and service (McCauley and Salter 1995). Although they might know of contraceptive methods, many believe common misconceptions such as that contraception causes infertility (Gorgen et al. 1998).

Almost everywhere the average age at first marriage has been rising while the average age of sexual initiation is getting progressively younger (McCauley and Salter 1995). As the gap widen young men have more sexual partners before marriage putting them at greater risk of impregnating young women and increasing unwanted pregnancies, and risk of being infected with STI and HIV/AIDS (Magnani et al. 1995; McCauley and Salter 1995). Earlier sexual initiation may be explained partly by the decline in the age at which puberty begins in boys and girls.

Men's gender roles can harm men's health as well as their partner's. A mixture of cultural norms, social expectations, and men's sex drive encourages men to engage in risk taking sexual behaviour (Barker 1996; CEDPA 1996). Some societies as in Haiti and Thailand accept married men having extramarital sex, either with girlfriends or with commercial sex workers (Tangchonlatip and Ford 1993; Ulin et al. 1995). Also in many Latin American and Caribbean cultures the concept of machismo encourages men to be promiscuous to prove their masculinity (Barker 1996). Such male gender roles can contribute to their contacting STI and passing them to their partners or wives.

CHAPTER 4

RESEARCH METHODOLOGY AND THE DATA

4.1 INTRODUCTION

Conducting research on sexuality in Fiji is very difficult, due to the cultural sensitivity of the topic of research, the political situation in Fiji, and the research environment. As discussed in Chapter One and Chapter Two, discussion about sex and sex related topics is taboo and is not to be mentioned in public. Bryman (1984) argued that the problem under investigation dictated the method of investigation to be used. To enable the research team to obtain information on sexual behaviour from the target population where sexuality is a taboo and from others directly and indirectly related to the target population, different research methodologies have to be implemented.

This chapter discusses the different research methodologies used to obtain the information needed to enable the research objectives to be met. This chapter discusses some methodology issues in sexual behaviour research. Finally the different methods of analysing the data obtained from the research are also discussed in the chapter. The socio-demographic variables that are used, as independent variables, are included in the discussion on the method of analysis used.

4.2 METHODOLOGICAL ISSUES

Studies in sexual and reproductive behaviour, and sexually transmitted infections often employ survey methods. The quality of the research depends on developing reliable and valid methods for conducting survey of sensitive topics such as sexuality (Catania et al. 1990). A number of researchers have raised concern over the strengths and reliability of the data collected in sexuality research.

This research tries to address these issues in different ways as will be discussed in the later parts of the chapter. Some of the issues of sexuality research include the problem of language, refusal to grant permission to conduct the research, and response refusal. The chapter examines the different methods used to address the issues of sexual behaviour

research. The chapter then outlines the different research methods used to obtain the data needed to need the research objectives.

One of the issues in sexuality research, as Blinn-Pike et al. (2000) discussed is the difficulty in getting approval to conduct sexual behaviour research. These difficulties could be due to cultural values and preferences of the target population. Researchers have noted the importance of having an insider approach is an easier way of obtaining permission. That is, knowing someone who has links to the target population or the individual who gives permission for the research to be conducted. An example of which is when conducting an adolescent sexuality research in school, the insider approach taken is relying on teachers to be the main source of information on data that are difficult to obtain and to arrange interviews with individuals for data collection. This was the experience obtained at the 1999 Youth Risk Behaviour Survey in the USA. Utomo (1997) however stated that although she expected that she would have difficulty in obtaining permission to conduct sexual behaviour research in Indonesia, there was no disapproval from the government and the target group in general.

Brinson and Catania (1998) examined the difficulties respondents sometimes have in understanding the language and the vocabulary used in sexual behaviour research questions. The central issues in this case are in asking questions, especially questions relating to sexual behaviour, where appropriate language is needed. The language and vocabulary used can be obtained from respondents during the interview and used by the interviewer in the next round of interviews. This could enable respondents to understand the questions better as the language used was based on their common everyday language. However Catania et.al (1990) noted that this places an additional demand on the interviewer and would not work for self-administered questionnaire. Some terms may also be offensive to both the respondent and the interviewer.

An approach that is commonly taken to address the issue of vocabulary also includes the use of colloquialism or street language when referring to a particular sexual act. This approach is good for the target of a specific population. Some researchers have also used formal

language (Laumann et al. 1994; Welling et al. 1994) due to the regional nature of slang and respondents' varied understanding.

Brison and Catania (1998) stated that the issue of language is a problem because respondents rarely state or inform the interviewer that they do not understand the words in the questions. Respondents however still provide a response to the questions (Willis et al. 1991). Although they do not understand the questions, people are reluctant to admit that they do not understand the words in the questionnaire (Binson and Catania 1998). This could greatly influence the quality and the reliability of the data collected.

Eggleston et al (2000) explored the issue of self-reporting in sexual behaviour research. The argument is that when respondents are asked about sensitive topics such as sexual experiences, they might give what they consider to be socially acceptable responses. Intentional reporting of this type could give incorrect information to the interview (Johnson and Delamater 1976). The types of errors discussed above are non-sampling area in survey data collection. To minimise invalid reporting as such self-administered questionnaire could neutralise respondents' reluctances to report.

The above issue is similar to response bias issue. This is when people tend to disclose more honestly in greater detail to people with whom they feel emotionally comfortable (Catania et al. 1996) and give less or incorrect information to those they are not comfortable with. This indicates that the interviewer does influence responses in a survey. Research have found that people tend to report more sexual information or make more sexual statements to female interviewers, and women are more influential than men as interviewers (Catania et al. 1990; Catania et al. 1996). However on a sensitive issue such as sexual behaviour, interviewer's sex and the age of the interviewer are also important factors, as more sensitive information could be obtained if the respondents and the interviewers have the same gender and are in the same age group. This however contradicts with the point mentioned above.

Johnson and Delamater (1976) stated that respondents' refusal to participate, either before or during the interview is an issue that affects the acceptable completion rate of the survey. Respondents could refuse to participate in the survey after being asked to participate. To

minimise the problem it is best to make a more personal approach at the first point of contact with the respondent, this includes a visit or a phone call, to explain the purpose of the study. In this survey it was observed that some respondents refused to continue with the interviews after they realised that the questions were too personal.

In the research of sensitive and culturally taboo topic such as sexuality, it is essential to use a wide variety of research methods in-order to obtain the data that is needed. Both quantitative and qualitative research techniques were employed in the data collection process.

4.3 RESEARCH METHOD

The applications of different research methods are discussed in the later part of this chapter. Researchers have observed that using both the qualitative and quantitative method of research is a great advantage (Bryman 1984; Lee 1995; Utomo 1997; Malungo 2000) as one research method complements the other.

4.3.1 Target group

The original study design was to obtain a sample survey of 1200 urban youths from the two major ethnic groups in Fiji, namely the Fijian and Indian men aged 15 to 24 years. The sample was to be collected from youths, about three quarters of whom are attending secondary and tertiary institutions in Suva at the time of the interview, and about one quarter are currently not enrolled in any formal education system. However, because of problems encountered in the field, the focus of the target population changed and I concentrated on the indigenous Fijian male youths only therefore reducing the targeted number to 1000.

The difficulty I encounter was mainly because of the sensitivity of the topic and sexuality is cultural not to be openly discussed in the Indian community in Fiji. As a result I encountered great difficulty in obtaining permission to interview Indian youths in Suva. School principals of the two Indian schools did not feel comfortable with the topic and informed me that parents would not allow their children to answer the questionnaires, so they were not in the position to allow the students to be interviewed. One high school principal informed me that if the parents knew that they did encourage the discussion on sexual behaviour and have given the consent for the interview to be conducted in the school, some parent would rebel

against the principal. The principal in trying to maintain a good relationship with the community and the parents, informed me that although he strongly support the research he could not approve for the student in the school to be interviewed. Another contributing factor was the ethnic differences. A lot of ethnic tensions exist in Fiji. As a Fijian it could be difficult to gain the trust of an Indian in Fiji. Therefore in attempting to conduct the research it was very difficult to communicate with the Indians.

As all the expected 1000 respondents are Fijians the results for the Fijian community are more robust than if there was a split between Fijians and Indians. The study area remained unchanged.

4.4 DATA SOURCES

The main approach to collecting the primary data source for this study was a combination of qualitative and quantitative methods. This research data was collected during a five months of fieldwork period, from March to August 2001, in Suva, Fiji. Secondary data used in the analysis is also discussed in this chapter. Other data sources include Archival resources, reports from different sources that have conducted similar research in Fiji, the 1996 census data, and literature collected from different sources.

4.5 QUANTITATIVE DATA

The quantitative data include both primary and secondary data but this section actually discussed the primary data only. The primary data set is from the questionnaire survey conducted in Suva with 822 young indigenous Fijian men, out of the 1000 proposed sample size. This was to establish their knowledge, attitude, beliefs and practices relating to sexual and reproductive behaviours. The topics covered social and demographic characteristics, knowledge of reproductive health behaviours, and sexual behaviour and practices.

4.5.1 Sampling procedure

Sampling can provide an efficient and accurate way of obtaining information about large population. Just how efficient and accurate depends on the type of sample used, the size of the sample and the methods of collecting data from the sample (de Vaus, 1995:19). Using random sampling a sample of 1000 individuals was selected from the target population.

To reduce sampling bias, which would invalidate the sample results, the sample was randomly selected. The sample was without substitution, as selected people may be different from the other people whose information would have been solicited; so those not found and those who refuse to be interviewed were not replaced. It was therefore crucial to make a second visit to reach all the selected people who were not available during the first visit. These second visits were mostly to schools. The research team made one revisit but, when individuals were still not available, they were withdrawn from the list of respondents. As part of the above method, an over-sized sample was chosen beforehand to allow for the individual identified but not available for interview or those who refuse to take part in the survey.

Two methods of random sampling were used in the survey. These were the cluster sampling and the systematic random sampling. The respondents were classified into two groups. First was the random selection of respondents who were chosen from the formal education system. These are the youths attending high schools and those in tertiary institutions. In selecting respondents from high schools and tertiary institutions, cluster sampling was first conducted in choosing the schools and institutions. That is a number was allocated to each of the schools, all the numbers were put into a box and only eight numbers were picked. The schools that represent the numbers picked were the school selected for the research. The same process was repeated for tertiary institutions. So from a list of all the nineteen high schools and eight tertiary institutions in Suva, eight schools and four tertiary institutions were randomly selected.

The second stage was also to make a simple random selection of classes and courses that these students take. Four courses and four classes were chosen from each school and institution. This was conducted in the same way as the first stage of random sampling. Finally, in identifying the respondents, systematic random sampling using a random start was carried out.. A proportional number of respondents were chosen from each class and from each course in the case of tertiary institutes. Administrative staff members at the schools and institutions helped me randomly select my respondents. The class list from all the high schools was in alphabetical order of the male students' surnames. Every third person from the class list was selected for the questionnaire interviews that were either self-administered

or by interview depending on the interviewee's choice of interview method. As for the students in tertiary institutes the class list included date of birth and so every third male below the age of 25 years were selected for the interviews.

The survey also covered those not in the education system. These second group of respondents, which is those males age 15 to 24 years, living in Suva but not in any formal education, was randomly selected using a systematic random sampling. Two suburbs, Raiwaqa and Nabua, in the city's central business district (CBD) were selected. This is purposive selection or sampling as the two suburbs have a high proportion of Fijian population. Appointments were made with some of the individual for later interviews when they could not be available on the first day. A similar process was followed in the CBD; three areas hangout areas were identified and the research assistants randomly selected their respondents and interviewed them. The sample was taken from the city centre including three points of contact. These were the Village Six cinema, Downtown Boulevard, and Sukuna Park. These are also the points of contact for the selected respondents. The target number of respondents from this area was 130. The interviews in these areas were carried out between Monday and Friday. No questionnaire interview was conducted on Saturdays and Sundays, as these days were left specifically for qualitative data collection. These areas were chosen as it was observed that they were frequented by youths. The sampling process discussed above is biased towards young men who hang out in groups, members of suburb gangs. It is noted that some young men in the suburbs do not hang out with other young men in the area. However as some individuals selected from the CBD and the suburbs were in the formal education system, they were not withdrawn from the sample. This resulted in a higher proportion of respondents stating that they were still in the formal education system.

The respondents chosen from the two suburbs were either interview at home or at the area of contact. The target was to interview 100 respondents from the two suburbs. The respondents in these areas were also given the option of being interviewed or to self-administer the questionnaire. These self-administered questionnaires were completed in the presence of one of the member of the research team. Questionnaires were not given out for over night collection, although some of the respondents requested for this. They were informed that the research team was willing to make a second visit in-order for them to

complete the questionnaire in the presence of one of the research team members. This was because if a question was raised or a query on a question was made, it could be asked by a member of the research team. Every third male youth the researcher met was identified in the suburb was asked if they were willing to be interviewed. If they were over the age of 25 years, they were requested to participate in informal in-depth interviews. This process was also followed in the CBD. This was to reduce the likelihood of the youths willing to participate, from feeling rejected if they did not participate.

A random selection of individuals was made in two suburbs and in the city's central business district (CBD) using systematic random sampling. Every fifth person that passed the point of contacted that was selected were requested if they were willing to participate in the survey. If they agreed they were asked if they were below 25 years of age, if not they were acknowledged for their willingness to participate and were informed that they do not meet the criteria. After agreeing to be interviewed, the respondents were invited to choose to go to the RFHAF conference room (less than 5 minutes walk) to be interviewed or to self-administer their own questionnaire. This was to maintain the privacy that they need when answering the questions, as most of the questions were too sensitive to be asked in a public place. A quick snack was also provided to them at the RFHAF office. If the respondents are too shy to go to the RFHAF office, they are taken to the nearest coffee shop or food-court where they chose to complete their questionnaires by being interviewed or self-administer their own questionnaire and at the same time have hot or cold drinks and some snack.

4.5.2 Sample Size

As shown in Table 4.1 the study contacted 968 individual respondents for the questionnaire interviews. Of the total individuals contacted 103 respondents refused to participate in the survey while 43 respondents did not complete the questionnaires. The incomplete questionnaires were not included in the analysis. The two main reasons some of the respondents stated why they did not do the questionnaire were because of religious taboo as it is a sin, or because of the cultural taboo in discussing sexual behaviour openly. For those who did not complete the questionnaire, it was observed that most did not attempt Part 5 and Part 6 of the questionnaire. Although a second visit was made, 32 respondents could not be interviewed after several attempts to contact them so they were dropped from the list.

These were mostly young men from schools and institutions. A total of 822 questionnaire interviews were used as the primary data for this study.

Table 4.1: Questionnaire Interview during the 2001 Reproductive and Sexual health survey, Suva, Fiji 2001 (percentage)

Target	INTERVIEWED		REJECT	NOT INTERVIEWED
	Full	Partial		
1000	822 (82.2%)	43 (4.3%)	103 (10.3%)	32 (3.2%)

The stratified cluster sample breakdown is shown in Table 4.2. A sample probability of over 80 per cent response rate was obtained from each cluster when selecting and conducting the questionnaire interview. In the sample students in high school and those in tertiary institute were treated separately because of the age differences between the two groups and the level exposure, because as discussed in Chapter Seven education influence the expectations on sexual behaviour. When in the school system young men are discouraged to have intimate relationships but at tertiary level they are perceived to be adult and can have intimate relationships. The above sample strata cannot be said to be statistically representative of youths aged 15-24 in Suva because most respondents for currently in the formal education system.

Table 4.2: Breakdown of sample by strata

Strata	Target No.	Cluster sample probability	Sample	Sub-cluster in selected cluster	Sampled respondents
Formal	740	86.1	637		
High school	480	80.2	385	No. of classes – 4	385
Tertiary	290	86.9	252	No. of courses – 4	252
Non-formal	230	80.4	185		
Suburb	100	81.0	81	----------	21
CBD	130	80.0	104	----------	38
Total	1000	82.2	822	----------	680

4.5.3 Questionnaire design

Questions for the 2001 RSHKB (Reproductive and sexual health knowledge and behaviour) survey was adopted from a number of questionnaires surveys conducted between 1993 and 2000. These surveys were all on reproductive and sexual health. These included; the Demographic and Health Surveys of different countries, the Adolescent Male Sexual Behaviour Survey in Metro Manila 1993 (Lee 1995), the Jakarta Marriage Values and Sexual Survey 1994-1995 (Utomo 1997), the Fertility and Reproductive Health Survey in Fiji, 1994

(Seniloli 1995), and the Male Reproductive Health Survey in urban Suva, Fiji, 2000 (Kaitani 2000). To meet some of the objectives, some questions were formulated specifically for this survey.

The questionnaire for the RSHKB survey was developed for male respondents aged 15 to 24 years. It was divided into seven parts namely (see Appendix 1):

Demographic characteristics
Knowledge of reproductive health
Gender relationships
Dating and pre-coital behaviour
Culture and reproductive health
Practices in relation to reproductive health
Reproductive and sexual behaviour

Part 1 of the questionnaire was designed to obtain information and data on general demographic characteristics of the respondents. This covers the independent variables, the socio-demographic factors that can influence reproductive and sexual knowledge, attitudes, and practices. Part 2 relates to the respondents' knowledge of reproductive health, account for the sources of knowledge, knowledge of contraception, safe sex and STIs, and knowledge of available reproductive health services.

Questions for those who were sexually active were left to the last part of the questionnaire. This was done to enable the respondents to build up their confidence with the interviewer, for those who had face to face interviews, or with the research team for those who had self-administered questionnaire, before the personal and sensitive questions were asked. Another reason was that, as some of the self-administered questionnaires were administered in school, young men who are sexually active would not be easily identified by other respondents when answering the questionnaire, as at the final stage every one concentrates on answering the questionnaire and were more at ease with the survey environment.

In Part 3, questions on gender relations were asked to assess the respondents' perceptions of sexuality and gender. These perceptions could influence their behaviour. It is also a measure of young men's attitude towards women. Part 4 questions on dating and pre-coital behaviour

were asked to assess the respondents' understanding of dating, and their perception of the behaviours involved. The responses also showed the respondents' attitude towards appropriate sexual behaviours. Culture and reproductive health questions, Part 5, evaluate the respondent's understanding and knowledge of what is the culturally acceptable behaviour. This can influence public and private behaviour of an individual. The final two parts of the questionnaire are interrelated; they assess the respondents' sexual practices. The questions were designed to assess the respondents' sexual practices including the sexual risk behaviours for those who have ever been involved in any one form of sexually activity.

Some adjustments were made to the questionnaire after the pre-test in early March 2001. The pre-test was conducted between March 13th and March 27th 2001. The adjustments included the reorganisations of some of the questions that respondents did not understand; some questions that were repeated were removed; and some questions and some choice of responses that were deemed irrelevant were also removed from the questionnaire. Some questions were re worded or restructured in order for the respondents to understand the questions. Additional choice of responses was given to some questions as a result of the responses received during the pre-testing of the questionnaire.

4.5.4 Field administration process

The first steps taken in the field was to obtain permission from the schools and from the tertiary institutions selected above. Blinn-Pike et al. (2000) stated that an insider approach is important in obtaining permission to conduct research in some environment, and this was the approach I took to obtain permission from the selected schools and institutions. After having a teaching career in Fiji for the last 20 years and teaching in Suva for the last 12 years, I had come to know many of the school principals and academic staff. As a result it was not difficult to make an appointment with the school principal and to obtain permission from them. Only one selected school did not allow the questionnaire survey to be conducted in the school, the principal however allowed the students to participate. As the school was within walking distance of my flat, I arranged with some teachers to bring the selected students to my flat and there they filled in the questionnaires. Others interviews were all conducted in the classrooms or the school hall. For this arrangements were made with the

subject teachers to make available the male students who were selected for the questionnaire survey.

Only one school stated that permission was to be granted by the parents. The principal stated that the survey questions were too sensitive, so the selected students were given a consent form and an information sheet for the parents to read and sign. 72 per cent of the selected respondents return the consent forms giving permission by their parents to participate in the survey. The survey was conducted in school after the consent forms were returned. This school however did not allow the student in forms three and four (aged 15 to 17 years) to participate in the questionnaire interview, as the principal think that they were too young to be exposed to the questions and the survey topic.

Before the interviews, both individual and group were conducted, respondents were informed about the purpose of the survey. This introduction was conducted by myself or by one of the research assistants, in my absence. Respondents were informed about the objective of the survey and the anonymity of their responses. It was emphasised that no names was required and that at the end of the interviews the questionnaires were to be placed in the envelopes provided and the envelopes were to be sealed. It was stressed that the only person to unseal the envelopes and use the data was the researcher. The introduction was conducted in either Fijian or English, depending on the choice of language that the respondent is more comfortable with. Introduction lasted about 5 minutes and respondents were allowed to ask questions if there were any queries.

As discussed earlier, questionnaires were answered in two ways. They were either self-administered or filled by the interviewer during face-to-face interviews. The survey was self-administered in two ways: first, on individual basis, where the respondent preferred to answer the questions on his own in an isolated area and the research assistant was there to assist him when requested; the second, collectively, as in the case of schools and tertiary institutions where students were seated in the classroom or the school hall, and independently answered the questionnaire. Two or three interviewers assisted the respondents, depending on the size of the group. The group size ranged from 10 to 25 respondents self-administering the questionnaires at one time and having 2 or 3 members of

the research team in the hall to assist them with any queries they might have while answering the questionnaire. The school staff was requested not to come near the survey area as their presence would influence the responses the students would give because the students would not be at ease if someone they know was around, especially if it was a teacher.

Face to face interviews were mostly conducted with tertiary students and those respondents identified in the streets and in the suburbs. In some cases, once the face to face interview was in progress, the respondents would requested that they read and answer the questions themselves (self-administered) because they found the questions, asked by the interviewer, to be too personal and too sensitive. Some when, at the end of the interview, asked why they changed their mind, they stated that they were not comfortable with the questions being directed to them. They preferred to read and answer the questions on their own.

Only one tertiary institute had a collective session where all the respondents were in a lecture theatre and at one given time and using the self-administered process they completed the questionnaire. In other tertiary institutes, where possible the selected respondents were approach at the end of the lesson and with consultation with the lecturers in-charge of the class, arrangements were made to conduct the self administered questionnaires in groups for those who prefer the above. However for those who preferred to have face to face interviews appointment time were make with them and the research team was there to conduct interviews for them. It was observed that most of the respondents prefer to do self- administered process. This was encouraging as Catania et al. (1996) noted that it gives respondents greater control over the answered to give and it decreases question threats.

4.5.5 Field assistants

Two sets of field assistants were used in the research. The first group were those employed during the pre-test and pilot study. These were university students who were experienced research assistants. They included, one female and two males. My experiences in interviewing young men and the experiences of the female fieldworker was useful in assessing how to discuss sexuality issues with the opposite sex. The different experiences the research assistants had was recorded and compared at the end of each week..

Heterosexual respondents for instance, may have a number of strong emotional reactions to being asked questions on their sexual behaviour by an opposite-gender interviewer, that in turn could elicit over or under-reporting of sexual activity. In discussing a sensitive issue such as sexual behaviour, Johnson and Delamater (1976) observed that because the interviewer is of the opposite sex the respondents can have the intention of reporting incorrect information. Eggleston et. al. (2000) observed in a survey of Jamaican adolescents that the high rate of inconsistency amongst youth in reporting age of first sex and over report their sex experiences or under report their experience was more frequent to males interviewers as compared to females. However in the present research it was noted that in a survey on a sensitive topic such as sexuality, to have the same gender interviewer is an advantage because there will be less chance of over reporting or incorrect reporting.

I had to identify a second group of research assistants for primary data collection. This was because the three university students I employed earlier were busy with their university work and did not have time to continue with the survey. In associating myself with the Reproductive and Family Health Association in Fiji (RFHAF), a non-government organization. I was able to identify four research assistants from the above NGO. These were young unmarried men aged between 22 and 24 years. They were volunteer peer educators for RFHAF. These research assistants had a good knowledge of reproductive and sexual issues. They also had research experience, as they were part of a team that had conducted one research on sexual and reproductive behaviour for RFHAF. The survey was titled "Survey on Young People" and the research method used to collect data was a structured interview technique. There was a need to educate the researcher on how to conduct other research methods including in-depth interviews and focus group discussions.

The research assistants for the questionnaire survey were given two days training in the RFHAF conference room. The first day was on conducting the questionnaire survey. This session was divided into two parts. Firstly there was a brainstorming session on conducting questionnaire surveys and secondly the team was given a practical session were they interviewed each other and next go out into the streets to try and interview two individuals from the target population. This was to enable the interviewers to have a better understanding on how to work in the field and how to approach respondent. The session

concluded with a general discussion on the problems they encountered during the practical session. Ways of solving these problems were also identified and discussed.

The second day of training was used to discuss the qualitative approach. Each research assistant was given a diary to record their daily events and to record any observations they have made in relation to young men's sexual behaviour. The first part of the session was a brainstorming session. This was followed by a practical session where I conducted a focus group discussion with my four research assistants. This discussion lasted slightly more than one hour. In the afternoon, each research assistant was asked to identify a young man that he could interview in the afternoon. The in-depth interview was recorded and at the end of the interview we listened to one recorded interview and commented on how they could improve their questioning technique. At the end of the first weekend of interviews, the research assistants were more familiar with their work and were more experience in formulating new questions during in-depth interviews and focus group discussions.

Other fieldwork assistants included the individual who transcribed about 50 per cent of the in-depth interviews. In-depth interviews were either in Fijian for some and in English for others. Another female was employed to compute all the transcribed work. Two personals were also employed to do the survey data entry on SPSS. They computed 90 percent of the survey data before I returned to Australia at the end of my fieldwork while the remaining 10 per cent on the questionnaire survey were computed.

4.5.6 Interview venue

The interview environment has a great influence on the response given by the respondents. It was therefore important to choose a venue that is comfortable and not threatening to the respondent. The survey was conducted in four different environments with two different settings. Interviews were conducted in schools and tertiary institutions, on the streets, in private offices and in homes. Two or three research assistants in each classroom were around to help the respondents with their queries. This same procedure was followed for tertiary institutions where collective self-administered procedure was followed. One-to-one interviews were mostly administered in tertiary institutions, on the street and in food-courts, in the offices (RFHAF/STI clinic) and in homes. Interviews conducted in homes included

those conducted at the respondent's home, at the respondents' friend's flat, and at the researcher's flat. The respondents chose their interview venue. Some interviews were conducted at my flat because research assistants and respondents could not identify a place that was suitable for them. In most cases the respondents did not want to be seen or heard by others so they requested a private interview.

4.6 DATA ANALYSIS

Various appropriate data analysis methods were employed for analysis of quantitative data. These include uni-variate, bi-variate, and multi-variate analysis. The survey data were analysed using the Statistical Package for the Social Sciences (SPSS) computer package. The bi-variate analysis included frequencies and percentage distributions, and cross-tabulations. Multi-variate analysis and specific statistical tests are discussed in the later part of this chapter.

4.7 SOCIO-DEMOGRAPHIC CHARACTERISTICS

The socio-demographic characteristics of the respondents are shown in Table 4.2. There is a slightly higher proportion of respondents in the 15-19 age group as compared to those in the 20-24 age group. This is similar to the national indigenous Fijian male population age distribution of those age 15 to 24, as the 1996 census data (Bureau of Statistics, 1998) showed that 54.9 per cent of those age 15 to 24 are in the age category 15-19 and 45.1 per cent are age 20-24, 53.9 per cent and 46.1 per cent respectively for the Suva male population distribution.

The residential status of the respondents is identified through whom they are currently living with (staying with parents, living with friends, staying with relatives) or the type of reside that they live (own home, hostel/boarding house) in at the time of the interview. Respondents identified one of the choices of answers given. As noted the majority of the respondents stated that they were living with their parents and about a quater of the respondents sated that they were living in the hostels/boarding houses. This indicates that those in hostels or boarding schools are in the Suva for education reasons, because there is no commercial boarding facility available to young men except for schools, tertiary institutes, the military camp and the bachelors' quarters for the single police officers.

More than 50 per cent of the respondents stated that they had a higher secondary education attainment. It must be noted however that most of the respondents are still in the education system and they are stating their current education status when asked about the level of education attainment.

The area of childhood upbringing is based on the question *"Where were you brought up as a child?"* There were three choices as response to the question. These were in the village, in a farm/rural settlement, or in town/city. Those brought up in villages and in a farm/rural settlement were classified under rural and those brought up in towns/city were classified under urban. More than 50 per cent of the respondents had their childhood upbringing in the urban environment. It must be noted that this does not mean that they had their childhood upbringing in Suva, because there are twelve other urban centres in Fiji. It was observed that about 30 per cent of the respondents have lived in Suva for more than 10 years and only 13.6 per cent of the respondents have leaved in Suva through out their lifetime.

The area of childhood upbringing could have a lot of influence on the sexual behaviour of the individual. As those brought up in the rural setting are more likely to have had the extended family as the main supporting mechanism for education on cultural moral values. While in the urban setting this is the responsibility of the nuclear family and the parents sometimes do not have enough time to commit to educating their children on these value. Their traditional roles also play an important role. This is because their time could be spent on paid employment and other community and religious commitments. Those in rural areas also have a lot on traditional role as a traditional Fijian setting this support mechanism plays an important role in educating the young on the acceptable behaviour pattern including sexual behaviours.

Religion plays an important role in influencing the attitudes and beliefs of an individual. More than 90 per cent of the Fijian population are Christians, however those who are practising Christians are of a much lower percentage. The data showed that all the respondents indicated that they belonged to a Christian denomination but only 44.6 per cent stated that they regularly go to church. Below is the question asked to the respondents;

Q8.	How often do you go to church or to religious gatherings?
	1. Every day
	2. Every Sunday
	3. I go to every religious gathering
	4. Sometime
	5. Rarely
	6. Never

Respondents who chose numbers 1 to 3 were classified as *regular church* attendants and those choosing numbers 4 to 6 were classified as *not regular* church attendants. Religion has a great influence on the individual's attitudes and behaviour and the teaching of the Christian principles could greatly influence an individual's behaviour. This is a major reason why religion and religious commitments were taken into account as having a social influence on an individual's behaviour pattern.

Table 4.3 shows how age influences some of the socio-demographic variables. As age is the controlling variable in most analysis, the table shows that age influence the residential status of the individuals. More than 50 per cent of those aged 15 to 19 were still residing with their parents, at the time of the interview. More than 50 per cent of those aged 15 to 19 are regular church attendants as compared to a slightly lower percentage, 44.8 per cent, of those aged 20 to 24.

The relationship between education attainment and age clearly indicates that most of the respondents are still in the formal education system. It must be noted that between the age of 15 and 17 an individual is expected to be at the Junior high school level, between ages 17 and 20 they are expected to be at High school level, and from age 19 years an individual is expected to be at the tertiary level, including any system. As most of the respondents are stating their current level of education, at the time of the interview, we cannot conclude that this is their final and highest education attainment. Some of the respondents will continue in the system and achieve higher levels.

Table 4.3: Descriptive Analysis of the Socio-demographic Factors

Socio-demographic variables	*Number*	*Percentage*
Age		
15-19	465	56.6
20-24	357	43.3
Residential status		
Staying with parents	394	47.9
Own house	41	5.0
Living with friends	33	4.0
Hostel/boarding school	201	24.5
Staying with relatives	153	18.6
Marital status		
Never married	758	92.2
Married/de facto (living together)	44	5.4
Divorced/separated	20	2.4
Highest education level attained		
Junior secondary or below	174	21.2
Higher secondary	423	51.5
Tertiary level	225	27.4
Currently a student		
Yes	680	82.7
No	142	17.3
Religion		
Catholic	128	15.6
Methodist	331	40.3
Seventh Day Adventist	80	9.7
Assemblies of God	149	18.1
Others	134	16.3
Church attendance		
Regular	400	48.7
Not regular	422	51.3
Area of childhood upbringing		
Urban	455	55.4
Rural	367	44.6
Parent's marital status		
Never married	36	4.4
Married/de facto	651	79.2
Separated/divorced/widowed	135	16.4
Father's occupation		
Professional	278	33.8
Service	189	23.0
Others/No response	279	33.9
Unemployed	76	9.2
Mother's occupation		
Professional	133	16.2
Service	160	19.5
Others/No response	137	16.7
Unemployed	392	47.7
TOTAL	822	

Source: Computed from the 2001 RSHKB survey

Table 4.4: Distribution of selected socio-demographic variables by age (percentage)

Socio-Demographic Variables	*Age*	
	15-19	**20-24**
Educational Attainment		
Junior high or below	33.1	5.6
High School (Fm 5-7)	55.9	45.7
Tertiary level	11.0	48.7
Where are you currently residing?		
With parent	54.6	39.2
Own home	0.9	10.4
With friends	1.3	7.6
Hostel/boarding	19.1	31.4
With relatives	24.1	11.5
Area of childhood upbringing		
Urban	46.2	67.2
Rural	53.8	32.8
Church attendance		
Regular	56.3	44.8
Not regular	43.7	55.2
Total number of respondents	**465**	**357**

Source: Computed from the 2001 RSHKB survey

4.8 QUALITATIVE DATA

To substantiate and complement the quantitative data, and also to expand socio-cultural dimensions to the data, the qualitative data was collected from both the target group and those not in the target population. The non-target population included men aged 25 years and over, and women from fifteen years and over. A variety of techniques, as discussed in the next section, were used to collect the data. Women were used as key informant and also because of their experiences with men in relation to sexual and reproductive health behaviours. This is an important group as in a community where heterosexual relationship is the only accepted relation, so women are men's partners in an acceptable relationship. To observe both sides of the relationship it is important to know the views and the observations that women have made. The information women give crucial in understanding the socio-cultural influences on the reproductive and sexual behaviour of young men.

4.8.1 Qualitative Research Methods

The importance of qualitative approach and its contribution to demography is widely accepted today (Hull 1975; Caldwell and Hill 1988). The qualitative approaches to the research involved intense and continuous contact with one group where a wide range of

flexible research method is used (Caldwell and Hill 1988). The qualitative techniques used in the data collection are discussed below.

Techniques used to collect the data were: focus group discussions (FGD), in-depth interviews (both formal and informal), life stories, and participant observations. Various categories were used to select the individuals participating in the data collection. These were 1) age group, that is, between 15-24 or 25 and over; 2) gender; 3) parents of youths/adults or parents of young children (meaning those below the age of 15 years), and grandparents and uncles. Other groups interviewed included prostitutes (both females and males), educators (such as teachers/religious leaders), taxi drivers, and nightclub bouncers. Officials from the following government departments, NGOs, and regional and international organizations were also interviewed Ministry of Health, the Ministry of Education, Secretariat of the Pacific Community (SPC), United Nations Population Fund (UNFPA), Fiji School of Medicine (FSM), Fiji Women's Rights Movements, Fiji Council of Social Services (FCOSS), Reproductive and Family Health Association of Fiji (RFHAF), UNPFA Adolescent Counselling Project, STI Clinic, the MCH clinic, AIDS Task Force, and World Health Organization (WHO).

4.8.2 Focus group discussions

Five focus group discussions were conducted. As shown in Table 4.4 these included two with the target population (one from those aged 15-19 and another for those aged 20-24), two with mixed groups of males and females. The two groups differ as one was from individuals aged 15 to 24 and the other FGD consisted of individuals ages 25 and above. The fifth FGD was with older males aged 25 years and over. Participants for the FDG were all volunteers, that is, they are not paid. Some however are also invited to participate.

Each discussion group consisted of 6-12 participants. All focus group discussions were conducted at my flat, because total privacy was needed during the discussions. The researcher recruited the participants from the schools and from tertiary institutes, and conducted the discussions with the help of the research assistants. Some members of the focus group discussions also participated in the questionnaire survey. On two occasions the research assistants conducted the FDGs because the participants were not comfortable in

the presence of the researcher who was much older than they were. The FGDs were recorded by the research team and transcribed by the research assistant paid to transcribe the interviews. Young men and women between the ages of 15-24 also took part in the Focus group discussions.

Table 4.5: Focus group discussions during the Reproductive and Sexual Health survey, 2001, Fiji.

Category	*Number*
Males	
15-19 years old	1
20-24 years old	1
25 years and over	1
Total	**3**
Mixed sexes	
15-24 years old	1
25 years and over	1
Total	**2**

Source: Computed from the 2001 RSHKB survey

It was noted that information gathered from the FGDs were mostly on knowledge, attitudes, beliefs, and experiences of others (mostly friends and relatives) but very little on the individual experiences of the participants. The social taboo of the topic made some of the participants feel uncomfortable discussing their 'private life' in public. However the research team tried every possible ways to obtain as much information as possible from the members of the FGDs. The FGDs lasted an average of one hours and 30 minutes. At the end of the discussion the FDG members were treated to a quick snack.

4.8.3 In-depth interviews

Forty-eight (48) interviews were conducted with the target population and a further twenty (20) with key informants. Key informants included parents, older males, members of different institutions discussed earlier, service providers, and prostitutes. Each in-depth interview lasted an average of one hour and 30 minutes. All in-depth interviews were recorded and later transcribed by the research team. After reading through the computed transcribed work I again did a second round of listening to the interviews. This was to ensure nothing, including expressions and tones used were excluded from the transcribed work.

In-depth interviews were conducted on a one-to-one basis. Interview sites included parks, my residential flat, food courts, work sites, and private offices. Some respondents needed total privacy; so the interviews were conducted in a counselling room of the AIDS Task Force (NGO) office in Suva. Some others were not concerned about the venue. The research team was however very particular about the environment as this influence the responses and the concentration of the interviewee.

Life stories were an extra part of the in-depth interviews. Life story interviews were taken at different from in-depth interviews as each individual was interviewed on three separate occasions. There were four life stories collected from male participants aged 19, 24, 42 and 49. In order to allow time for the participants to recall and remember their life stories, the interview was in three stages. First, an in-depth interview, where the participant was identified and permission requested for further interviews. The second and third stage were when most detailed information was obtained from the participants, and they had been given time to think about some of their lifetime experiences that they might have forgotten. This also built up their confidence in relating to the researcher. Two research assistants collected the two life stories from the male youths while I collected the other two life stories from adult men. The reason for this was because the youth related well to those in their own age group and of the same sex. I collected the other two life stories from older men because it is not acceptable for a youth to be inquiring about an older man's sexual behaviour.

4.8.4 Participant observations

Information from participant observations was collected in two ways. First, is my direct observation of events in the study area during the fieldwork, as I witnessed and participated in the nightlife in Suva, attended *kava-drinking* sessions with men in their homes, offices, and in the marketplace, and associated myself with the different groups studied. Secondly, I put into context my experiences from the past. One such occasion was the circumcision ceremony and the rituals associated with it. Another incident was my observation of a young man in an urban setting being forced to marry a young woman that his father had brought from the village. The young man was punished (beaten) for he refused to marry the girl that his father had arranged for him to marry. However he was finally forced into marrying the girl, who was a cross cousin.

Another is my experience with the children (teenagers and young adults) in my extended family today. After having informal discussions with my nephews and nieces I learnt that their sexual behaviour and experience are carefully concealed from their parents and the topic is a taboo in family discussions. However once these youths started working it became acceptable for them to bring their partners home. This indicated how becoming an income earner could influence the decision by the parents to accept that their children can start having relationships with the opposite sex and are able to look after themselves.

4.8.5 Informal interviews

Data was also collected through informal interviews. Informal interviews included discussions with people on the street, both during the day and at night. This also included informal discussions with friends, relatives and other people with whom I had conversations. This also included the *kava (*a traditional Fijian non-alcoholic drink) drinking sessions where informal talk and jokes were passed around. These sessions were very informative, and considerable information was gathered from informal interviews. Drinking kava is a major form of social gathering for men. These drinking sessions are where they share with their other male friends their activities for the day.

During the sessions I was able to learn about individual experiences of some of the men that I talked to. Discussions with the group were at times also generated after throwing in an idea about the sexual behaviour of the male youths in Fiji today. Personal experiences were shared in the group. In one kava drinking session, an elderly man in his 50s approach me after the session and thanked, saying that he had never before openly discussed his sexual experience and the session was very educational to him. He stated that he had learnt a lot in the one night session. Although this was a positive response, some men in the kava sessions were not easy with me being a female as cultural values restrict the discussion on sexual issues to one gender and not cross gender.

Taxi drivers were good informants because they were well informed, by their passengers about the every day activities of the city. They knew about the illegal brothels, the common spots where lover meet and places where dating partners go for a quiet time. The drivers, in driving people around from one place to another know of motels that are used for "*one night*

stand" and the ones that are used for hourly stay, and having hourly rates. These are frequent places for casual sex. Some drivers, both Fijian and Indian males, even know of call girls and they work with them to get the call girl's client to the meeting place. A common pattern observed was that Fijian taxi drivers know of most Indian girls and some Fijian girls, while Indian drivers know of Fijian girls only. Nightclub bouncers and security guards were approached, and informal discussions were conducted with them at their work sites. They were very informative about the night activities of the city, including the frequency of casual sex, and the existence of prostitutes in the nightclubs.

At the end of the discussions I would find a place to sit and write down what I had gathered from the informal talks. At other times I would find a place to quietly record on tape a summary of my discussion with the informant. Late in the evenings I made a record of all the informal discussions and the important points that I had gathered from informal interviews after each interview.

4.8.6 Data analysis

Except for informal interviews, the qualitative data collected were all recorded on tape and transcribed later. Informal interviews were written in summary or in note form. Note diaries that the research assistants used were collected and were a good source of information. The data collected and analysis are used to support or contradict the arguments and findings from the data collected during the survey questionnaire. Information gathered cannot be generalised for the data not representative because of the smallness of the sample and it is not statistically representative.

4.9 SECONDARY DATA

Three secondary data sources are used in the analysis. These include the Fiji Census of Population and Housing, 1996, data set and report, the Reproductive Health Clinic Survey (RHCS) on STI client's 2000 data, and the Male Reproductive Health Behaviour survey (MRHB) data and report that I administered in 2000. These data are used to explain behaviours that are not measured in the primary data; and also to support and challenge findings from the primary data.

Data were also collected from available literature. This included archival studies, which was conducted to enable me to a better understanding of the cultural behaviours of indigenous Fijian men. The change of focus led to the inclusion of a chapter on the historical perspectives of men's sexual behaviour. This enables me to understand the changes in the sexual behaviour of Fijian men since the period before European contact.

4.10 ETHICAL CONSIDERATIONS

Ethical considerations are important in collecting data on the sensitive or taboo topic of sexuality. I took into account the following ethical considerations when conducting my research. This research was given ethical clearance from the Australian National University Human Ethics Committee prior to going to the field.

4.10.1 Voluntary participation

Consent was asked of all participants before the survey was conducted. Respondents were informed of the aims of the study before consent was requested. Participants were told that if they did not wish to participate in the interview they were free to leave, or in cases where the interviews were held collectively and self-administered, to remain in the class and do other work until the session was over. They were also informed that if, in the process of answering the questions, they did not wish to continue any further, they could leave and give their reason, if they so wished, at the bottom of the page.

4.10.2 Informed consent

In the survey, three groups of individual consent were granted. Consent was obtained from the school principal and then from the individual students. There were instances where school principals did not want to take this responsibility; therefore students took consent forms home, and consent from the parents was obtained for respondents who were willing to participate in the interviews. In these instances parents were given an information sheet, explaining the purpose of the research. The parents than had to sign the consent forms if they allowed their children to participate in the interviews. Thirdly, individual consent was given before the questionnaire was administered. Attached in Appendix 2 is the Information sheet and Consent form given to respondents and to parents of respondents.

For in-depth interviews and focus group discussions individual consent was given before conducting the interviews. The consent forms and information sheets were given out to the

participants. Consent forms were signed by respondents willing to participate in the research. Commercial sex workers, however, did not want to sign the consent forms because they feared the legal implications of their being exposed so their request was respected and they did not sign the consent forms. They however gave their verbal consent and it was recorded on tape.

4.10.3 Anonymity and confidentiality

The most obvious way in which participants can be harmed in survey research is if the confidentiality of responses is not honoured [de Vaus, 1995:19]. Confidentiality is important to the respondents in order for them to share the truth about themselves and to hide nothing from the researcher or the interviewer.

Complete anonymity and confidentiality is important in this research because of the sensitivity and the cultural taboo associated with this research topic. Respondents to the questionnaire were told not to write their names on the questionnaire. For in-depth interviews, respondents were identified by their age and were informed at the beginning of the interview that their names would not be used at any time. This was strictly observed during the interviews. During the focus group discussions participants were given name tags, and these fictitious names were used when addressing each other. They were identified with their fictitious names. This was to observe the anonymity of the participants.

To improve the quality and honesty of response, the respondents were assured of confidentiality of information gathered. As their identity cannot be traced because of fictitious names, they were assured that no one else would access the data and their names would never be used to identify them. This, as observed in some interviews gave the respondents the assurance that they will not be able to be identified when the research findings are discussed.

4.11 LIMITATIONS

The survey data showed that 82.7 per cent of the respondents are in educational institutions. However, the 1996 census showed that only 40.3 percent of the total indigenous Fijian men aged 15 to 24, living in Suva, were attending educational institutions. The data is therefore biased towards those in the formal education system. However one must note that the

census data accounts for those on full-time studies while the survey data include those on part time student to be in the formal education system. This is because there are cases in Suva where individuals see themselves as still in the formal education system although they are only part time students in some tertiary institutes.

The in-depth interviews, life stories, and focus groups were conducted on a voluntary basis. This was because of the sensitivity of the topic of discussion, rather than representation of the population, and generalisations cannot be made from the data. Information obtained from the data collected from the qualitative methods above, are therefore used to substantiate and complement the arguments obtained from the quantitative data.

4.12 PROBLEMS ENCOUNTERED IN THE FIELD

The major problem encountered in the field was the unwillingness of Fijian parents to give permission for adolescent children to participate in the questionnaire survey. There were also individuals who did not agree to participate, as the sensitivity of the research topic was a major draw back to some individuals. The self-esteem of those who did not complete the questionnaire and those who refused to participate could be a consistent bias as these were mostly individuals who did not participate because of religious reasons. This reduces the proportion of those with a strong religious influence participating in the survey.

Identifying participants outside the formal education system was a major problem as sexuality was not discussed in public and as a woman it could be very difficult to find young men who are willing to discuss their sexual behaviour with a middle aged woman. Hang out groups were therefore identified as it was easier to approach a group of people rather than introducing the topic to an individual you do not know. This was a major limitation.

When conducting research on sexuality one must be aware of the chances of under or over statement of activity. During the interviews and through experience the research team was able to identify individuals who were either under or over stating their sexual activity. These could be identified by the change in the tone of participant's voice, and through some non-verbal body language that they use. One example could be when the participant does not

look at you when relating their story. With continuous discussion and by rephrasing questions it was possible to address these problems.

The research team was given names labels by others because of the questions the teams asked respondents. This did not make it easier for the team to find individuals who were willing to participate. The research team was on some occasion told to leave the homes because the questions asked were to sensitive and parents did not allow them to be asked or discussed in their homes. This took place in the suburb of Raiwaqa and Nabua.

It was earlier anticipated that the fieldwork was going to be a smooth process of data collection. The research found out that there was a gap that needed to be bridged between the research and the community in general. It was difficult to reach out to the grass-root people. Many different approaches had to be taken to reach the target population and other key informants. This was a difficult task.

4.11 SUMMARY

Various methods have been used to analyse the different datasets. Collection of primary data and inputting the data into the computer were the first stages of the process. This was completed on the field. In analysing quantitative data univariate, bi-variate and multivariate techniques have been applied. More detail on the analysis procedures is given in the respective chapters where they are used.

Analysing the qualitative data on the other hand begin with listening to the recorded interviews and focus group discussions, reporting on the informal interviews as fieldwork note, transcribing the interviews from audio tapes into written manuscripts, and recording field note from participatory observations. With the assistance of my research assistants the first stage of the analyses were all done during the fieldwork. This was during and shortly after data collection. The interviews were conducted in English or in Fijian. All the interviews that were conducted in Fijian were translated into English. More detail on these is given in the respective chapters.

CHAPTER 5

CHANGING TRADITIONAL SEXUAL NORMS AND VALUES

5.1 INTRODUCTION

The Fijian culture has undergone many changes due to the influx of Western culture. These changes have combined the traditional customs and beliefs that are ingrained in Fijian society with the new attitudes that are being introduced. Lifestyle in the Fijian society is changing very fast due to a number of reasons, as Western influence brings in new technology and material goods, along with new ideas about life and how people should live. The increase in Fijian exposure to Western culture has created a conflict between traditional values and the desire to become more modern. It is important to understand the dynamics that this conflict is creating when studying reproductive and sexual behaviour.

To understand the current sexual behaviour it is important to look at the sexual behavioural changes over time. The Fijian sexual behavioural norms have changed overtime since the arrival of the 'white men' in the eighteenth century. The past is an important concept in Fijian culture. Epeli Hau'ofa (Borofsky 2000) emphasised the importance of the "past" in native Pacific Island cultures including those of Tonga and Fiji. In these cultures, the specific native words for the past itself refer to the future. The past in the languages of these two cultures means *"the time in front"* when explained in native languages and dialects. In the native Fijian languages, the past is referred to as: *gauna e liu* (Bauan dialect). *Gauna* means time and *liu* means front. *Gauna mai muri* in Fijian denotes the future; *muri* means behind. Language is the medium in which a society's stored knowledge of the past is passed on from generation to generation. The importance of the past in Pacific island societies is part of indigenous philosophy, and hence the thinking and terminology behind the concepts that denote it; "*e liu*;" identified that the past is in fact the future. Our ancestors have always acknowledged the importance of the past to learn lessons for the future. The past is a storehouse of knowledge for understanding the future.

In order to understand the current reproductive and sexual behaviour of young Fijian men one must first have a basic understanding of the changes that are occurring in the traditional and cultural norms and values of reproductive and sexual behaviour in society. This chapter identifies some of the cultural norms and values in Fijian society that played an important role in influencing the sexual and reproductive behaviour of Fijian men. The chapter discusses the traditional relationships in the kinship system and the community that encourages and restricts sexual relationships. The traditional marriage system including

polygamy and the importance of virginity for women is discussed. The initiation period for both young men and women is discussed, including the first menstrual cycle and circumcision. The chapter also discuss the concept of the *"Bure ni tagane"* (men's house), its role and functions in influencing men's sexual behaviour. Finally the influence of European contact, including Western influence, on the sexual behaviour of men is discussed.

5.2 KINSHIP RELATIONSHIP

The kinship relationship in the Fijian society partially explains the cultural and traditional roles of each individual in the Fijian society. The basic principles underlying the kinship structure vary to a very small degree in the different partners of the Fijian society. I will discuss the principle as observed in the Lau group, my province of origin[1], in particular my village Taira on the island of Vanuavatu, a Polynesian community I will also make some comparisons with the relationship in the interior of Vitilevu, Nasoqo[2] village in the province of Naitasiri, a Melanesian community. I was born and bred into these two social structures and through experience I have learnt the kinship relationship in the two groups. My knowledge of the two systems and of the associated social behaviour partner is a result of the actual coaching during my earlier years and of the continuous application of the principles that I am now attempting to analyse.

Nayacakalou (1955) stated that males of the same generation their relationship as brother *(veitacini)*, both real[3] and classified[4]; and cross-cousins (*tavale*), real or classified. Men classify female relatives of the same generation the same way, that is according to whether they are the sister (*ganena*), real or classificatory or cross-cousin (*tavale*) real or classified. For females there is a similar mode of classification of male and female relatives in her generation. A similar mode of classification is made in the first ascending generation between parents and cross-parents[5] and in the first descending generation between children and cross-children. In this way we distinguish the two types of relationship, lineal and 'cross'. These are the basis of determining taboos and open relationships within the kinship structure. It is of fundamental important in the social structure.

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1. Lau is the province where was father is originally from. I am from the island of Vanuavatu, in the Lau group (as shown in Figure 2.2).
2. My mother is originally from Nasoqo village. As Fijians have a patrilineal society. My mother belongs to her father's clan and is a member of her father's village.
3. Children of the same mother and/or the same father.
4. Children whose mothers are sisters or parallel cousin, or whose fathers are brothers or parallel cousins, or where the mother of one and the father of the others are cross cousin (that is real or classified). The terms classificatory and parallel cousins will be used interchangeably.

Kinship relationship plays an important role as a social control in the Fijian society. In the whole of Fiji the brother-sister *(veiganeni)* taboo plays an important role in influencing the sexual and reproductive behaviour of men. Brothers and sisters are said to be *veitabui*, that is, taboo to each other. They may not come into physical contact and may not address each other except through a third party (although the brother is freer to reproach his sister directly or to command her to perform his bidding). The brother has a corrective and protective authority over his sister. An authority that sometimes supersedes even that of the father or mother. The sister regards her brother as sacred to her, and as one who must be obeyed and whose sanctity is supreme. Reference to certain subjects like sex must not be made by anyone in the presence of both a brother and his sister.

In the *veiganeni* relationship there are a lot of sexual taboos. As a sign of respect there is no open sex discussion in the presence of a *veiganeni.* In some communities in Fiji, such as the Lau groups and in Tokatoka, Tailevu (Nayacakalou 1955), the *veiganeni* have very little direct communication with each other. This symbolises respect that they have for one another. Parents are therefore not able to discuss sex related issues in the presence of both their sons and daughters. This must be done separately for each gender group. In this relationship any form of sexual relationship is strictly forbidden. This is a form of social control that restricts sexual relationships between individual who are related and to control incest.

For the above relationship the males in the extended family ensures female family members observe the sexual behaviour norms of the community. They ensure that the female relatives do not have sexual relationships with others in the community, if such relationship exists and comes to their knowledge they can confront the men and either ask the man to marry their female relatives or warn them to end the relationship. The male relatives could also beat up their female relatives in a bid to warn them to stop such relationship. This shows that men played an important role in ensuring their female relatives uphold the sexual norms and sexual values of the community.

Among the *veitavaleni* or cross cousins, both real and classified, having a sexual relationship is encouraged. This practice is common in most parts of Fiji including Lau, Tailevu (Nayacakalou 1955), and most parts of Vanua Levu (Hocart 1952) . In this relationship as Nayacakalou (1955) discussed, marriage is accepted but not encouraged. Cross cousins of opposite sexes in most parts of Fiji regard each other as "natural husbands and wives". In the Lau group they treat each other as husband and wives, address each other by the term

watiqu meaning my spouse and are rather incline to behave with playful familiarity. While sexual indulgence between such persons is not subject to taboo, no sexual familiarity is necessarily involved. However in some parts of Western Fiji immediate cross cousins, that is, those whose parents are immediate brothers and sisters are regarded as brothers and sisters, although they call each other *tavale*. They have respect for each other in the same way, as discussed above, as do for the *veiganeni* and for the *veitacini*.

These traditional kinship ties are important in the Fijian culture. It enables individuals to be able to show respect for one another (parallel cousins), talk about sexual relationship openly (cross cousins), and sets social controls on individual relationships and behaviour. Fijians place high importance on the individual's place within a family and on the importance of the kinship relationships, emphasising both the individual's status within the family and status of the family itself. A person's actions reflect on the rest of the family, so if a young man is acting inappropriately and showing little respect to the importance of his kinship relationships with another family then the people will think that it was the fault of the parents and the extended family.

5.2.1 Extended family

The kinship relationships explained above identifies the relationships between individuals in an extended family. The definition of an extended family in a Fijian society includes all blood relatives and those relationships that are created through marriage. The extended family is responsible for enforcing controls on sexual behaviour. The older generation in the extended family educate the young members on the traditional and cultural norms and values, and the expected behaviour in the society. This is generally the responsibility of the grandparents, granduncles and grandaunts, father's sisters and female parallel cousins, and mother's brothers and male parallel cousins. This indicated the different role each kinship member play in the extended family.

The extended family members would encourage a young man in the family to have a courtship relationship with a woman if they think the young woman is worthy enough to be a member of their extended family. The judgement includes her family background, her social behaviour, and her economic and social status. The young woman would try to gain the favour of the women in the extended family of the young man she is courting, as the extended family members have great influence in encouraging or discouraging relationships.

5.3 SEXUAL INITIATION

From birth to puberty children were left to mix with each other. There was no sexual segregation and children ran around the village with no clothes on. At puberty they were dresses, with the women wearing skirts and young men wearing the *'malo'*. In most parts of Lau boys were initiated between eight and thirteen years and the initiation of boys into adulthood centres in the rites of circumcision. Girls were recognised as young women after they have their first menstruation. When a young girl has her first menstrual period the family prepares a feast and celebrates her entry into womanhood. This is still widely practiced in most village communities in Fiji, and it is especially done to the eldest daughters in the family.

5.3.1 Circumcision- a cultural expectation

Circumcision in Lau was conducted in groups and this was mostly during the harvest season because they believed that inflammation was less likely to occur when everything in nature was dying (Thompson 1940). However occasionally a youth dies as a result of the operation. The initiation is done in secrecy and away from the village. The operation in done by the medicine man who had learnt of the art through observation and practise. Then the initiated are taken to a men's clubhouse in the village where they were confined for four nights under the doctor's care. After the fourth night the circumcised left the men's clubhouse for the first time and bathe in the sea. They were for the first time given a *'malo'*.

A youth's life changes radically after his circumcision. He was accepted immediately as an adult male in the community and so had all the privileges of a full grown man. Women and girls defer to him and he could begin to have secret love affairs with those who were not taboo to him. In Lau circumcision in Vanua Levu was never an individual affair. Although the concept of initiation was the same it was however conducted in batches on public occasions. It was part of the funeral ceremony of a chief, so it was not identical to Lau. There was beliefs that the boys were *'iloloku'*, that was, they were buried with the chief and young men, an adult now took their place.

5.3.2 Modern concept of circumcision

Circumcision today still follows the traditional rituals as of the past, that is, after the fourth nite a feast is held to commemorate that the young boys' entry into adulthood. Beddings from mats brought in by close relatives are made for the circumcised to sleep on. These are gift give by the relatives to the circumcised. For the first for nights the circumcised do not bath of wet the wound, they tare sponged by their aunts who care for them. After the

fourth night a feast is prepared and the circumcised go to the river or preferably to the sea and bathe until the bandage on the wound falls out. The bathing can take hours, until the bandage falls off, as it is believed that if the bandage is not removed after the fourth night the young men will become a troublemaker in the future. At the end of the day the extended family gathers and the feasting takes place. The extended family members bring along the *'vakamamaca'*, in the form of mats, tapa, or materials (mostly in 2 metres). This is symbolic of dry clothes given to the circumcised to wear after bathing. After the four nite the circumcised less restricted but must continue to bathe in the sea until the wound heals. If far from the sea they bathe in a tub of salt water prepared at home.

They are not longer referred to as *"boci"* meaning uncircumcised, immature. This occurs at the age of between 5 and 10 years. Circumcision commonly takes place during the school holidays, as the young boys have to be bed stricken therefore not disturbing their school attendance. The younger age of circumcision is related to the age of school entry as parents think that their children would best be circumcised before attending school. Circumcision at birth is not common in Fiji however some parents do allow their sons to be circumcised at birth.

Below is the summary of a discussion with Ben (aged 45) and Dan (aged 40) on circumcision.

> *Ben and his friend Dan discussed their view on circumcision with me. I informed them about the history of circumcision in Fiji. They were shocked to learn that circumcision was a cultural tradition before Christianity. Dan stated that he thought men were circumcised because of their religious beliefs. Ben informed us that he was taking his 10 years old son to their village in Christmas, because he wanted him to be circumcised in the village. When asked why did he want his son to be circumcised he stated that all Fijian men are circumcised and he does not what his son to blame him (the father) not getting circumcised. He stated that all to be a real man one must be circumcised. It is an important process in a Fijian man's life. When asked why the village he stated that the traditional rituals are important and because he was unfamiliar with the rituals he would prefer that his son be looked after by his extended family in the village. He stated that in the village circumcision is done for a group of cousins so his son will not be alone. I questioned the right of the child to say not to circumcision but Ben insisted that it was the right of the father to ensure that his son becomes a* 'real man'. *Dan on the other hand was too sensitive to the topic and did not want to contribute a lot to the conversation. He maintained that circumcision today is because of the Christian influence and Fijian men are circumcised because they are Christians.*

Most Fijian men today believe that they are circumcised because it is a Christian expectation. Some men stated that to be a "real man" one must be circumcised. The discussion above shows that some Fijian men see circumcision as a process that all Fijian men must participate in. The reason for circumcision, to some young men, is not clear.

5.4 MEN'S HOUSE

Among the tribes in Fiji, where Melanesian blood predominates, the *'bure ni sa'* or unmarried man's house was a universal institution. In the Lau group the strong admixture of Polynesian blood had in some degree broken down the social laws connected with this house, although in most villages the house existed (Thomson 1908; Thompson 1940). Among the interior tribes of Viti Levu the *bure ni sa* existed until recently as part of the social life of the village. The *bure ni sa* was usually the largest house in the village. It was the men's club-house in the day and their sleeping house at night. Women and young boys below the age of puberty were not allowed into the house.

A young man was initiated before becoming a member of the *bure ni sa.* The initiation to manhood was carried out through the process of circumcision[6] for men as in the Lau group. In an informal interview, during my survey, a woman explained that in 1992, on her first visit with her eldest daughter to her husband's village in the interior of Viti Levu she observed the existence of the men's house. One afternoon her husband went to rest in the big Fijian *bure* in the middle of the house. Their daughter went looking for her father and walked into the bure and woke her father. He brought his daughter home and was annoyed with her, telling her that girls were not allowed into the *bure* because that was the men's house. She was surprised to hear of the men's house for there was no men's house in her village and in the surrounding villages in Tailevu. As stated above the practice has long been abolished in many parts of Fiji and for the communities that still had the men's house till the 1990s, the norms and practices associated with it, as will be discussed below, were not enforced and implemented.

The *bure ni sa* played an important role in the control of the sexual behaviour of the youth. At puberty, that was after circumcision, a young man takes his place in the *bure ni sa.* From puberty all the young men were moved to sleep in the *bure ni sa* while the females remained in the care of their parents. In the clubhouse the men watch over each other, while young women slept in their parent's house at night. This action prevented courting and premarital sexual relationship.

When a woman announced that she was pregnant the husband was moved back to the clubhouse if he has a monogamous relationship because a woman was forbidden to have sexual coitus during pregnancy and during lactation. The man was expected to abstain

5. As will be discussed in the later part of the chapter. Also discussed in chapter 8

from having coitus with his wife during lactation periods because if they broke the taboo, the newborn could be crippled or the infant would have health problems. Married men were therefore looked after and guarded upon by other men in the clubhouse who ensured that the taboo was enforced. The prolonged abstinence ensured that the child was well nourished and also meant prolonged child spacing was observed. During this period of abstinence the mother was devoted to the rearing of the child and she was relieved from the more arduous duties in the family house.

The *bure ni sa* formally prevented sexual relationships which are now only forbidden. The young men deserted the *bure ni sa* and slept in their family homes in the village in close proximity to the women. This was an endeavour by the missionaries to inculcate family life it however resulted in the decaying of social morality. The association of young men and women developed the sexual instinct.

5.5 TRADITIONAL MARRIAGE CUSTOMS

Traditionally there was no marriage ceremony as it is today. Match making was arranged by the older members of each tribe and in making marriage arrangements consideration of land and local prejudices gives a tendency towards inbreeding, especially in the alliances of cross cousins. Inbreeding or consanguineous marriage is desirable. The Fijians look upon the marriage of cross cousins as the most natural of all marriages. Not only are the lands held together by such a contract, it is also believed that the blood of the tribe is kept pure. However men have been known to marry relatives of an unmarriageable type such as classificatory sisters or daughters, in cases where they are biologically distant enough (Nayacakalou 1955).

Traditionally if a man wants to marry a woman he would inform his relatives and his relatives would present the *tabua* (whale's tooth) to the woman's relatives asking for approval for marriage. In the olden days the woman is then carried, even if not at her free will her family would use force to take the woman to the man's family home. In most of the eastern parts of Fiji, as in Vanua Levu (Hocart 1952) and the Lau group, the bride is then taken to the groom and a feast is prepared by the groom. In taking the bride to the groom the relative of the bride prepare traditional items, *iyau,* such as mats, nets, clothes, food, and things that specialise in producing, and present them to the groom's relatives. In exchange the groom's relative in return present them with their *iyau.* This is a form of traditional exchange. A lot of exchange of traditional wealth was involved in the presentation of gifts between the two extended families.

Through arranged a person's family chose their spouse. The partner normally came from two different mataqali and often from two different villages (Ravuvu 1983). The parents of the male chose the bride, sometimes with the knowledge of their son, sometimes not. This arrangement is also beyond the decision of the couple involve especially the women. As Ravuvu (1983) explained that if the proposal is not agreeable to one of them (the couple), it is the duty of each member of their own group to persuade them. A young person's plea against such a proposal is not usually listened to. They are expected to do as their parents wish.

The woman is than left with her husband for cohabitation for in four nights. A white tapa sheet is spread on the couple's bed. This is to obtain proof of virginity, as the white sheet must have bloodstains from the breaking of the hymen if the bride was a virgin. The morning after cohabitation the groom informs his relatives if he has deflowered her or otherwise. If the bride was a virgin there was joy in both the bride and the groom's party. The groom's relatives than present a pig and prepares a feast to the bride's family after cohabitation. The presentation of the pig symbolises the status of the girl upon cohabitation. If she was a virgin a small hole is made in the pig to take out the entrails, however if she was not a virgin the pig was split from head to the groin.

The importance of virginity to women was a social control that imposed restriction to sexual coitus before marriage. If the bride was not a virgin the shame was on the bride's relative and mostly on the parents. In Lau a female was from birth expected to have a virgin lock. This was a small portion of hair, on the left, that was never cut since birth. The tresses symbolised that the particular female was a virgin. If a young woman was no longer a virgin she was expected to cut the tresses as a woman having the tresses openly declaring to the public that she was a virgin. A woman without tresses means that she was no longer a virgin. This was not acceptable in society. Some of the traditional processes are still observed however the importance of the virgin lock has almost disappeared but practised on very rare occasion. Women are no longer expected to be virgins before marriage but if such case does occur the process explained above is observed.

5.5.1 Elopement

The introduction of Christianity into Fiji resulted in the changing of some of the cultural norms that influence sexual behaviour in Fiji. The marriage customs of the present day are appropriate to those of Christianity. Love matches are becoming accepted and occasionally

elopement took place. This is not consistent with the Laun culture where elopement is not acceptable. Seniloli (1992) however, observed that in her study that elopement was common.

Elopement, *'veidrotaki'*, can take place under different circumstances and for different reasons. Two lovers could elope because the relatives of one of the lovers do not see the lovers as a perfect match. This is common when the girl's relatives disapprove of the match or another man's family has proposed for the girl's hand and her family have accepted. The second is when a young man's friends do a match making and takes the girl to the young man. This is normally done in groups and on most occasions the couple have never communicated. This is done to young men who are too shy to speak to young women. When a couple elope the man takes the woman to his family resident or to his uncle's home and inform the family and friends that he has brought a woman to be his wife. Once they have spent the night under the same roof the man's relatives are expected to inform the woman's relatives that the young man has brought the woman to be his wife.

Below is an example of an elopement where a woman related her experience when she eloped with her husband. Cultural expectation and respect plays an important role in this example.

> *Mere, now a mother of five related how she got engaged to her husband, at the age of seventeen during her first year at nursing school, after having met him once and spending the night with him. She said they met for the first time at a community fund raising dance and he asked her to come back to his village with him and spend the night at his parent's house, and he would bring her back to her parent's house in the morning. In the night he told her that he loved her and asked her to marry him. When she woke up in the morning his mother saw her and told her that she should stay there with him, so she did not return to her parent's house. Her husband was asked if he wanted to marry Mere, he responded affirmatively, Mere was asked the same question and out of respect for the family she agreed. Her husband's family took a* tabua *to her family and informed them that she was at their home and asked for approval for Mere to marry their son and to ask for forgiven because they have taken Mere to be their son's wife. When her family accepted the* tabua *they were traditionally engaged and have been living together since. Mere stated that she did not know her future husband's name until the next morning. She stated that he wanted to marry her because she was young (17years old) and he was getting old (29 years old). She stated that the motivation behind marrying him was because he was good looking (handsome) and more strongly because his mother saw her in the morning and desired that they get married. This she stated destroyed her future career to be a nurse, for she did not return to continue her study because she got married.*

In the Fijian culture if a woman stays over at a man's house and his parents sees them in the morning there is strong pressure upon the woman to marry the man if he desires. This is because the couple has probably engaged in sexual coitus and traditionally premarital sexual relationships, especially for women, are not accepted. Therefore to maintain respect the woman is pressured to marry the man if he desires. The above example shows that the Western view of love marriage, based on long term relationships can not always be applied

to the Fijian view of love marriage as in choosing a partner most Fijians youths are still strongly influenced by tradition and parents' influence is strong.

5.5.2 Polygamy

Polygamy in the Fijian society was actually confined to comparatively few men. Thomson (1908) quoted James Calvert as saying that "*Polygamy is actually confined to comparatively few. It is only the wealthy and powerful who can afford to maintain such an expensive indulgence*". Therefore the more powerful and wealthy a chief was, the more wives they were able to acquire. In getting a wife from a different tribe the chief would strengthen their alliance with the wife's tribe, so marriages were also for alliances. Thomson stated that the high chiefs had harems of from ten to fifty women, counting the concubines. The chiefs of inland tribes had five to six wives who cultivated their plantations for them and were more agricultural labourers than wives.

Polygamy was observed to have accommodated men's sexual drive when one of the wives was pregnant or during lactation. As coitus was discouraged during pregnancy and during lactation, a man resorts to the companionship of other wives and leaves the pregnant wife to observe the social restriction against sexual coitus during that period. However those in monogamous relationships, as mentioned above, moved back to the clubhouse until the abstinence period was over.

The changes in the system from a polygamous to a monogamous society had little effect on the social system. Thomson (1908) stated that when the early missionaries broke down polygamy the chiefs did not seem to have a lot of difficulty about it as they were married to their principle wives and the rest of the wives were returned to their families. These women did not wait for long for a husband because there was a certain prestige in marrying a woman who had belonged to a high chief. The discarded wives did not complain because in the harem they were exposed to the jealously and tyranny of the chief wife and were also subject to daily mortification.

Although polygamy was abolished, the chiefs did not take away with the practice. Until the mid twentieth century, chiefs in some parts of Fiji had only one wife but other women were present in their household as concubines. In an interview with a 75 year old Fijian man in Suva he stated that in the 1940s he could recall that the high chief from Lau had the right to choose any woman he wanted to spend the night with, meaning to have sexual coitus with. The chosen women from within the village and from other villages on the

island or from other islands were groomed by their relatives and sent to the chief. These resulted in the chiefs having children from different women. Looking after the chief's child was prestigious in the community. This practice was also observed on the island of Koro in the mid 20th century, where a great and powerful chief on the island had a barren wife. The chief however had a son to a woman in a different village and another sons and two daughters by another woman in another village. Both the villages were neighbouring villages to the chief's. It was believed that he also had a son from a woman in his own village but because they were parallel cousins this was not acknowledged. This showed that although polygamy was abolished, chiefs and other powerful men in the village maintained the practice indirectly and had concubines instead of wives.

5.5.3 Western influence

Today traditional arranged marriage is rare in the Fijian society. Men and women choose their own partners. This transition to love marriages has occurred as a desire to be westernised in society. However many traditional beliefs of marriage are applied to love marriages. These include the power of the parents in deciding the partner of their children and the underlying separation between men and women. Although Fijians are having love marriages because of their desire to become 'Westernised', the western ides of love relationships that precede marriage are not applicable in Fijian society. This is because separation between men and women does not facilitate these western ideas and the second reason is based on the two cultures conceptual idea of marriage.

Among the Western society the purpose of marriage is a joining of two people who love each other. This is not the purpose of marriage in Fijian society. In Fiji marriage has a functional purpose. Traditionally marriage was used to connect two families. Ravuvu (1983) stated that *"Quite often the two groups had been intermarrying for some generations, and each marriage consolidated and reaffirmed the relationship."* Although marriage today does not hold the same function, it does hold a function purpose. Due to division of labour, men and women need each other, as each have certain duties and from childhood they are taught the duties that their gender requires them to know.

Western influence has had an influence on marriage in the Fijian society, as marriages are no longer a bond between two families due to the changing lifestyle caused by Western influence. The development of better transportation and communication networking system has made people marrying further away from their villages than before. This means that in some cases the families of the couple involved do not know each other. The set

gender roles in a marriage is also changing for women are now also working on wage employment and women through women's right groups are advocating equal opportunities. These changes are more prominent in urban than in rural and villages areas.

5.6 GENDER RELATIONS – CULTURAL MODEL

In studying sexuality it is important to understand the cultural model surrounding the relationship between men and women. In the Fijian culture men and women are supposed to have minimal contact. The type of contact that occurs is regulated by cultural restrictions and the degrees of these separations can be seen throughout their lives. Another important aspect is the domination of men within the separations of sexes. The division between sexes is supported, enhanced, and in part created by the strong theme of patriarchy. Patriarchy has laid the ground works for many of the underlying attitudes that relationships are based on.

The separation between men and women is a strong theme in the Fijian culture. It can be seen in many aspects of their lives. Institutions including churched, schools, village life, and parents all set guide lines for minimal contact between different genders under the age of twenty-one and the Fijian culture also has unwritten laws about the interaction of men and women based on how they are related.

The Fijian culture has facilitated the division between men and women in many ways. This includes the division of labour. Men are supposed to spend their days out of the house working in the garden or having a job. Women, as in the Lau group, spend their days taking care of the household and are expected to cook, clean, take care of the children. In the Melanesian culture they are also expected to collect firewood and do some gardening with their husbands. These divisions are strongly recognised and some tasks are considered feminine and some masculine (Ravuvu 1983). If a man cooks for his family he would be teased by the women in the community and told not to do women's work.

The separation between men and women is also seen in where the different sexes sit. Men are traditionally supposed to eat before the women and children. This does not happen in the present day but during meals women sit at the bottom of the tablecloth while men sit at the top. This idea of sitting in different areas is also seen at almost all times when men and women sit together. In ceremonies, church, and any time where *yaqona* is present men sit separately from women.

This separation does not remain at a formal level. It underlies interaction throughout the day. When a husband and wife are together in public they do not interact on a personal level. They do not show affection to each other in any public areas, even when in their own home public shows of affection are not accepted. Burton (1910) and Ravuvuv (1983) observed that Fijians counted it a weakness to show any signs of attachment for the wife.

5.6.1 Male Dominance

The Fijian way of life is highly influenced by the attitude that men have higher status then women. Men sit separate from women because they are seen as more important. Positions are inherited and passed down through males and women are able to assume positions only when all the male possibilities are exhausted. Fijians trace their decent through males. Ravuvu (1983) noted that the feeling of belonging to the father's group emphasises the important of the male. Although women are also recognised as important to society, men are seen as the more respected sex.

Respect is resounded throughout daily activities in the Fijian culture. During ceremonies men participate while the women are required to sit behind the men not participating in the function. Ravuvu (1983) stated that females generally occupy a subordinate position in any family situation, and in formal clan or tribal gatherings they expect to assume a lower position than males. This inferior position of women also applies to the relationship between a husband and his wife. Within the household the men also traditionally have higher status. They hold the position of being the head of the household thereby having the final say in decisions and the actions of their wives. This attitude plays a significant role in the relationships between men and women throughout their dating and married lives. The traditional roles are influenced by Western values but there is still an underlying motif of male dominance.

Male domination is a strong theme within marital relations. Men are seen as the more authoritative sex. They are also seen as dominant from the societal viewpoint and this is portrayed within the underlying attitude towards marriage. These attitudes are seen in traditional acts, such as the woman leaving her house to go and live with the man. The extend of male domination is also seen in the way a woman obeys her husband's decision although she might not agree with the decision. Male domination in the Fijian society also comes out as domestic violence. It is not uncommon for a man to hit his wife. Domestic violence in Fiji is widespread and it is another way that male dominance can be seen in the

culture (Veramo 1995; Ravuvu 1983; Secretariat of the Pacific Community 2001; Seniloli 1992).

Male dominance affects the way Fijian men and women conceptualise intercourse and related issues. This is illustrated in a number of ways. One is seen in who initiates the act of copulation. The initiation of intercourse in the Fijian culture is almost always verbalised by the man. Men also feel free to ask women to have sex even if the two of them are not in a relationship. There is also a strong pressure on women to have sex because men feel entitled to pressure women. Coitus in the Fijian perspective happens in a male oriented way and it is focused around the pleasure of the male.

5.7 WESTERN INFLUENCE ON TRADITIONAL CULTURE

The exposures of the Fijian society to other cultures and experience have impacted on the cultural and traditional reproductive and sexual norms and values. Around 200 years ago British missionaries came to Fiji and colonised. Fiji was under the British Commonwealth for 96 years form 1874 to 1970 and is still part of the Commonwealth member countries. During the British ruling of Fiji the English imported Indians to serve as indentured workers on the sugar cane fields. Although Fijians have had a significant amount of exposure to Indian society, this has not had the affect that the influence of Western culture has. This is because Indian culture also supports arranged marriages, and separation between men and women. Therefore they were not exposed to ideas that were different from their own.

The exposure to Western culture has become the most influential factor in indigenous Fijians changing attitude. Fijians feel that they are behind the Western culture in both technological and cultural way, they feel the Western culture is more advanced so they desire to incorporate what they see as Western beliefs, possessions and behaviour into their own culture. The amount of exposure that they have had to Western culture is very limited. The exposure is mostly with wealthy tourists. The other way that they learn (as will be discussed in Chapter 6) about Western culture is through movies, books, magazines, internet and information on globalisation, and songs. This gives them a limited view of Western society since the portrayal within these media is superficial and idealized. Fijians are trying to incorporate as part of their relationships the principles they have been exposed to, therefore adopting a shallow notion of love that is affecting their relationships.

Keesing (1982) examine the influx of Western culture and proposed a view that the qualities that Fijians attribute to traditional ways are actually not the traditional ways but rather ideas that they have adopted to hold on to a piece of their culture. This is happening because people are being faced with Western ways and are losing their customs. Therefore they try to counteract these ideals by grasping to their custom. These allow them to feel that they are retaining their culture although these ideals do not stem from their traditional culture but from beliefs that were based upon outside influence. This argument is relevant to the influence of the church on sexual behaviour. The church informs young people that dating is wrong and it emphasis that the Bible says not to have sex until married.

Meleisea (1987) stated that the traditional culture adopts the ways of the Western culture and many of the ideas that were adopted did not make sense within the culture that they were adopted by. These are self-fulfilling prophesies and the uncritical acceptance of these ideology of development leads to the demolishing of the traditional institution and the creation of new ones with the expectation that society will be better off. This idea is true in the implementation of love relationships. These relationships are not healthy and are creating problems with in the society.

5.8 SUMMARY

Relationship, including sexual relationships, between men and women continue to change as Fiji becomes exposed to increasing amounts of Western culture. Western influence on the traditional values and morals of reproductive and sexual behaviour have influenced and impacted the Fijians since early European contact in the late 1800s. This affects all areas of lives, economically, religiously, and within their daily lives. Although many of the traditional views have remained as influences within their relationships, these are slowly changing as the rest of their lives change.

Sexual relationship in Fiji is retaining many traditional beliefs. There is a strong domination by men seen in the way that intercourse happens and is perceived by both men and women. There is also still a negative stigma toward women who have premarital sexual relations and women who have children born out of wedlock. These traditional values are overriding the attitudes towards relations even as changing ideals are brought in by the influence of Western culture.

CHAPTER 6

KNOWLEDGE ON SEXUAL AND REPRODUCTIVE BEHAVIOUR

6.1 INTRODUCTION

The type of information young men receive is important in determining the attitude and behaviour of the individual. Research findings, as discussed in Chapter 3, have shown that to the youth the main sources of information on sexual and reproductive behaviour is mass media. This includes newspapers, videos, motion pictures, television, magazines, and books. There are other different sources of information available in Fiji and these sources will also be discussed in this chapter.

This study is focused on what is perceived and what is expected to be the sources of reproductive and sexual behaviour information to adolescent and young adult males in the Fijian society. This chapter first discusses the sources of information and examines how useful the information is from the perspective of the respondents. It then examines the respondents' knowledge of sexual behaviour, knowledge of contraceptive methods, and knowledge of available services. Finally the chapter discusses the use of contraceptive methods and the availability of services.

6.2 SOURCE OF INFORMATION

The type of information on reproductive and sexual behaviour that an individual receives depends on the source of information. Different sources of information disseminate different types of information to the audience. Information can be disseminated orally (verbally), in writing or in picture forms, and through observation or by looking at how other people behave. The most common sources of information to young males are through written and pictorial form, and through observations. Parents mostly use the oral form of communication relaying information to their children and the children also observe the parents' behaviour of family members and neighbours and learn from them. Friends mostly use all the three sources of information discussed above.

The survey gathered information on whether the respondents received information on reproductive and sexual health from the following sources, namely, Father, mother, other relatives, friends (including girlfriends/partners), mass media (including newspaper, magazines, books, films, radio, and television), schools, and counsellors and teachers. These were the seven major classifications of sources of information. Respondents were

also asked if they found the information received to by useful at all. A four points scale was given ranging from very useful to not useful at all.

Below is the format of the questions used in the questionnaire to gauge responses. Those stating that they received information from their girlfriends and those stating they received information from friend were put into one group. The same process has been done to those receiving information from the mass media. In the analysis all forms of mass media

The statements below mention several sources of information that you might have used to get information on reproductive and sexual health.

Please answer this by circling the score of your choice for each of the following sources, according to the key scores mentioned below.

Key: 1 = Not useful at all 3 = Useful
2 = Not useful 4 = Very useful

		Use this source Yes(Y)/No(N)	If YES, usefulness of information (Score)			
1.	Girlfriend	_____	1	2	3	4
2.	Mother	_____	1	2	3	4
3.	Father	_____	1	2	3	4
4.	Other family members	_____	1	2	3	4
5.	Friends (peer)	_____	1	2	3	4
6.	Counsellor/religious leaders	_____	1	2	3	4
7.	Newspapers/magazines/books	_____	1	2	3	4
8.	Radio/ TV/film	_____	1	2	3	4
9.	School (Teacher)	_____	1	2	3	4

(items 7 and 8) were classified into one general group namely mass media. This was because in the literature these items generally come under mass media.

The data from the questionnaire was analysed using frequency and percentage, and bi-variate cross tabulation on the seven different sources of information as shown in Table 6.1. Respondents were asked to identify one of the four scales ranging from very useful source to not a source of information. In the analysis the scores were divided into two groups, namely useful and not useful. Scores 1 and 2 were classified as 'not useful' and scores 3 and 4 were classified as 'useful'.

Table 6.1 shows the percent of respondents who stated that they did receive information on reproductive and sexual behaviour from the different sources and the percentage that stated that the information they received were useful. Friends (88.3 per cent) and mass media (87.2 per cent) were the two most common sources of information. A slightly smaller proportion (66.4 per cent) of the respondents stated that their father was a source

of information on reproductive and sexual health. Similarly the percentage of respondents who stated that they received information from their mothers, and from counsellors was 70 per cent. For all the sources of information discussed in the analysis more than two thirds of the respondents stated that they received information from these sources.

Table 6.1: Proportion that received information on reproductive and sexual health from different sources and proportion that found the information useful

Source	Received information		Useful information	
	Number	Percent	Number	Percent
Father	546	66.4	0	0
Mother	562	68.4	0	0
Other relatives	587	71.4	409	49.8
Friends	726	88.3	582	70.8
Mass Media	717	87.2	654	79.6
Schools	643	78.2	474	57.7
Counsellors	573	69.7	406	49.4

Source: Computed from the 2001 RSHKB survey
(N=822)

6.2.1 Parents as the source of information

Although more than half of the respondents stated that they received information from their parents, none of the respondents indicated that the information obtained from their parents were useful. Mothers were stated to be a source of information by 68.4 per cent of the respondents while a slightly lower percentage of 66.4 stated that their father was a source of information. In a Fijian society mothers are responsible for looking after their children and educating them to behave however fathers show little interest in educating their children to behave in a respectable manner, however they are well informed about their children's behaviour and they are the law enforcers in the family. Fathers punish their children if they misbehave.

Young Fijian men indicated that they did not find information they received from their fathers and their mothers to be useful. This could indicate that parents are not educating their children on the importance of the reproductive and sexual health behaviours. On the other hand the children might not see their parents as the tool for disseminating knowledge on reproductive and sexual behaviour. Children might not seriously consider the oral advice that comes from their parents.

Below are extracts from a focus group discussion on parents' role as a source of knowledge. All are taken from focus group discussion. The focus group discussions are numbered with FGD1, FDG2 etc, and each participant is numbered with a, b, c, etc.

Therefore participant FGD3d means that the participant is from focus group discussion three and is identified as participant 'd'.

> *"My parents do not talk about it at all at home."(FDG1c.)*
>
> *" My parents do give me advice and this is on a one to one basis with my mother. It is normally on informal basis and not serious talk." (FDG2a.)*
>
> *"Well in my case my parents only talk about it when there is some problem. This happens to my sisters but not to my brother and me. My sisters get lectured by my mother and on a few occasions they are punished, beaten, because they go out at night and return home very late into the night. For my brother and I our parents do not counsel us. This may be because we do not get pregnant." (FDG4f)*

From the above viewpoint it could be assumed that parents do counsel their sons but to a smaller extent as compared to their daughters. The point raised also indicate that young men do not receive useful information from their parents because parents do not talk about reproductive and sexual health behaviours with their sons and when there is discussion it is conducted in an atmosphere of anger and tension with the result that young men do not benefit from the discussions.

In-depth interview and informal discussions with parents indicate that parents are reluctant to educate their children on reproductive and sexual health. Parents feel that their children are not old enough. During interviews some parents felt that their children are not mature enough to be sexually active. These are young men and women or adolescents aged between 13 and 19 years of age. The age at which children become sexually active is not clearly defined by the parents who were interviewed. Some parents based maturity on to age, others according to the educational status or education level in schools. Discussion with parents indicated that parent expect that while their children are in the formal schooling system, that is up to the high school level, their children are unlikely to be engaged in any form of sexual relationship.

The parents wait until it is too late and their children are already sexually active. Below are extracts from three interviews with three different parents.

> Case 1:
> ***Manasa**, (a highly educated, Fijian father, school teacher, aged 43)*
> ***Mili:*** *At what age do you think we should educate children on reproductive and sexual health?*
> ***Manasa**: "It depends how developed the children are. Parents should first be educated on the topic before they educate their children. We have our eldest son who is in Form 3, and is 14 years old. We always discuss talking about sexual relationships with our son, but we think he is not ready for the talk yet. We will wait for him to mature. Then we will decide on who should do the talking, my wife or me. We will wait till its time… I think my wife will be better to talk to our son because I do not feel easy talking about the topic with my son… We will wait till its time, then we will see who does the talking."*
>
> Case 2:
> ***Mere** (a Fijian mother, 52 years old, business woman)*

Mili: *Do you talk about sex with your children?*
Mere: *"My daughter is very independent and responsible, so I do not see the need to discuss the issue with her. However I find it easier to talk to my two grown up sons about sex. With my sons I advise them about the right and the wrong types of women. What are the different types of women they can find? They always make fun of what I say. They joke about it a lot. I am very open with my two older sons. .... My husband does not have the time to talk to the boys as he is busy with our family business."*

Case 3:
Sala *(a Fijian mother, well educated, lay preacher, strong religious background)*
An informal discussion was generated with a group off friends over a cup of tea. The topic of the discussion was my research topic – Fijian men's sexual behaviour. After lively and informative discussion with the group, Sala, one of my friends excused herself as it was late in the afternoon and she had to go home. As she stood up to live her last comments were
"I am going to a prayer meeting tonight. Oh No! This discussion has made me unholy"

The first case indicates that some parents think 14 years of age is about the right age when parents' should discuss sexual relationships with their children. This however depends on how developed the children are with regards to sexuality. The case study clearly shows that some fathers do not see it to be their responsibility to educate their sons on sexual behaviour. In observing the community, it was noted that most fathers spent less time with the family. Some fathers stated in informal discussions that it was the responsibility of the mother to educate the children on moral values and the acceptable behaviour of society. If the children misbehave it is then the responsibility of the father to punish them. The issue is mixed it includes misbehaving, punishment and the importance of the children. These concepts are assumed but perhaps different fathers have different definitions. This could be generalised to most fathers, as it is a cultural norm in the Fijian custom for fathers to discipline their children.

Because it is the responsibility of the father to discipline the children, fathers discipline their sons when they do not conform to the sexual behaviour norms of the Fijian society. This is done through physical punishment or verbal lectures (in a tense environment and using abusive words) about acceptable sexual behaviour. Some young men therefore do not find information from their father to be useful because the way the information is disseminated would influence the receiver's perception of the information that is disseminated. This is clearly indicted in Table 6.1 showing that none of the respondents found the information on reproductive and sexual health that is disseminated by their parents to be useful to them. This was interesting for although parents do disseminate knowledge the children do not find the information useful. The analysis was crossed checked and I also found it surprising that not one of the 822 respondents stated that the information was useful.

Some other reasons why fathers are not informing their children about reproductive and sexual health behaviour were gathered from in-depth interviews and informal interviews. They include fathers putting the responsibility on the mother to educate and discipline the children, and fathers spending less time in the homes because of work commitments, community commitments, religious commitments, and having grog (kava drinking) party groups till the early hours of the morning.

Case study 2 indicates how one mother finds it easier to communicate and educate her two sons on sexual health. As the mother stated, her sons would joke about the matter. This could indicate that some children do not regard the information from their mother to be useful. The other point is that the mother was not really giving her sons sex education, but only telling them which women to avoid. This is sex education to most Fijian parents. Case study 3 shows that the mother would never discuss sexual behaviour in her household, as it is not acceptable in religion. This could be one of the reasons why parents do not give useful information on sexual behaviour to their son.

A schoolteacher stated that pornographic and girlie magazines for men, including the foreign (US, Australian) *'Playboy'* magazines, are confiscated from students in the school. This was common in the lower form, among boys 14 to 16 years of age. These kinds of magazines do not provide much sex education, as they are mainly titillation and the message that they provide implies that it is acceptable to play around with girls. Such magazines are a common source of information to young men. The type of information related to the public from the playboy magazines is in conflict with Fijian norms.

6.2.2 Other sources of information

Friends (88.3 per cent) and mass media (87.2 per cent) are the two main sources of information on reproductive and sexual behaviour for young Fijian men. Three quarters of the respondents, four fifth stated that they obtained useful information from mass media. Magazines, books, newspapers, videos, and movies were easily accessible to the respondents. They live in the capital city where the above mass media are readily available. Movies and videos are not effectively censored in Fiji. This allows young men to access any type of information they need.

Peer groups can be of different forms. They are formed in schools, in religious groups in the communities they live in, and with other relatives. These different types of peer groups also play different roles in educating an individual on reproductive and sexual knowledge.

In schools boys mix around with those in the same age group and their common interest is education. Members of other peer groups could be having peers who are older or younger than the individuals. The effects such relationships have on the individuals are discussed in chapter seven and eight. It was observed that an individual could have many different types of peer group. This is mostly based on the social functions and social gatherings of the group. A young Fijian male could have a different sets of peers in their area of residence, one set in school, another with relatives and one with their religious group members. This could be a contributing factor to friends being the most common source of information on reproductive and sexual behaviour, for it is generally assumed that when a group of young Fijian men meet their most common topic of discussion will be about girls and sexual experiences.

Mass media is a major source of information on reproductive and sexual health. Young men exchange ideas that they read in magazines. They exchange magazines with their peers. Magazines are available over the counter and there is no age restriction on any type of magazine. This also applies to videos and films. Videos can be purchased by anyone regardless of the age restrictions on them and you can watch any movie regardless of the age restrictions that are clearly printed on the posters in the cinemas. The general availability of the above could be a contributing factor to the research finding, showing that 87 per cent of respondents stated they received information from the mass media. Young Fijian men stated that information obtained from mass media was useful, though it is quite likely that it is in violation of cultural norms.

Schools were also seen as a source of information, with 78.2 per cent of the respondents stating that they received information from school and 57.7 per cent stating that the information received was useful. There are two main ways of disseminating knowledge to young male students: firstly through the school curriculum as discussed below and secondly through male teachers who discipline the male students and teach them moral values and the norms of society.

The study shows that 57.7 per cent of the respondents found the information received from schools to be useful. Schools in Fiji have subjects that include reproductive and sexual health in the syllabus. The two subjects are Basic Science for those between forms one and four (at junior secondary level) and Biology and Family Life Education for the between forms five and seven. While Basic Science is a compulsory subject and has a section called reproduction, Biology and Family Life Education are not compulsory. This

results in students not taking up the subjects at a higher level and missing out on being educated in schools on reproductive and sexual health. This could be the reason why slightly more than half of the respondents found information on reproductive and sexual behaviour received in schools to be useful.

Family Life Education is designed to educate students on sexual and reproductive health. This is an elective course and not all schools choose to teach Family Life Education. Four of the seven schools visited offer Family Life Education. However one school principal stated that the curriculum taught to the students is modified and censored by the administrators. This could be because they assume that knowledge of some sexual behaviour can encourage the students to practise what they are taught. A teacher commented that although Family Life Education is a subject that is in the school timetable to be taught at its allocated time, other academic subjects are taught in its place because Family Life Education is not examined at the end of the year. This indicates the importance of the curriculum to the administrators, as academic and externally examined subjects are preferred to non-examinable subjects.

The survey showed that only 37.6 per cent of the respondents have been offered Family Life Education in school. Interview and FGDs showed that some students who take family life education in school play truant during the lesson and lock themselves up in the rest room in order to miss the contact hour for the lesson. When asked why they played truant, they replied that they do not feel at ease with what is discussed during the classes.

Some religious groups are also active in education and disseminating knowledge of reproductive and sexual health to the community. The Seventh Day Adventist (SDA) church plays an active role in educating the community. They have show groups that go out into schools and community organizations to perform puppet shows miming, and have role play on reproductive health issues. The Catholic churches addresses young married couples but like the Methodist church do not encourage sex education for unmarried youths.

Information received from the above sources discussed is not always educational. In some cases such as television series it does not always promote socially acceptable behaviour. Some series encourage casual and unprotected sex. Informants mentioned the "Shortland Street" as one such television series. This also applies to motion pictures and videos. The information received from playboys could be interpreted as encouraging casual sex. Sex

education books, films, videos, and magazines are almost non-existent in Fiji. Information from peers is not always useful, although the individuals may think it is useful. Some of the information from friends are myths and will be discussed in the later parts of the chapter.

6.3 FACTORS INFLUENCING SOURCE OF INFORMATION

A bi-variate analysis on how age, education, area of childhood upbringing, religion and residential status is related to the different sources of information on reproductive and sexual health is shown on Table 6.2. The table shows that as young men grow older their parents are less likely to be a source of information, while friends and the mass media grow as sources of information. It must be noted that as the individual grow older they tend to spend less time with their parents and more time with friends and peers.

Education is an important factor influencing the sources of information. The analysis shows that 94.6 per cent of those who have attained high school education and above stated that friends and mass media were sources of information to them, compared with only 64.9 and 59.6 per cent respectively for those obtaining junior secondary school level and less. In general there is a clear indication that more of the young men with higher education do receive information from the different sources as compared to those with junior secondary education or less.

The analysis indicates that current residence has a great influence on parents being sources of information. 83.6 per cent of the respondents living in hostels and boarding places indicated that their father is a source of information and 87.1 per cent indicated that their mother is a source of information, while only 57.6 and 59.9 per cent of those living with their father and mother reported that they were a source of information. This is expected as in a Fijian community, before a child leaves home to stay in a hostel or boarding place the parents will see it as a responsibility to advise them on what they will expect when they leave home. They will be advised on the disadvantages of having girlfriends and having sexual relationships. While when the sons are at home, parents assume that they are under their watchful eyes and do not have special sessions to counsel their son. There is not much restriction placed on the sons as compared to daughters.

Table 6.3 shows the bi-variate cross tabulation of socio-demographic variable by those indicating that the information they received were useful. More than 50 per cent of those between ages 15 and 19 years stated that the information they received from each of the sources were useful, while less than 47 per cent of those aged between 20 and 24 years stated likewise. This could indicate that as they grow older young men are likely to learn

Table 6.2: Percentage that received reproductive and sexual health information from the different sources of information, by socio-demographic factors.

SOCIO-DEMOGRAPHIC CHARACTERISTICS	*SOURCE OF INFORMATION*							
	Father	**Mother**	**Other relatives**	**Friend**	**Mass media**	**School**	**Counsellor**	**Total respondents**
ALL RESPONDENTS	66.4	68.4	71.4	88.3	87.2	78.2	69.7	822
Age								
15-19	68.8	69.7	71.0	85.4**	83.9**	77.2	69.0	465
20-24	63.3	66.7	72.0	92.2	91.6	79.6	70.6	357
Education								
Jnr sec & below	49.4**	53.4**	52.9**	64.9**	59.8**	48.3**	44.8**	174
High sch & above	71.0	72.4	76.4	94.6	94.6	86.3	76.4	648
Childhood Residence								
Urban	60.7	62.2	65.1	84.8	84.8	73.8	64.0	455
Rural	73.6	76.0	79.3	92.6	90.2	83.7	76.8	367
Religion								
Catholic	65.6**	70.3	58.6**	85.9**	82.0**	71.1**	69.5	128
Methodist	60.4	64.7	69.8	86.7	85.8	77.3	66.8	331
SDA	72.5	71.3	75.0	83.8	82.5	76.3	68.8	80
AOG	67.1	65.8	78.5	89.9	89.9	79.2	70.5	149
Others	77.6	76.9	77.6	95.5	95.5	87.3	76.9	134
Rel. Commit								
Committed	73.7**	74.4**	74.4*	90.8**	88.6**	82.7**	76.1**	422
Moderate	56.4	59.3	65.8	83.1	83.1	70.7	60.6	307
Not committed	66.7	71.0	76.3	94.6	94.6	82.8	71.0	93
Residence								
Parents	57.6**	59.9**	47.0**	85.5**	84.0**	70.1**	61.4**	394
Own	61.0	61.0	53.7	97.6	97.6	90.2	63.4	41
Friend	66.7	63.6	54.5	72.7	72.7	69.7	51.5	33
Hostel	83.6	87.1	47.3	98.0	96.5	91.0	84.6	201
Relatives	68.0	68.6	58.2	83.7	83.7	81.0	77.1	153
TOTAL	546	562	587	726	717	643	573	822

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note: (N=822) (* p<.05; ** p<.01);

Table 6.3: Percentage stated that the information received from the sources was useful by socio-demographic factors.

Socio-demographic characteristics	*Sources of useful information*										
	Other relatives		**Friends**		**Mass media**		**School**		**Counsellors**		**Total**
ALL RESPONDENTS	49.8		70.8		79.6		57.7		49.4		822
Age											
15-19	51.6		66.2		75.9	**	63.0		54.2		465
20-24	47.3		76.8		84.3		50.7		43.1		357
Education											
Jnr sec and below	36.8	**	43.1	**	51.1	**	33.9	**	29.3	**	174
High sch and above	53.2		78.2		87.2		64.0		54.8		648
Childhood resident											
Urban	43.5	**	84.8	**	84.8		46.4	**	40.9	**	455
Rural	57.5		92.6		90.2		71.7		59.9		367
Religion											
Catholic	43.8	*	56.3	**	71.9	**	40.6	**	46.1	*	128
Methodist	45.9		62.3		77.0		56.5		45.6		331
SDA	62.5		78.8		77.5		65.0		58.8		80
AOG	54.4		82.6		85.9		58.4		47.0		149
Others	52.2		86.6		87.3		71.6		59.0		134
Religious Commitment											
Committed	51.7		69.2		79.4		62.6	**	79.4		422
Moderate	50.2		70.0		80.5		53.7		80.5		307
Not committed	39.8		80.6		77.4		48.4		77.4		93
Residence											
Parents	76.4	**	55.8	**	76.4		51.8	**	47.0	**	394
Own	90.2		61.0		90.2		56.1		46.3		41
Friend	72.7		54.5		72.7		69.7		51.5		33
Hostel	90.5		75.6		90.5		58.2		43.3		201
Relatives	71.9		57.5		71.9		69.9		64.1		153
TOTAL	409		582		654		474		406		822

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note: (N=822) (* p<.05; ** p<.01)

from experience other than depending on other sources of information on reproductive and sexual behaviour.

Table 6.3 shows that education attainment does influence the source of useful information. Less than 16 per cent of those with a less than high school qualification do state that the information received from the different sources are useful while between 53 per cent and 56 per cent of those with high school and above high school attainment found the information from the different sources to be useful. There is very little difference in percentage receiving useful information for those who have education attainments at high school and above high school level. This could indicate that they have a better understanding of the information they received, and that family life education and biology curriculum offered in schools could be a contributing factor as these are only offered at high school level.

Table 6.3 shows that more of those living with their parents (43-46 per cent) stated that the information they receive from each of the five sources of information were useful. Although 90.5 per cent of those living in the hostels stated that the mass media is a source of information, only 27.8 per cent of the respondents stated that the information received were useful.

6.4 KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH

Information from the survey indicated that there are many sources of information on reproductive and sexual health available to these male youths. In most cases, except for information from parents where no respondents found the information received to be useful, more than 50 per cent of the respondents stated that the information they received were useful. Discussing what young men perceive to be useful included advice on how to approach a woman and ask them for a date. Below is a list of what some men stated were useful information on reproductive and sexual behaviour.

How STIs are spread from one person to another and how to cure STI?
When can a woman become pregnant?
What happens if you have intercourse with a virgin?
What should a man do during a date, so that his partner will appreciate him?
How can a girl be prevented from getting pregnant?
Information on how to use condom.
Information on how to have coitus.
Some positive information on having sexual relationships.

Information on reproductive and sexual health is readily available to the public in Fiji. There is a lot of IEC in Fiji. This is through the advocacy groups such as the Reproductive and Family Health Alliance of Fiji and the Aids Task Force, some regional and

international organizations, and the government through the Ministry of Health and the Ministry of Education. Most IEC materials are in the form of charts, pamphlets, and available through service providers. Observations from the field have shown that although there is a changing attitude from the service providers, in-depth interviews for young men showed that they are reluctant to visit the service providers who are thought to be mainly female nurses, retired nurses, or homosexuals, who would give them lengthy counselling before the service is provided. Peer educators are also counsellors but most men see peer educators to be too young to share their experience and knowledge so little respect is give to them.

Films and videotapes are readily available to the public, schools have available subjects in the curriculum, and books and magazines are readily available. These sources mostly depict sexual behaviour but contain little discussion of reproductive and sexual health behaviour. Those who receive this information are led to assume that all the information from films, videos and magazines are the norms of society and behaviour.

6.4.1 Myths of sexual and reproductive behaviour

More than 50 percent of the respondents, as shown in Table 6.3, regarded information obtained from friends, mass media, and other relative as healthy. During the focus group discussions and the in-depth interviews it was observed that not all the information the respondents receive and regard to be useful was indeed useful. Some of the information they received were myths and were misleading and incorrect. Below are two examples of the myths that young Fijian males receive from friends and other relatives.

> *"If you masturbate straight after having sex, than you can not be infected with STIs or HIV/AIDS." Male (19)*

> *"I heard this from my girlfriend: After having sex, you will have to jump up and down on the bed if you do not want to get pregnant or straight away after having sex you drink a jug of water to wash down the semen." Male (22)*

Through these beliefs young men assume that they can avoid their partner from infections and avoid unwanted pregnancies.. If awareness programs do not reach all youths and such myths are not corrected young men risk seriously reproductive and sexual health problem. Instead myths will continue to be passed on from one individual to another. Respondents after all, identified friends as the most useful source of information.

The myths of sexual and reproductive behaviour need to be documented and awareness programs set up correct the misconceptions circulating in the community. Through discussions with young men it was noted that most of them do the stories they are told and

they have even cited examples of people who have experienced the miracle cures and prophylactics described in the myths.

6.4.2 Obstacles and problems in knowledge dissemination

A discussion with a father is shown below:

> *Case 1:*
> *Do you discuss sexual and reproductive behaviour and health issues at home?*
> *No. I think it is due to our cultural view this topic is a taboo. I think this is why in our Fijian setting this kind of topic is avoided.*
> *Do you think it is good to discuss sexual and reproductive health behaviours in our homes?*
> *Yes, but I don't think it will work because when we want to talk about it our parents wouldn't listen to us. (19 yr old Male)*
>
> *Case 2:*
> *Do you discuss sexual and reproductive health behaviour topics at home?*
> *No.*
> *Why not?*
> *We regard it as a taboo because it involves our private parts. It is discussed among older people only or among peers.(22 yr old male)*
>
> *Case 3:*
> *Do your parents talk to you about reproductive health behaviours?*
> *Yes. My parents travel overseas most of the time. Last year, they sat me down and asked me whether I have a girlfriend. The first time they asked me, I was numb with shock, and I couldn't speak and answer them. But the second time they asked me, I said yes. They advised me about the difficulty of having a family. They told me if I want to have a family, I have to study hard in school and try to be financially secure first before thinking of starting a family. (19 yrs old male student)*
>
> *Case 4:*
> *Do you discuss about sexual and reproductive health behaviours at home?*
> *No. I only talk about it with my friends. We don't talk about it at home because it is a taboo to our culture. (22 yr old male)*

There is indication from the interviews that parents do little to educate their sons about reproductive and sexual health behaviour. A reason commonly accepted in the Fijian society is that it is culturally a taboo to discuss human sexuality in the family arena. In Fijian society it is not only cultural taboo, it is also a religious taboo. These are the main forces discouraging open discussion of sexual behaviour. Chapter Five explains the traditional restriction, taboo, on discussing sexuality. There are relationships in the kinship system that allows for the open discussion on sexuality and this is outlined in the previous chapter.

The examples given above show the difference in attitude of some parents and the attitude of young men towards discussing sexual and reproductive behaviour in the family. The young men know that it is a cultural taboo and can only be discussed with their peers. This is a clear indication that it is a cultural taboo to discuss sexual and reproductive behaviour in the family. Case 3 shows a different approach that the parents try to take, that is in

knowing that their son was sexually active they advised him on the difficulty of having a family, but not on the sexual and reproductive behaviour and the consequences and issues in sexual behaviour. There was no advice on the acceptable behaviour in society. This is a clear indication of how parents try to evade the issues and discussions of sexual and reproductive behaviour with their children. During interviews with parent, both formal and informal, the parents explained the difficulty of discussing sexual and reproductive issues with their children who are of different ages and different gender.

Some of the young men who have refused to participate in the questionnaire survey and refused to have interviews and informal discussions stated that they would not answer the questions because of their religious beliefs. This indicates how religion and religious beliefs have influenced the young men's view on sexual behaviour and knowledge dissemination in society. As a result of the assumed cultural and religious taboo, parents pass the burden to formal educators.

Parents assume that it is the responsibility of the formal educators, teachers in schools, to educate children on reproductive and sexual health behaviour. Schools in Fiji are oriented towards formal academic knowledge and the curriculum covers the biological aspects of sexuality. Family Life Education is also taught in some schools, but not as an-examinable subject and as a result only a few schools offer the subject to their students. The Ministry of Education gives schools a choice among the following range of electives: physical education, music, art and craft, computing, family life education etc. They may choose only two. In a sports and music loving society like Fiji, physical education and music takes priority over other electives. This leaves little chance for family life to be taught to most students in schools.

Negative attitudes of school administrators and educators, and the lack of available resourceful teachers is also a problem. During the field research it was noted that some educators and well-educated administrators were very conservative when addressing reproductive and sexual health needs of adolescents and young adults. At a boys' high school, the research team was informed that only the boys from forms five upwards (that is those who are 17 years old and above) could participate in the survey and prior approval from their parents was needed. Parents of 78 per cent of the target respondents agreed to the request while the 22 per cent that did not reply to the request including those who disagreed and those where request did not reach the parents.

Discussions with teachers in the school revealed that students at lower levels, that is forms three and four (14 to 16 year olds) often have pornographic magazines, including 'Playboy' magazines, confiscated during school hours. The administrators ignore the apparent needs of these teenage boys for more accurate and appropriate reproductive and sexual health information.

The use of religious leaders as family life education teaches is an approach needing further investigation. During the research I observed that in two secondary schools female Christian deaconesses were the family life educators. This in many ways reflects the national situation. In the Ministry of Education, the office in-charge of Family Life Education is a Methodist church minister of religion. Educators view sexual and reproductive health education in school as a religious issue. It is seen as having a close association moral values of sexual behaviour and these are identified with the Christian values, even though Fijian society has heterogeneous religious beliefs and values.

In a large multi-racial school in Suva, the school principal informed me, that the students would not participate in the survey because the questions were too sensitive and the topic is culturally a taboo in the society. The principal stated that permission from the Ministry of Education was needed. The Ministry of Education had granted the researcher permission to conduct the survey in the school. The principal then informed the researcher that because of his religious beliefs and values he would not allow the researcher to conduct the survey in the school. Later discussion with the Vice Principal and the Assistant principal showed that they were both shocked to hear of the Principal's stand. They only commented that most of the students in the school are sexually active and that cannot be denied.

At another school the principal informed me that after consultation with his two assistants, they agreed that they would not allow the interviews to be conducted in the school compound. However they could allow the research team to use their students as informants but all interviews were to be conducted outside the school boundary. The principal informed the researcher they have enough problems with drug use and do not wish to encourage their students to have sexual relationships. The school however offers family life education to students from forms five to seven. When this was pointed out to the principal, he informed me that he controls the units and topics to be taught to the students, because he feels that some sensitive topics should not be taught to the students.

6.5 KNOWLEDGE OF AVAILABLE SERVICES

Knowledge of available services can influence the use of those services. To be able to use the services available an individual must first know that the service is available and where it is available. Respondents in the questionnaire interview were asked if they knew of the following available reproductive health services: the family planning clinics; the reproductive health clinic; and the STD clinic. Two other questions were asked to those who had heard of the available services: whether they know that the services provided were free and if the respondents had ever used the service. Those who did not know of the service skipped these two questions above.

The three services shown in Table 6.4 below are provided and serviced by the Ministry of Health, which is a government department in Fiji. The family planning clinic is part of the Maternal and Child Health Care clinic (MCH). The service is available in every hospitals and health centres in Fiji. The MCH clinic provides free counselling on contraceptive methods and free contraceptive methods to the public. The clinic is generally viewed as a clinic for married women with children and is generally serviced by female nurses. It is not a youth friendly or male friendly service. This general perception does influence the use of the service.

The reproductive health clinic and the STD clinic are the same. The clinic was previously known as the STD clinic before the name was changed to a user-friendly name. The clinic has an STDs clinic and an adolescent counselling centre. The centre is better known as an STD clinic and it is generally assumed that those visiting the clinic have been infected with STDs. The STD clinic treats those infected with STDs, provides counselling and give free condoms to the public.

Table 6.4: Knowledge of the available services, free access and ever used the available service (per cent).

		Those who know the service	
Type of service	*Know the service*	*Is the service free?*	*Ever used the service?*
Family Planning Clinic			
Yes	54.4	89.5	28.0
Total respondents	822	447	447
STD Clinic			
Yes	50.7	83.0	37.2
Total respondents	822	417	417
Reproductive Health clinic			
Yes	44.9	86.2	37.4
Total respondents	822	369	369

Source: Computed from the 2001 RSHKB survey

For all the three services discussed in Table 6.4, there is a clear indication that only about half of the respondents know of the available services. For those that know of the services, more than 80 per cent know that the service is free and less than 40 per cent have ever used the service. The service that is most poorly used by the male youths is the family planning clinic with only 28 per cent of those that know of the service stating that they have ever used the service. About 90 per cent of the respondents who know of the family planning clinic know that the service provided by the clinic is free. Only 28 per cent of those that know of the service have ever used the service. Less than 50 per cent of the respondents knew that the service provided at the STD clinic and the Reproductive Health clinic was free. This indicated that young Fijian men make little use of the services that are available at no cost and they do not take advantage of the situation available to them.

Interviews with young men showed that they do not go to the family planning clinic because of fear that others might know that they looking to obtain free condoms and this could reveal they are sexually active. This implies that there is little privacy in the clinic. Information gathered from a focus group discussion showed that the service providers at the above clinic are not always friendly and they give lengthy advice that the respondents do not want to hear. Below is a story related to the researcher during a focus group discussion session;

> *Solo an eighteen years old student stated that he goes to the family planning clinic to collect condoms for himself and for friends. He was the only courageous one in the group and did not care about being ridiculed or joked about by the nurses in the clinic. All the while he has been going to the clinic he is told off by the nurses in-charge of the clinic and is always advised to stop having sex. He knows that the nurses always joke about him because he frequently visits the clinic obtain free condoms. This he feels has discouraged his friends from obtaining free condoms from the clinic, because his friends are too shy to approach the nurses.*

This could indicate why young men do not want to use the service at the family planning clinics. Young Fijian males seldom visit the clinic because, as discussed in the FGDs, they know that in the clinic is a very public place. The community will come to know that they had been receiving free condoms. As a result they will be ridiculed and looked down upon for being sexually active before marriage.

The reproductive health clinic in Suva is a new user-friendly name for the STD clinic. From observations in the field the researcher observed that not many youths use the adolescent counselling centre. One of the reasons could be that those visiting the clinic were associated with having STDs. Table 6.5 shows that only 44.9 per cent of the respondents know of the reproductive health clinic. There is indication that education qualification influences knowledge of the available reproductive health clinic. As discussed

above, the name change could be an influential factor, as more respondents come to recognise it as a STD clinic.

The percentage of respondents who stated that they have used these available services is less than 20 per cent for each of the services discussed. This reflects the lower participation rate from young men, in free reproductive and sexual health service. Young men were asked in interview and focus group discussions to state why they do not visit these available services. Reasons given included the following: there is no need to visit the service because they are not sick; the service providers are too rude; It is only for women; do not know the service; and too shy to go to the clinics.

Age has a statistically significant relationship with the knowledge of the three available services discussed and the use of the services available. Table 6.5 shows that a higher percentage those at an older age, age group 20-24 years, know of the available services. A high percentage of those at the older age group also know that the service is free. For each of the available services, those aged 20-24 has a higher percentage indicating that they have used the services as compared to those aged 15-19 years. This shows that as the young men become older they become more knowledgeable about the available services and they also use the services.

Education has a statistically significant relationship with the knowledge of the three available services discussed and the use of the services available. Table 6.4 shows that the higher the education attainment, that is for those obtaining a high school level of education or above, more likely they are to know of the available services. A high percentage of those at that have an educational attainment of high school level or above also know that the service is free. For each of the available services, those with an education attainment of high school level or above have a higher percentage indicating that they have used the services. This shows that educational attainment does influence the knowledge and use of the available services.

6.6 USE OF AVAILABLE SERVICES

Fijian men make very little use of the available services. Table 6.4 showed that STD clinic is used the most, with 19.6 per cent of the respondents stating that they had used the clinic. The STD clinic and the reproductive health clinic are generally assumed to be for both males and females, while the family planning clinic is generally assumed to be providing services for women. This could be a reason why only 16.1 per cent of the respondents stated that they have used the service provided at the family planning clinic. Some of the

Table 6.5: Knowledge of available services, free excess to the service and ever used the service age, religiosity, education, and area of childhood upbringing.

TYPES OF SERVICES	*SOCIO-DEMOGRAPHIC VARIABLES*									*Total respondents*
	Age		**Religiosity**			**Education**		**Childhood residence**		
Family Planning Clinic	15-19	20-24	Com.	Mod	N/Com	Jnr sec	High+	Urban	Rural	
Know of the service	46.5	64.7**	55.9	43.3	83.9**	34.5	59.7**	58.5	49.3**	822
Know the service is free	90.7	88.3	92.4	87.2	84.6	85.0	90.2	90.2	88.4	447
Ever used the service	18.1	37.2**	28.8	22.6	34.6	20.0	29.2	30.8	23.8	447
STD Clinic										
Know of the service	41.3	63.0**	48.5	46.3	71.0**	23.0	58.2**	58.0	41.7**	822
Know the service is free	79.7	85.8	85.6	77.5	86.4	77.5	83.6	83.3	82.4	417
Ever used the service	27.1	45.8**	38.3	35.9	36.4	15.0	39.5**	40.5	31.4*	417
Reproductive Health Clinic										
Know of the service	41.9	48.7*	51.4	32.6	55.9**	24.7	50.3**	43.5	46.6	822
Know the service is free	85.6	86.8	91.7	68.0	98.1**	74.4	87.7*	85.9	86.5	369
Ever used the service	27.7	48.3**	38.7	27.0	51.9**	23.3	39.3*	39.4	35.1	369

Source: Computed from the 2001 RSHKB survey
Note: ** -$p<0.01$, * - $p<0.05$ (This is from the Chi-squared test);
Com – Committed; Mod – Moderately committed; N/Com – Not Committed;
Jnr Sec – junior secondary school or below; High+ - High School and above

young men during the interviews and during the FGDs stated that they do go to the family planning clinic to get condoms. This is however very rare.

The medical officers at the STD clinic in Suva stated that the clinic commonly provides service for commercial sex workers in Suva. This included both female and male sex workers. They visit the clinic for regular check ups and to obtain their supply of condoms, as condoms are free from the clinic. Some patients to the clinic were regular patients. The clinic is well serviced with one male nurse and one female nurse to attend to the clients.

However anyone who walks up to the clinic is assumed to have a STD. On two occasions, when I asked for the doctor in-charge, I was informed by the student nurses fill in the patients' record card before going in the Doctor's room. This assumption that everyone coming into the clinic was an infected patient reveals one of the barriers to visits for educational or other purposes. This attitude discourages young men from visiting the clinic to collect condoms. This could be an indication that the name STD clinic does indicate that the service provided is only for those with STD infection, while in effect neglecting to make potential users aware of other services provided at the clinic. Other services provided at the clinic included the adolescent reproductive health counselling centre and the peer educators' centre.

Only 1.9 per cent of the respondents brought up in housing settlements had used the STD clinic. This is the lowest proportion of users, compared with those brought up in other areas. Settlements are isolated from villages and towns. They are mostly nuclear families or a closely related extended family unit living together. As Table 6.5 showed it could be assumed that those visiting the STD clinics were there because they thought they might have an infection. By contrast a high proportion, 18.3 per cent, of those brought up in villages have used the STD clinic when compared to those brought up in other areas. It must be noted that other sources of condoms include the health centres, where they are free, and the retail shops and chemists.

6.7 KNOWLEDGE OF CONTRACEPTIVE METHODS

Knowledge of available contraceptive methods will obviously influence men's use of the methods. Men need to be well informed about the contraceptive methods. The Ministry of Health provides contraceptive methods freely through family planning clinics. These clinics are generally assumed to provide services for married women. But today the focus has changed and clinics try to be user-friendly to men and unmarried women.

In the questionnaire interview respondents were asked if they have ever heard of a number of different types of contraceptive. For those that have heard of the method, they were further asked if they know that the contraceptive method is free or not. They were also asked if they or their partner had ever used the contraceptive method. The different types of contraceptives methods discussed in the questionnaire interview are the pill, IUD (loop), injectable, condom, vasectomy, withdrawal, and the rhythm method.

Table 6.6 shows the percentage distribution of respondents who stated that they have heard of the three commonly used female contraceptive methods in Fiji, including the Pills, IUD, and injection methods. Pills the most commonly known method as compared to the other two methods, with 68.5 per cent of the respondents stating that they knew of pills method while only 36.7 per cent and 44.3 per cent knew of the IUD and injection respectively. Pills have been the most commonly used contraception method since the 1970s (Bureau of Statistics 1976)

Table 6.6: Percentage distribution of knowledge of contraceptive method, free access to the contraceptives, and ever used the contraceptive method.

Type of Contraception	*Heard of the contraception*	*Among those who had heard*	
		Is it free?	*Ever used?*
Pills			
Yes	68.5	45.6	5.5
Total respondents	(822)	(563)	(563)
IUD			
Yes	36.7	50.0	3.3
Total respondents	(822)	(302)	(302)
Injectable			
Yes	44.3	49.2	9.9
Total respondents	(822)	(364)	(364)
Condom			
Yes	90.1	69.5	48.0
Total respondents	(822)	(741)	(741)
Vasectomy			
Yes	45.7	44.7	2.1
Total respondents	(822)	376	(376)
Withdrawal			
Yes	37.1	NA	54.4
Total respondents	(822)	NA	(305)
Rhythm			
Yes	31.9	NA	31.1
Total respondents	(822)	NA	(262)

Source: Computed from the 2001 RSHKB survey
Note: -'Ever used the method' includes both the respondent or their partner had ever used the method.

Those who had childhood upbringing in villages had the lowest proportion knowing the available female contraceptive methods as compared to those brought up in other areas. It is interesting to note that those brought up in settlements have the highest proportion knowing the female contraceptive methods.

Table 6.7 shows that there is a statistically significant positive relationship between education qualification and knowledge of available female contraceptive methods. There is a significant positive relationship between age and knowledge of female contraceptive methods. The table also shows that the young men of the Assemblies of God church are better informed about the available female contraceptive as compared to other religious denominations.

It must be noted that knowledge of condom as a contraceptive method has increased since the outbreak of HIV/AIDS. Condom is advertised as a safe sex method, to prevent STDs and HIV/AIDS. Table 6.6 shows the percentage of respondents who have heard of the male contraceptive methods and the natural methods. Condom is well known to respondents, 90.1 per cent of the respondents knowing of condoms. Table 6.7 show that education qualification has a positive relationship with knowledge of condom as a contraceptive method. This indicated that area of residence and education attainments have great influence on young men's knowledge of condom use as a contraceptive method.

Vasectomy is known to 45.7 per cent of the respondents. Age has a statistically significant positive relation with knowledge of vasectomy as a contraceptive method. Although vasectomy has been available in Fiji since the 1960s it was only in the late 1990s that it has become general knowledge to the public. The 1974 Fiji Fertility Survey reported only two (2) cases of vasectomy (Bureau of Statistics, 1976). Only 25.2 per cent of those brought up in villages know of vasectomy, while about 50 percent of respondents in other areas of childhood upbringing know of vasectomy. This showed that knowledge of vasectomy has not been well disseminated to the village communities.

So-called '*natural methods*' are not well known to the respondents. About 37 per cent of the respondents stated that they have heard of the withdrawal method and 32 per cent have heard of the rhythm method. Education qualification and age have a positive relationship with young men's knowledge of these methods. Those brought up in settlements are best informed about the natural methods as compared to those brought up in other areas. The reason for this is not clear from the survey results.

After the questionnaire surveys on a few occasions, the research team had lengthy discussions with individuals who had requested that the calendar method be explained to them. The respondents wanted to know about the safe period for sexual intercourse. It was noted that some requested private discussions while others were more open and asked for explanation openly, in the presences of others. This reflected widespread ignorance and interest about natural methods. I later arranged for an awareness session to be conducted by RFHAF at the schools. This was conducted after approval from school administrators and it proved to be a success.

6.7.1 Use of Contraceptives

Condom was stated to be the most commonly used contraceptive method. Table 6.5 shows that 46.6 per cent of those sexually active had used condom, 28.2 per cent stated that they had used the withdrawal method, 21.1 per cent had used the Rhythm method and only 3.6 per cent had used vasectomy. Of the three main types of male contraceptives, condom is the most commonly used contraception method among young Fijian men. However male contraception is seldom used as female contraception has a higher prevalence rate compared to male contraception. The following are some of the reasons gathered from focus group discussions and in-depth interview (both formal and informal) stating the reason why young men do not use condoms:

Do not get any feeling (no sexual pleasure when using a condom)
Too drunk
Shy to collect from the clinics
Do not know where to get condoms
Condoms burst- not reliable
Do not know how to use condom.

Vasectomy is not common, it must be noted that having children in a Fijian society is a symbol of masculinity and Fijian men feel an obligation to have a son. Having a vasectomy is not seen as an acceptable behaviour for young men. In 1980, a close friend of mine, then 22 years old, had a vasectomy operation because he did not want to have children. These are rare occurrences amongst Fijian men. The man now regrets his decision as he now realises that he can never have children.

The withdrawal and the rhythm contraceptive methods are not a commonly used by young Fijian males in urban Suva today. Catholics and Assemblies of God members have a higher proportion, 47.1 and 42.7 per cent respectively, that had used rhythm method as compared to Methodists and SDA church members, having 8.4 and 7.9 per cent respectively. This is contributed by the religious beliefs. Catholics were not encouraged to use modern contraceptives so they resort to the natural methods.

Table 6.7: Knowledge of available contraception by Age and Education attainment

Types of services	*Socio-demographic variables*									*Total respondents*
	Age		**Religiosity**			**Education**		**Childhood resident**		
	15-19	20-24	Com.	Mod	N/Com	Jnr sec	High+	Urban	Rural	
Pills										
Know of the contraceptive	60.9	78.4**	69.7	61.9	84.9**	53.4	72.5**	68.6	68.4	822
Know the contraceptive is free	36.7	54.6**	46.6	37.4	62.0**	45.2	45.7	53.5	35.9**	563
Ever used the contraceptive	5.3	5.7	6.5	4.7	3.8	3.2	6.0	3.8	7.6*	563
IUD										
Know of the contraceptive	26.9	49.6**	37.0	30.3	57.3**	27.6	39.2**	43.3	28.6**	822
Know the contraceptive is free	40.0	57.1**	50.0	41.9	64.2*	60.4	48.0	60.9	29.5**	302
Ever used the contraceptive	0	5.6**	2.6	2.2	7.5	0	3.9	3.6	2.9	302
Injectables										
Know of the contraceptive	35.1	56.3**	44.5	41.0	53.8	36.2	46.5*	44.2	44.4	822
Know the contraceptive is free	42.3	54.7*	46.3	43.7	74.0**	50.8	48.8	63.7	31.3**	364
Ever used the contraceptive	7.4	11.9	10.1	8.7	12.0	11.1	9.6	10.4	9.2	364
Condoms										
Know of the contraceptive	89.9	90.5	90.8	88.3	93.5	86.8	91.0	89.9	90.5	822
Know the contraceptive is free	67.0	72.8	67.9	69.7	75.9	62.3	71.4*	72.4	66.0*	741
Ever used the contraceptive	46.2	50.5	48.3	48.0	47.1	49.7	47.6	51.3	44.0*	741
Vasectomy										
Know of the contraceptive	33.8	61.3**	38.9	49.8	63.4**	24.7	51.4**	56.0	33.0**	822
Know the contraceptive is free	35.0	51.6**	48.8	35.3	57.6**	34.9	45.9	49.0	35.5**	376
Ever used the contraceptive	0	3.7*	1.8	1.3	5.1	2.3	2.1	2.0	2.5	376
Withdrawal										
Know of the contraceptive	28.8	47.9**	36.3	37.5	39.8	24.1	40.6**	40.4	33.0*	822
Ever used the contraceptive	50.7	57.3	65.4	40.9	51.4**	52.4	54.8	51.6	58.7	305
Rhythm										
Know of the contraceptive	23.9	42.3**	36.0	24.4	37.6**	24.7	33.8*	32.7	30.8	822
Ever used the contraceptive	29.7	32.5	37.5	25.3	17.1*	44.2	28.8*	28.2	35.4	262

Source: Computed from the 2001 RSHKB survey. Note; ** -$p<0.01$, * - $p<0.05$;

Table 6.9: Percentage that stated that they have heard of the STIs by age, religiosity, education attainment, and childhood residence.

Mode of transmission	*Socio-demographic variables*									*Total*
	Age		**Religiosity**			**Education**		**Childhood resident**		
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*	
Herd of syphilis	61.7	80.7**	69.9	65.8	83.9**	43.1	77.2**	71.0	68.7	822
Heard of gonorrhoea	82.2	91.3**	84.6	86.6	91.4	66.7	91.4**	88.8	82.8**	822
Heard of HIV/AIDS	91.6	98.9**	92.7	97.1	96.8*	84.5	97.5**	96.0	93.2*	822

Source: Computed from the 2001 RSHKB survey.
Note; ** -p<0.01, * - p<0.05;

Table 6.10: Percentage that agree that the behaviour is a mode of transmitting HIV/AIDS by Age, Religiosity, Education attainment, and childhood residence.

Mode of transmission	*Socio-demographic variables*									*Total respondents*
	Age		**Religiosity**			**Education**		**Childhood resident**		
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*	
Kissing	26.9	18.2**	26.8	22.1	9.7**	43.7	17.6**	23.1	23.2	822
Holding hands	12.9	4.8**	12.6	7.5	1.1**	20.7	6.3**	8.6	10.4	822
Sexual intercourse with an infected person	90.5	95.0*	89.3	95.4	96.8**	78.7	96.1**	91.4	93.7	822
Having multiple partners.	83.7	93.6**	85.3	90.6	91.4	81.6	89.7**	90.5	84.7**	822
Having sex intercourse with a prostitute	84.7	89.6*	83.6	90.2	90.3*	80.5	88.6**	88.6	84.7	822
Not using a condom during sexual intercourse	85.6	93.6**	90.5	86.6	90.3	77.6	92.1**	90.8	86.9	822
Homosexual sex	71.6	88.0**	76.1	79.8	87.1	75.3	79.6	85.3	70.6**	822
Blood transfusion	87.7	91.3	87.0	93.8	84.9**	78.7	92.1**	88.6	90.2	822
Sharing a razor with an infected person	63.2	88.2**	66.4	81.8	83.9**	52.3	79.9**	80.7	65.9**	822

Source: Computed from the 2001 RSHKB survey. Note; ** -p<0.01, * - p<0.05;

6.8 SEXUALLY TRANSMITTED DISEASES

Knowledge of sexually transmitted infections is important in influencing the sexual behaviour of any individual. Men can prevent the spread of STDs and HIV/AIDS through the practice of safe sex and the use of condoms. The two most common STD infections in Fiji are syphilis and gonorrhoea. In the questionnaire survey respondents were asked if they have ever heard of the three types of STIs namely syphilis, gonorrhoea and HIV/AIDS. Table 6.8 shows that 94.8 per cent of the respondents have heard of HIV/AIDS, with 86.1 per cent and 70 per cent have heard of gonorrhoea and syphilis respectively. The high percentage of young men that have heard of HIV/AIDS is because of the national, and global awareness campaign on the killer disease, HIV/AIDS.

Age has a statistically significant relationship with knowledge of STDs. Table 6.9 shows that age has a positive relationship with knowledge of STDs. A higher percentage of those in the older age group (20-24 years old) have heard of each of the three STDs, as compared to those in the lower age group (15-19 years old). The difference in percentage in the two age groups is very low for those that have heard of HIV/AIDS. This indicates the wide coverage of IEC on HIV/AIDS.

Table 6.8 Percentage who has heard of the three main sexually transmitted infections.

	Number	Percent
Ever heard of syphilis		
Yes	575	70.0
Ever heard of Gonorrhoea (Tona)		
Yes	708	86.1
Ever heard of HIV/AIDS		
Yes	779	94.8

Source: Computed from the 2001 RSHKB survey
(N-822)

Table 6.9 shows that there is a significant relationship between young men's knowledge of STIs and their education attainment. Those having attained a high school level or high education attainment are more likely to have heard of each of the three STI as compared to those that have educational attainment that is below high school level.

In the questionnaire survey respondents were asked to identify if some of the sexual acts and other acts were modes of transmitting HIV/AIDS. Table 6.9 shows that most of the young men know the main modes of HIV/AIDS transmission. 89.1 per cent of the respondents

stated that not using condom during sex could result in getting infected with HIV/AIDS. 92.5 per cent stated that having sex with an infected person is a mode of transmitting HIV/AIDS. There is a clear indication that young Fijian males know the different modes of transmitting HIV/AID.

There is a statistically significant relationship between age and the knowledge of how HIV/AIDS is transmitted. Table 6.9 shows that a higher percentage of those aged 20-24 years correctly identified the modes of transmitting HIV/AIDS as compared to those in the 15-19 years age group. This indicated that as young Fijian males grow older they become more knowledgeable about the different ways of transmitting HIV/AIDS.

Table 6.11: Percentage that agreed that a person can get HIV/AIDS through the mode of transmission below

Mode of transmission	*Number*	*Percentage*
Kissing	190	23.1
Holding hands	77	9.4
Sex with an infected person	760	92.5
Multiple partners	723	88.0
Sex with a prostitute	714	86.9
Not using a condom during sex	732	89.1
Homosexual sex	647	78.7
Blood transfusion	734	89.3
Sharing a razor with an infected person	609	74.1

Source: Computed from the 2001 RSHKB survey
(N=822)

Analysis in Table 6.10 shows that there is a significant relationship between education attainment and knowledge of the different ways HIV/AIDS can be transmitted. The higher the education attainment of the young Fijian men the more likely it is that they will know about the different modes of transmitting HIV/AIDS. The table shows that 96.1 per cent of those that have attained High school education and above stated that sex with an infected person is a mode of transmission while 78.7 per cent of those having had Junior high school education and below stated that sex with an infected person is a mode of transmission.

The modes of transmission of HIV/AIDS are well known to the respondents. Table 6.11 shows that between 74.1 to 92.5 per cent of the young men interviewed could identify the different ways of transmitting HIV/AIDS. Less than one quarter of the respondents incorrectly identified Kissing as a mode of transmitting HIV/AIDS and less than 10 per cent

stated that holding hands is a mode of transmission. This indicates that most young men know of how an individual can be infected with HIV/AIDS.

6.9 SUMMARY

Parents need to reassess their role in educating young men on reproductive and sexual health behaviours. Although parents disseminate knowledge to their sons, young men do not perceive the information to be useful. There is a need to examine the type of knowledge that is disseminated, how parents educate their sons and when and where the education process takes place.

Young men are knowledgeable about some aspects of reproductive and sexual health. This includes their knowledge of HIV/AIDS, their knowledge of some of types of contraception, and knowledge the main types of STIs and how people are infected. However there is a need to educate young men to realise that they are at risk of being infected with HIV/AIDS and other STIs if they do not practice safe sex. Although condom is known to more than 90 per cent of the respondents, however most have little knowledge of how to access the services where condoms are free.

In summary young men have limited knowledge of reproductive and sexual health behaviours. They are largely ignorant but they want to learn. There are avenues that need to be explored to enable young men to be well informed. The source of good and accurate information on is limited.

CHAPTER 7

ATTITUDES TOWARDS REPRODUCTIVE AND SEXUAL BEHAVIOUR

7.1 INTRODUCTION

Attitudes to sexual and reproductive behaviour can be influenced by many different factors including cultural background, religious beliefs, education, and sexual experience. Indigenous Fijian males are generally assumed to become sexually active and engage in sexual intercourse after they leave the formal school system regardless of their age. In having intimate relationships men assumes that it must include sexual intercourse. Coitus is associated with partnering and once two individuals build a close relationship with each other society assumes that coitus follows.

This chapter examines the attitude and perceptions of young men towards sexual and reproductive behaviour. The chapter is divided into five major parts. This includes the dating behaviour, premarital sex, contraceptive use, gender roles, and gay and CSW as subgroups. The chapter include both quantitative and qualitative analysis of men's attitude, with regard to the sub titles outlined above.

7.2 DATING BEHAVIOUR

In the Fijian culture going on a date is not encouraged because it is not a cultural norm. This is a new concept that was introduced by the European settlers or *Kaivalagi* (as discussed in Chapter 5) in the early nineteenth century. Fijian parent disapprove of their children going out for dates because it is generally assumed that a dating couple have intimate relationship involving coitus. Most young men are never taught how to behave when dating or during courtship as it is a western or foreign concept so the older generation know little about dating behaviour. Generally ideas about dating and courtship behaviour are mostly obtained from motion pictures, video, TV series, romantic novels, and magazines. Information on dating and courtship experiences is also received from friends and peers relating their experiences. Such information is perceived to be the norms of dating behaviour and they can include behaviours that are not acceptable in society.

Traditionally a young man's family presents *tabua* or whales tooth to the girl's family requesting for approve to marry the girl. This could be conducted at the early childhood stage (from the age of five) or when the couple have reached their teens that is between the ages of 10 to 15. When approval is give the partners can court each other when they

become young adults but it has to be in public. If they intend to go out in the evening they have to be accompanied by one of the girl's younger brothers or sisters or her cousin. The young man will be allowed to visit the young woman's home and talk with her. His family now has the obligation to nourish the young woman therefore they will bring food to the woman's home regularly until they are married. However if a young man dates a young woman in secret and the woman's family finds out about the affair the man and his family is excepted to present a *tabua* or *yaqona* to the woman's family asking for forgiveness because it is generally assumed by the society that sexual intercourse has occurred, this is called the *bulubulu* or the burying of the hatches. After the *bulubulu* the partners could openly court and this could finally leading to marriage. If the *bulubulu* is not carried out, the young woman's male relatives will try to beat up the young man involved and will force him into taking the woman as the wife. This is because in the Fijian communities it is generally perceived that when a young men and a young woman have courtship without supervision it is generally assumed that they will have penetrative sexual intercourse.

Courting in the Western concept is very different from courting as a Fijian concept. Dating in the Western concept involves a process of coming to know your partner better. The stages involve sharing of information about each other, going outing and understanding each other, and as a final stage sex is involved when both parties think that the time is appropriate and that they have established a strong relationship and can trust one another. It does not only involve sexual relationship, as in the Fijian concept. In the Fijian concept when a man takes a young woman for a date he is expected by his friends and peers to have sexual intercourse with the woman. If not his peers could label him as not being a macho, or 'real man'.

The perceived attitude to dating differs for different individuals. The questionnaire interview defined dating as "an activity where a male and a female without blood relationship go out all alone, for example, to watch a movie or to stroll." Dating was classified into two categories, the first was the first date category, meaning dating a person for the first time, and the second was the regular date category. Young men were asked to separately identify behaviours that they think were acceptable in the first and second categories of dating. It is perceived that some behaviour that is acceptable when dating a regular date would not be acceptable when having a first date.

Below are some statements from interviews with young men on what they do when having a date.

"When dating I take girls to movies, play pool, or we walk around talking. I never take them to the nightclubs. When I ask a girl to go out with me I would take them to a place and talk romance with them." (Jese 19yrs old).

"We go out to see movies, stroll, we chat and have sex sometimes." (Paula is a student, 18 years old)

These statements show that young men have different perspectives of which dating behaviours are more acceptable in the society. Some go on dates and have no sexual coitus, while others assume that sexual coitus is an acceptable dating behaviour.

Below is a layout of the question asked to obtain information on young men's attitude and perception of what is the acceptable behaviour for a dating couple.

Q47. If someone is dating, what do you think is proper sexual behaviours that the dating couples can engage in?
Please circle your answer for each of the following behaviours.

	First date		Regular partner	
	Yes	No	Yes	No
1. Holding hands	1	2	1	2
2. Hugging	1	2	1	2
3. Intense hugging	1	2	1	2
4. Cheek kissing	1	2	1	2
5. Lips kissing	1	2	1	2
6. Breast fondling	1	2	1	2
7. Genital fondling	1	2	1	2
8. Petting with full penetration.	1	2	1	2
9. Petting to ejaculation/orgasm	1	2	1	2
10. Penetrative sexual intercourse.	1	2	1	2

In answering the question, respondents were required to answer yes or no for each behaviour, this reduce the chances of respondents rejecting less intensive responses in favour of more intensive. However it could be possible for some responses to be in the direction that someone thinking that coitus is acceptable would think holding hand was too weak and hence not acceptable. The question as shown above was structured to reduce the problem of understatement.

7.3 FIRST DATE

Different behaviours, as shown above, were listed and the respondents were asked to state if they think the behaviour was an acceptable behaviour on the first date or not. Table 7.1 shows that as the sexual behaviour become more intensive, a lower percentage of the respondent agree that this is an acceptable dating behaviour when having a date with someone for the first time. The three most acceptable dating behaviour when couples date

for the first time are as follows, firstly holding hands, secondly cheek kissing and finally hugging. More than half of the respondents agreed that these are acceptable behaviours on a first date.

The sexual behaviours above could be classified into three categories, namely, less intensive, intensive, and very intensive behaviour. The less intensive includes holding hands, hugging, and cheek kissing. The intensive category includes intensive hugging and lips kissing and the very intensive behaviours include breast fondling, genital fondling, petting with penetration, petting to ejaculation/orgasm, and penetrative intercourse.

More than half of the young men stated that less intensive behaviours are acceptable behaviour to engage in when taking a woman on a first date. Table 7.1 shows that less than a quater of the young men agreed that sexual behaviour during first date should involve very intensive sexual behaviour, as discussed above. This indicates that most young men do not perceive first dates to result in sexual coitus. However in in-depth interviews and focus group discussions young men stated that when young men are drunk, the women they date from nightclubs are mostly for one night stands and these mostly result in coital relationships.

Table 7.1 shows that age has a significant relationship to what young men think is an acceptable sexual behaviour during first date or courtship. More that half of the young men think that less intensive behaviour is acceptable during first date. More young men in age group 20-24 think the holding hands (81.2 per cent) and cheek kissing are acceptable behaviour during first date as compared to 68.4 and 60.2 per cent respectively. Young men between ages 20-24 are less likely to think that couples should engage in very intensive sexual behaviours during their first date compared to those aged 15-19.

Religious commitment has a significant relationship with what a young man think is an acceptable behaviour during first date except for intensive hugging and genital fondling behaviour. Comparing committed Christians, moderately committed and those not committed, it is observed that young men who are committed are less likely to think that less intensive behaviour are acceptable during first date as compared to those moderately committed and those not committed. However a slightly higher proportion of those who are committed think that very intensive behaviour is acceptable on first date as compared to those less committed. This is not indicative of the norm as it is generally perceived that committed Christians have less sexual intense. However these committed Christian young

men could be giving responses that they think are conforming to the society's expectations, as discussed above, indicating that dating or courting is not a cultural behaviour of the Fijians. Although there is a significant relationship between the two, the distortion could be due to the small proportion of young men not committed as compared to those stating that they are committed Christians. Another reason for the distortion could be that young men who are not committed gave responses that they think are acceptable in society.

Educational attainment influences a young men's attitude towards acceptable behaviour during first date. Those with junior secondary school attainment have a slightly higher percentage agreeing that the very intensive behaviours are acceptable during first date, while those with higher education attainment are more likely to disagree that very intensive behaviour as an acceptable behaviour, excluding intensive hugging. Education however has no significant influence on the attitudes towards less intensive and intensive behaviours. Less than a quarter of those with higher education attainment agree that very intensive behaviour was acceptable during the first date while about 30 per cent of those with junior secondary education agreed likewise. The more educated a young man is the less likely it is that they think it is proper to have penetrative sex during first date.

The area of childhood upbringing has a significant relationship with young men's attitude to first dating behaviour. Those brought up in urban areas are more likely to regard less intensive behaviour as acceptable behaviour in first dates, compared to those brought up in rural areas. One reason for this is because those brought up in the urban areas are more exposed to western culture and understand appropriate behaviour when courting or dating a girl for the first time. In the rural areas there is restricted discussion on the topic and young men learn through observing the mass media and through their peers. As dating is not a cultural norm (Chandra 2000; Thomson 1908; Veramo 1995) young men in rural areas have little understanding of the norms of dating and courting. Those brought up in urban areas are less likely to perceive that very intensive sexual behaviour acceptable during the first date as compared with those brought up in rural areas.

Table 7.1: Percentage of respondents stating what they think is the proper sexual behaviour that dating couple can engage in during their first date by age, religiosity, education, and area of childhood residence

If someone is dating, what do you think is proper sexual behaviours that the dating couple can engage in during first date	Socio-demographic variables									ALL	TOTAL
	Age		*Religiosity*			*Education*		*Childhood residence*			
	15-19	20-24	Com.	Mod	N/Com	Jnr sec	High+	Urban	Rural		
Less intensive behaviour											
Holding hands	68.4	81.2**	73.2	71.0	87.1**	66.7	75.9*	78.2	68.7**	74.0	608
Hugging	53.8	52.1	55.0	44.6	72.0**	58.6	51.5	58.9	45.8**	53.0	436
Cheek kissing	60.2	74.5**	59.7	70.7	82.8**	67.8	66.0	73.0	58.3**	66.4	546
Intensive behaviour											
Intensive hugging	36.6	30.5*	36.0	31.9	31.2	47.7	30.2**	35.8	31.6	33.9	279
Lip kissing	45.4	35.3**	49.1	34.5	25.8**	44.8	40.0	34.7	48.8**	41.0	337
Very Intensive behaviour											
Breast fondling	28.2	18.5**	29.4	16.3	24.7**	28.7	22.7	20.4	28.3**	24.0	197
Genital fondling	24.5	21.0	24.2	22.5	19.4	35.6	19.6**	23.1	22.9	23.0	189
Petting with full penetration	28.4	19.1**	27.5	18.9	18.3*	33.9	20.4**	19.6	27.8**	23.2	191
Petting to ejaculation /orgasm	26.7	15.4**	27.5	15.0	18.3**	32.2	19.0**	18.9	25.3*	21.8	179
Penetrative intercourse	25.4	12.9**	23.9	14.7	19.4**	32.8	16.5**	16.9	23.7*	20.0	164
Total number of respondents (N)	**465**	**357**	**422**	**307**	**93**	**174**	**648**	**455**	**367**	**822**	**822**

Source: Computed from the 2001 RSHKB survey

Note: 1. ** $p<0.01$; * $p<0.05$;
2. Com – Committed; Mod – Moderately committed; N/Com – Not Committed;
3. Jnr Sec - Junior secondary or below; High + - High School education and above.

Below is a summary of an in-depth interview:

> *In an interview with a 42 years old man, he explained that in his experience, he had his first date at the age of 17 years and had his first sexual coitus at the age of 19, with the same girl. This he stated was a common practice some 30 years ago. He however observed that today young men go to the nightclubs to look for women to have coitus with. As mentioned by an interviewee they go to the nightclub for the three Fs (Fix, Fuck, and Forget). Although the attitude to most young men did not agree to engage in very intensive behaviour during the first date, young men have indicated that in reality they do engage in very intensive behaviour on the first date.*

Young men's attitude to acceptable behaviours during first date is conforming to society's expectations. Interviews with young men showed that some go to movies for first dates, some meet their date at the bus shelters and sit and talk with their date while others meet them in town and take their date to fun centres or sit along the sea wall. It is mostly when young men are drunk that they try to have coitus with their one-night stands. They blame it on the influence that alcohol has, being drunk, on their behaviour that made them have coitus on their first date. Below is a statement from a 42 years old man who thinks that drinking too much alcohol does influence behaviour

"I do drink alcohol and I think it does influence behaviour, as you do lose some values when drunk with alcohol."

Some young men feel that the women also lead them on into having coitus on the first date. Some men perceive this behaviour as a macho men's act, as in Mike's case below. Others perceive it as an act of sexual abuse, as indicated in Max's case below.

> *"I once took out a 13 years old. She was excited over the school I came from. She wanted to have sex with me. I did not know that she was a virgin then. I did foreplay before penetration." (Mike 21 yrs old)*

> *"When I was a small boy, in class 8 I was assaulted by a woman who taught me how to have sex and what all to do during sex." (Max, 38 yrs old).*

The quotes above indicate that it is not the men who at all times initiate coitus, but the woman also. The above cases are both cases where the men assumed that the women wanted to have coitus. In the first case it is observed that although the young women was a virgin she accepted coitus on first date. The second case shows how an older woman educates a young man on what to do during coitus. This indicates how some women view acceptable behaviours during first dates.

7.3.1 Regular date

As indicated in the question shown above, Question 47, the same statements put forward for first date were also asked for regular dates. By regular date it means that the young man have been dating his partner two or three times or more. It is generally assumed that once two people know more about each other they will engage in more intensive behaviours.

This is clearly indicated in Table 7.2, as a very high proportion of young men think that all the behaviours listed in the table are acceptable behaviour when having a regular dates. Seventy-one per cent have a positive attitude to coitus with regular dates. More than 80 per cent of the young men perceive that intensive and less intensive behaviours are acceptable with regular dates while a slightly lower percentage of between 70 and 80 per cent stated that very intensive behaviour are acceptable with regular dates.

When having a regular date a man would assess the strengths and the weaknesses of the relationship or would have seek advise from others, mostly their friends, on their view of the strength of the relationship. In one of the informal discussions a young man related how, with his peers, they would discuss and evaluate their latest experience with women from the weekend or from the previous night. They shared their experiences and advised each other. The comments from their peers influence the decision to continue or to stop the relationship. Peer pressure was also observed to influence attitude to regular sexual behaviour. This was observed from focus group discussions and in-depth interviews. If a young man is in a religious social group where premarital coitus is a taboo, his peers all believe in abstinence till marriage, the young men is likely to have a similar attitude to those of his peers.

Age has a statistically significant influence on what young men think are the proper sexual behaviour regular dating partners can engage in except for penetrative sex. Young men between age 20-24 are more likely than those age 15-19 to think that all the sexual behaviours, except for petting to ejaculation/orgasm, listed in Table 7.2 are behaviours regular dating partners can engage in during a date or courtship. Less than half (48.6%) of those aged 20-24 thinks that petting with ejaculation/orgasm is a proper sexual behaviour for regular dating partners while 64.3 per cent of those aged 15-19 agreed. Having an ejaculation or orgasm without penetrative intercourse is not traditionally acceptable in the Fijian community. It is perceived to be an unhealthy and dirty act or sexual behaviour. Men who have ejaculation or orgasm without intercourse are joked about and commented on by their friends and the society in general if it becomes common knowledge. This could be the reason why a lower percentage of young men at older ages think the petting with ejaculation/orgasm is an acceptable behaviour for partners having regular date.

Table 7.2: Percentage of respondents stating what they think is the proper sexual behaviour that dating couple can engage in during regular date by age, religiosity, education, and area of childhood residence

If someone is dating, what do you think is proper sexual behaviours that the dating couple can engage in during regular date	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
Less intensive behaviour											
Holding hands	88.0	95.5**	88.4	94.5	93.5*	81.0	94.0**	93.6	88.3**	91.2	750
Hugging	85.2	94.4**	85.8	92.8	92.5**	79.9	91.7**	92.5	85.0**	89.2	733
Cheek kissing	82.8	92.7**	83.2	89.3	97.8**	74.7	90.4**	88.1	85.8	87.1	716
Intensive behaviour											
Intensive hugging	78.9	93.3**	81.0	87.6	95.7**	70.7	89.0**	89.0	80.4**	85.2	700
Lip kissing	85.4	95.5**	83.4	95.8	98.9**	81.0	92.1**	92.5	86.4**	89.9	738
Very intensive behaviour											
Breast fondling	78.3	88.5**	76.3	87.9	94.6**	81.0	83.2	85.3	79.6*	82.7	680
Genital fondling	66.2	85.4**	70.6	78.8	78.5*	70.1	75.8	76.5	72.2	74.6	613
Petting with full penetration	70.3	82.6**	69.4	81.8	83.9**	78.2	75.0	79.6	70.8**	75.7	622
Petting to ejaculation/orgasm	64.3	48.6**	63.5	79.2	76.3**	69.0	71.3	75.4	65.1**	70.8	582
Penetrative intercourse	68.6	73.7	66.6	74.9	76.3*	78.2	68.8**	72.5	68.7	70.8	582
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey

Note: 1 ** p<0.01; * p<0.05 :

2. Com – Committed; Mod – Moderately committed; N/Com – Not Committed;

3. . Jnr Sec - Junior secondary or below; High + - High School education and above.

Religious commitment has a significant influence on what young men think are the acceptable sexual behaviour during regular dates. A slightly higher percentage of the moderately committed and non-committed than committed young men agree that the behaviours are acceptable during a regular dates. This indicates that religious commitment could influence the attitude to dating behaviour, as there is also a significant relationship with the attitude to first dating behaviour.

Young men who had their childhood upbringing in rural areas are less likely to agree with all statements. Those who are better educated are less likely to agree that penetrative sex is an acceptable behaviour for regular dating partners. Young men with higher education are more likely to think that less intensive behaviour is proper but less likely to think that penetrative intercourse is a proper behaviour during regular dates.

More than 70 per cent of the young men think that all the premarital behaviour were acceptable during regular dates. This indicates that it has become a norm in society although it contradicts with the traditional norms that restrict premarital sex in society. In-depth interviews and FGDs revealed contradicting findings to the questionnaire interview stating that although premarital coitus is perceived to be unacceptable it is a common practice amongst Fijian youth today. In an informal interview with a middle aged man, he made the following metaphoric comment; *"Almost every young woman in our community today have holes"* meaning that they are no longer virgins. This shows how remaining a virgin until marriage is no longer a norm of the Fijian society.

7.4 PREMARITAL SEXUAL TRADITION

Young Fijian men and women were not expected to have sexual relationship until marriage. This practice has fast disappeared and today it is difficult to find a person who is a virgin until marriage. Traditional practice, such as inspecting the white cloth the covers the bed that the newly wed couple have their first penetrative intercourse on, has been a way of proving the virginity of a woman but there is no similar system for men. The premarital sexual behaviours discussed in this section include attitude to the importance of virginity for women and men, and attitude to sexual initiation, perceived age at first coitus and ideal age at marriage.

7.4.1 Attitude to virginity

In the traditional Fijian culture it is important that a woman is a virgin until marriage. However little is stated about the importance of men being virgins before marriage. The

importance of a women remaining a virgin until marriage custom is fast eroding and this can be observed in the survey findings. In the survey young men were asked if they agree that an individual should be a virgin until marriage. In FGD and in-depth interviews (both formal and informal) some young men stated that they want to marry girls who are virgins. In FDG 3 the group however commented that it would be difficult to find a female virgin in Fiji today. This indicates that the attitude towards premarital sex have not changed so much as practice. Although culturally a taboo, young men are accepting that premarital sex is becoming a norm of society and not many women remain virgins till marriage.

Below is the questions asked to obtain information on young men's attitude to the importance of remaining a virgin until marriage.

Q50. How much do you agree with the following statement about boys engaging in premarital sexual intercourse?
Please tick your choice for each item.

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly disagree

	1	2	3	4	5
h) A girl should be a virgin till marriage.					
i.) A boy should be a virgin till marriage.					

Table 7.3 shows that more than half (59.1 per cent) of young men value female virginity while a slightly less proportion (45.1 per cent) value male virginity. There is also a significant relationship between the respondent's age and their attitude to virginity. More of the young men at younger age, 15-19 agree that girls should be virgins until marriage while a higher percentage of those aged 20-24 agreed that boys should remain virgins until marriage. A similar finding was observed in Indonesia for both males and females (Utomo 1997). This indicates that age has a strong influence on an individual's perception towards the importance of virginity.

Young men's attitude to girls remaining virgins until marriage has a significant relationship with religiosity and area of childhood residence. Table 7.3 shows that young men who are committed Christians are more likely to maintain the girls should remain virgins until marriage compared to moderately committed Christians and those not committed. Young men with an urban area of childhood residence are less likely to agree that young women should be virgins until marriage compared to those with rural area of childhood residence. However in Table 7.1 rural respondents agreed more on more intensive sexual act during

first date compared to urban residents. Education has no significant influence on men's attitude to maintaining virginity till marriage. Men's attitude toward the statement that boys should be virgins until marriage is not significantly influenced by religiosity, education, and area of childhood residence. This indicate that young men do not view male virginity as an important concept in society, and this can be observed in the traditional norms of society, as discussed earlier in the chapter.

An in-depth interview with Jone a 21 years old tertiary institute student showed how he valued virginity till marriage.

> *Jone related his relationship with his girlfriend. They have been seeing each other for two years. His girlfriend is still in high school. He states that he prefers that his girlfriend remains a virgin till they are married. They have had plans to be married once Jone completes his studies in three years time. Jone however is having sexual intercourse with other women. He has recently been infected with STI. His girlfriend does not know that he has sexual relationships with other women. He stated that he prefers that his girlfriend remains a virgin till they are married, while he can have coitus before marriage.*

The statement also indicates that some men feel that it is important for women to remain virgins until marriage, especially the woman they intend to marry. This indicate that some young Fijian men have dual standards by expect their life time partners to be virgins until they are married while they are not. Some young men felt that the need to have sexually experienced before marriage was important to men, while other do not agree. Women in the above example are regarded as commodities. Jone showed that some young men want a virgin for a future wife and do not care about other women. These are selfish men who do not care about their virginity. However some men think otherwise and believe that men should be virgins until marriage. Below is an example of one case of a young man who feels that a man should be a virgin before marriage.

> *After a questionnaire survey a young men asked interviewer if a men is no longer a virgin if he masturbates. The interviewer replied that virginity is only associated with coitus. The young man was happy and proud of himself, and he proudly whispered to the interviewer that he was still a virgin. He however did not want the others to know about the matter. (Esala, 20 years old)*

The above experience shows that there are some men in society who do value abstinence till marriage. However one reason why Esala does not want anyone to know that he was still a virgin was because most of his friends will question why he cannot find a female sexual partner. It is perceived that macho men find female partners easily and can approach women, with little reservation, and ask for a date while those who cannot are either gay or not manly enough and are looked down upon by their friends.

In discussing the issues on virginity in the FGDs, many pros and cons were raised. Two advantages of remaining a virgin till marriage for both young men and women are firstly,

they will not be at risk of getting HIV/AIDS from their partner and secondly their family will be proud of them because they have followed and observed their traditional and religious beliefs. When a woman is known to be a virgin until marriage her husband's family will present traditional wealth to her family. This is a token of appreciation symbolising that they are privileged to get a woman who was a virgin. However some men stated that both partner need experience before marriage, the partners need to learn the art of sexual relationships including sexual intercourse and this can only come through practice. If a couple remained virgins until marriage they would have limited knowledge of the act of sexual intercourse. Some FGDs discussed the importance of being a virgin till marriage as this can reduce the risk of transmitting STIs.

7.5 AGE OF SEXUAL INITIATION

The perceived age of sexual initiation in the society can influence the behaviour of the individual. To be accepted in society young men must act in accordance with what they and their peers assumed are the norms of society. Below is the question used to obtain information on young men' attitude to age of sexual initiation. Due to the small number of respondents choosing choices 4 and 5 as their answers to questions 59 and 60, the two response choices were grouped into one and labelled number 4 (20 +yrs) in the analysis, as shown in Table 7.4.

Please circle the answers of your response

Q59. Generally, at what age do females in your society become sexually active?

1.	Less than 10 yrs	3.	15-19yrs	5.	25+yrs
2.	10-14yrs	4.	20-24yrs		

Q60. At what age do males in your society generally become sexually active?

1.	Less than 10 yrs	3.	15-19yrs	5.	25+ yrs
2.	10-14yrs	4.	20-24yrs		

As shown above, young men were asked to state the age group at which boys in the society generally become sexually active. A similar question (Question 59) was asked to young men, about the age at which girls become sexually active. It was observed in Table 7.4 that more than half of the respondents stated that both girls and boys become sexually active between ages 15-19 years. More than 90 per cent stated that young men and women are sexually active before 20 years. This indicated that young men perceive that before 20 most young men and women are sexually active. In assuming that men are sexually active before

20, adolescents could try to keep up with the assumed norms, and with pressure from peers, try to be sexually active by the assumed age.

It was observed in the in-depth interviews and in the FGDs that for those who were sexually active, the respondents would give a societal age of sexual initiation that is younger than their own age of sexual initiation. For those who were not sexually active they would give an age from some cases they already know or one that would relate to their observations. This was indicated in the FGDs and interviews when young men and women who were not sexually active were ask why they think that the age they gave was the expected age of first sexual intercourse, the usual reply was that they knew from observations and gossips or their friend were sexually active by that age.

Age, as shown in Table 7.4, has a significant influence on young men's perception of the age at which both young men and women before sexually active. The analysis shows that older men (those age 20-24 years) think that sexual activity for both girls and boys starts before the age of 15 years that is 46.5 per cent and 43.1 per cent respectively, while less that 30 per cent of those aged 15-19 stated likewise. This indicates that older men could have been removed from their own initiation and now look back thinking that sexual initiation is now earlier that their time or it could mean that the younger men are insecure and perceive older ages in order to conform to society's expectation because having sexual relationship at an early or young age is not respectful in the Fijian society.

There is a significant difference in the area of childhood residence of young men in relation to the age group they stated. Table 7.4 shows that 40.4 per cent of young men brought up in urban areas stated that boys would be sexually active before they are 15 years old while a lower proportion (28.6 per cent) of those brought up in rural areas stated likewise. Focus group discussion with students at high school level (FGD 2) showed that most students feel that at high school level they must become sexually active. When members of FGD 2 were ask if they were sexually active, meaning if they have had a sexual relationship or have had coitus, a men and a female members stated that they had no sexual experience, all other members did not hesitate to inform the group that they were sexually active.

Table 7.3: Percentage of respondents agreeing to statements on virginity by age, religiosity, education, and area of childhood residence.

Statements on virginity	Socio-demographic variables									ALL	Total
	Age		*Religiosity*			*Education*		*Childhood residence*			
	15-19	20-24	Com	Mod	N/Com	Jnr sec	High+	Urban	Rural		
"A girl should be a virgin till marriage"	62.4	54.9*	64.0	54.4	52.7**	54.6	60.3	51.9	68.1**	59.1	486
"A boy should be a virgin till marriage"	49.0	40.1**	41.2	49.2	49.5	46.0	44.9	46.4	43.6	45.1	371
Total number of respondents (N)	*465*	*357*	*422*	*307*	*93*	*174*	*648*	*455*	*367*	*100*	*822*

Source: Computed from the 2001 RSHKB survey

Note: 1. Com – Committed; Mod – Moderately committed; N/Com – Not Committed; 2. Jnr Sec - Junior secondary or below; High + - High School education and above; ** p<0.01; * - p<0.05

Table 7.4: Percentage of respondents stating the perceived age of becoming sexually active by age, religiosity, education, and area of childhood residence.

At what age do girls/ boys in your society generally become sexually active	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
Girls											
Less than 15 yrs old	23.9	46.5**	25.6	41.7	44.1**	19.5	37.5**	39.8	26.2**	33.7	277
15-19 yrs old	64.7	46.5	62.8	51.5	47.3	66.1	54.3	53.2	61.3	56.8	467
20yrs and over	11.4	7.0	11.6	6.8	8.6	14.4	8.2	7.0	12.5	9.5	78
Boys											
Less than 15 yrs old	29.0	43.1**	28.9	41.7	41.9**	29.9	48.3**	40.4	28.7**	35.2	289
15-19 yrs old	59.2	51.6	58.8	51.1	58.1	48.3	57.9	52.6	59.9	55.8	459
20yrs and over	11.8	5.3	12.3	7.2	0	21.8	5.6	7.0	11.4	9.0	74
Total number of respondents (N)	*465*	*357*	*422*	*307*	*93*	*174*	*648*	*455*	*367*	*822*	*822*

Source: Computed from the 2001 RSHKB survey; Note: ** p<0.01; * p<0.05 ;

Table 7.5: Percentage of respondents stating the ideal age at marriage by age, religiosity, education, and area of childhood residence.

Statement as in Questionnaire	Socio-demographic variables										
	Age		Religiosity			Education		Childhood residence		ALL	TOTAL
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Ideal age of marriage for girls."											
15-19 yrs	9.2	17.4	11.8	12.7	17.2	6.3	14.5	12.7	12.8	12.8	105
20-24 yrs	62.4	57.1	60.4	61.6	53.8	71.8	56.9	57.4	63.5	60.1	494
25yrs and over	28.4	25.5**	27.7	25.7	29.0	21.8	28.5**	29.9	23.7	27.1	223
"Ideal age of marriage for boys."											
15-19 yrs	7.7	7.0	7.6	7.2	7.5	16.1	5.1	8.4	6.3	7.4	61
20-24 yrs	48.2	41.7	52.4	36.8	41.9	46.6	45.1	42.6	48.8	45.4	373
25yrs and over	44.1	51.3	40.0	56.0	50.5**	37.4	49.8**	49.0	45.0	47.2	388
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey

Note: 1. ** $p<0.01$; * <0.05

2. Com – Committed; Mod – Moderately committed; N/Com – Not committed;
3. Jnr Sec - Junior secondary or below; High + - High School education and above.

Table 7.6: Percentage of respondents agreeing or strongly agreeing to statements on premarital sex by age, religiosity, education, and area of childhood residence

Statements on premarital sex	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood resident			
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Premarital sex is alright if you use contraceptives."	52.0	38.4**	43.1	48.5	51.6	51.1	44.8**	42.2	51.0*	46.1	379
"Premarital sex is alright if both partners agree but do not love each other."	28.4	28.9	24.9	30.0	40.9**	29.9	28.2*	29.5	27.5	28.6	235
"Premarital sex is alright as long as it is based on love."	47.7	38.9*	44.8	49.5	21.5**	47.7	42.9*	40.7	48.0	43.9	361
"Premarital sex is alright if a marriage proposal from parents was approved."	51.0	39.8**	41.2	54.7	39.8**	58.0	42.9**	46.4	45.8	46.1	379
"Premarital sex is alright if the couple are engaged and marriage date set."	54.2	44.5**	49.1	51.8	48.4	59.2	47.5**	47.0	53.7	50.0	411
"Premarital sex is never right."	27.7	38.7**	35.5	28.3	32.2**	16.7	36.7**	33.6	31.1	32.5	267
"Premarital sex is alright if you do it with a prostitute."	22.6	10.9**	19.2	16.9	11.8*	31.6	13.7**	15.4	20.2	17.5	144
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey
Note: ** p<0.01, * p<005.

Table 7.6a: Percentage of respondents agreeing or strongly agreeing to statements that premarital sex is never right who agree with the following statements on premarital sex by age, religiosity, education attainment, and area of childhood residence

Statements on premarital sex	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Premarital sex is alright if you use contraceptives."	39.5	20.3**	35.3	26.4	10.0*	51.7	26.9*	20.3	42.1**	29.6	79
"Premarital sex is alright if both partners agree but do not love each other."	39.5	5.8**	23.3	23.0	13.3	44.8	19.3**	19.6	25.4	22.1	59
"Premarital sex is alright as long as it is based on love."	41.1	20.3**	37.3	27.6	3.3**	48.3	28.2	24.2	38.6**	30.3	81
"Premarital sex is alright if a marriage proposal from parents was approved."	45.0	18.1**	32.7	37.9	3.3**	44.8	29.4	23.5	41.2**	31.1	83
"Premarital sex is alright if the couple are engaged and marriage date set."	45.0	21.0**	39.3	27.6	13.3*	51.7	30.3*	20.9	48.2**	32.6	87
"Premarital sex is alright if you do it with a prostitute."	23.3	6.5**	20.7	9.2	0**	44.8	10.9**	12.4	17.5**	14.6	39
Total number of respondents (N)	129	138	150	87	30	29	238	153	114	267	267

Source: Computed from the 2001 RSHKB survey
Note: ** $p<0.01$, * $p<0.5$

Table 7.6b: Percentage of respondents disagreeing or strongly disagreeing that premarital sex is never right who agree to statements on premarital sex by age, religiosity, education, and area of childhood residence

Statements on premarital sex	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Premarital sex is alright if you use contraceptives."	56.8	49.8	47.4	57.3	71.4**	51.0	55.1**	53.3	54.9	54.1	300
"Premarital sex is alright if both partners agree but do not love each other."	24.1	43.4**	25.7	32.7	54.0**	26.9	33.4	34.4	28.5	31.7	176
"Premarital sex is alright as long as it is based on love."	50.3	50.7	48.9	58.2	30.2**	47.6	51.5	49.0	52.2**	50.5	280
"Premarital sex is alright if a marriage proposal from parents was approved."	53.3	53.4	46.0	61.4	57.1*	60.7	50.7**	57.9	47.8**	53.3	296
"Premarital sex is alright if the couple are engaged and marriage date set."	57.7	59.4	54.4	61.4	65.1	60.7	57.6	60.3	56.1	58.4	324
"Premarital sex is alright if you do it with a prostitute."	22.3	13.7**	18.4	20.0	17.5*	29.0	15.4**	16.9	21.3*	18.9	105
Total number of respondents (N)	336	219	272	220	63	145	410	302	253	555	555

Source: Computed from the 2001 RSHKB survey
Note: ** $p<0.01$, * $p<0.05$

Religiosity has a significant influence on the perceived at of becoming sexually active. The Christian principle states that an individual must not be sexually active until marriage and becoming sexually active before marriage is sinful. About two fifth of those moderately committed and the not committed to religion stated that boys are sexually active before their 15th birthday while a lower percentage of those committed agreed (28.9%). Those not committed perceive that before the age of 20 all young men would be sexually active.

Many young men view sexual initiation as a process, beginning with circumcision (as discussed in Chapter 5), where they are introduced to sexual intercourse. Some men observed that young men's sexual initiation or first sexual intercourse would involve their sexual encounter with an older and more experience woman, a gang or group sex, or a process where one is forced into having coitus, through peer group pressure, after being dared by their friends.

Some young men had their first sexual experience from sexual assault or older women forcing young boys into sex. In the Fijian society men are perceived to approach women and initiate sexual relationship. It is bad manners for women to approach men for sexual relationships. Below are to cases of young men stating that they were forced into sex with older women.

> Case 1
> *"When I was a small boy in Vatukoula I was assaulted by a woman who use to work at the shop. I was in class 8 than. She used to give me extra change and we use to share the money at the end of the week. One weekend after sharing the money she invited me to drink alcohol with her. She taught me how to have sex and what all to do during sex". (Max, 38yrs old)*
>
> Case 2
> *When I was 10 years old I was molested by one of my female cousins. We went to the village for a function and went to sleep at my uncles house in the village I was sleeping at night when this cousin of mine started touching my private parts and taking off my clothes. I was frightened and when I wanted to call some one, she closed my mouth and told me to keep still. I did not even understand what she was trying to do to me because at that time sex was beyond me. Although I had an erection I did not really know what it meant then...*
>
> What was your first sexual experience like?
> *It was a girl who goes to Saint Josephs. We met during the hibiscus carnival after my friend introduced her to me. We went to my house and did it beneath our house. I asked her if she can lie on the ground and she said yes. I lost my virginity to her but she was not a virgin then.*
> (He stated that his age at first sex was 14 years.)

In Case 1 an older woman bribes a young boy and when both were under the influence of liquor she seduce him. This was his first sexual experience and he was educated by woman on what to do during sex. Practical lessons in sex education is not heard of in Fiji, although some societies in other parts of the world use commercial sex workers to educate young men on sexual acts. Although the man saw this as an assault, he also acknowledged that it

was educational. In Case 2 the young men was innocent. He did not recognise the sexual assault as his first experience. He stated that his first sexual experience was with another woman and lost his virginity at 14. The two cases show that older women also force boys into sex but these experiences are not openly discussed and the victims do not inform others fearing being accused to be abnormal if they do not enjoy sex with female partners.

7.6 IDEAL AGE AT MARRIAGE

The general perception in the Fijian community is that men marry later than women. As mentioned in Chapter Five a Fijian man will marry when he is able to look after a family, that is when he is seen to have a source of income as either a farmer or an employee. A man must ensure that he will be able to look after his wife before getting married. This discourages a man from marrying in their early twenties, as shown in the 1996 census the average age at marriage for Fijian men is 26.7 years, by then they are mature and more likely to have a source of income that can support a family of their own. Marriage is globally associated with sexual relationship and it is important to identify what young men think is the ideal age at marriage. The legal minimum age at marriage in Fiji is 16 years for females and 18 years for male and 21 years without parental consent (Pulea 1986; Booth 2003). This has little bearing on the Fijians because they already have a late mean age at marriage.

Table 7.5 shows the different factors contributing to young men's attitude to the ideal age of marriage. Educational has a significant relationship with the respondent's notion of the ideal age at marriage for both girls and boys. Most young men assume that both girls and boys become sexually active or have their first coital experience at age 15 and 19 years. However as shown in Table 7.5 more than two-thirds of the young men stated that the ideal age of marriage for women is 20-24 years. 47.2 per cent stated that the ideal age of marriage for men is 25 + years while 45.4 per cent stated that it is 20-24 years. This shows that young men generally perceive both men and women to be sexually active before marriage.

There is a significant relationship between education and young men's responses to the ideal male age of marriage. About half of those with higher education stated that the ideal age at marriage is 25 years and over while only 37.4 per cent of those with junior secondary school attainment stated likewise. Religiosity has a significant relationship with young men's perception of the ideal age at marriage for males. More than half of those committed to religion stated that age 20-24 years is an ideal age of marriage for boys while more than

half of those not committed and moderately committed stated that 25+ years is an ideal age
of marriage. Religiosity and education therefore influence young men's attitude to the ideal age of marriage. The ideal age can influence the age at which a young man decides to get married, as they try to conform to society's expectation.

Young men perceive that women marry at a younger age than men. Table 7.4 shows that there is an ideal sex difference in the age at marriage, 27.1 per cent stated that 25+ years was the ideal age at marriage for females to be married while 47.2 per cent stated that this age group was the ideal age at marriage for men. Area of childhood residence has no significant influence on the perceived ideal age at marriage for both women and men. This could be due to the strength of cultural factors and ties within the urban and rural communities.

7.7 PREMARITAL COITUS

Statements, as shown in Table 7.6, were used to understand young men's attitude to premarital coitus. The responses were ranking scale from 1 to 5 (denoting strongly agree, agree, neither agree or disagree, disagree, and strongly disagree). This measured the young men's attitude and perception towards premarital coitus (sex). However for the analysis, tables, and discussion, as shown in Table 7.6, 7.6a, 7.6b, responses have been combined with strongly agree and agree under "agree" and strongly disagree and disagree and neither agree nor disagree under "disagree". Premarital sex in the statements contained in the tables discussed above refers to premarital coitus.

Table 7.6 shows that about one third (32.5 per cent) of the respondents agreed that premarital sex is never right. Half of the young men agreed that it is acceptable to have coitus if the couple was engaged and the marriage date set and 46.1 per cent agree that premarital sex is acceptable if parents have approved marriage proposal. Love plays an important role in attitude to premarital sex as 43.9 per cent agree that premarital sex is acceptable when it is based on love while a lower proportion of 28.6 per cent agree to premarital sex without love. Only 17.5 percent of the young men agree that premarital sex with a prostitute is acceptable. This indicates that prostitution is not acceptable in the Fijian society, however as show above to some extent premarital sex with CSW is accepted.

Responses to statements on premarital sex are significantly influenced by age, religiosity and education. While 27.7 per cent of those aged 15-19 agree that premarital sex is never

right a higher percentage (38.7) of those age 20-24 agree likewise. Age has a significant negative influence on agreeing to all other statements except for one (*Premarital sex is alright if both partners agree but do not love each other*). This indicates that younger men aged 15-19 have more positive attitude to premarital sex compared to older once, age 20-24. Education has a significant influence on agreeing with premarital sex. The higher the educational attainment the more conservative young men are to premarital sex. This indicated that those with less education agree to premarital sex more that those with higher education. Religious commitment does influence the attitude to premarital sex. The more committed a young man is to religion the less likely it is for him to agree that premarital sex is acceptable if both partners agree but do not love each other. However it is observed that religiosity has a significant positive influence on agreeing that premarital sex is acceptable if you do it with a prostitute. Although the proportion agreeing is very low, this result could be influenced by the skewed distribution of religiosity of the respondent as only 11 per cent of the respondents are not committed. Area of childhood residence has little influence on statement on premarital sex it has a significant influence on agreeing that premarital sex is acceptable if contraceptive is used. Young men with rural childhood residence are more likely to agree to the statement as compared to those with urban childhood upbringing. Other statements have no significant relationship with the area of childhood residence.

Analysis on young men's attitude toward premarital sex was further divided into two parts. This was done because although about one third agreed that premarital sex is never right, some young men have conditional approval for premarital sex. The first, as shown in Table 7.6a, was the attitudes of those agreeing that premarital sex is never right and the second was on those disagreeing that premarital sex is not right. However of the 267 who agreed that premarital sex is never right only one made no conditional approval to premarital sex, about 30 per cent agreed to premarital sex if contraceptive was used, if it was based on love, if marriage proposal from parents was approved, or if the couple was engaged to be marriage. A low percentage of 14.6 per cent agree that premarital sex is all right with a prostitute. This indicate society's attitude to prostitution. Prostitution of any form in the Fijian community is not acceptable.

Table 7.7: Proportion of respondents agreeing with the following statements and questions on contraceptive use by age, religiosity, education, and area of childhood residence

Statements and questions on contraceptive use (as asked in the questionnaire).	Socio-demographic Variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com.*	*Mod*	*N/c*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Is vasectomy commonly used among men in your community?"	3.2	15.7**	9.2	7.5	9.7*	3.4	10.0*	11.4	5.2**	8.6	71
"Males in your society usually (commonly/mostly) use birth controls?"	10.8	9.0**	6.4	15.3	8.6**	9.8	10.0**	8.1	12.3**	10.0	82
"Is the use of condom common in your community?"	43.4	46.8	41.0	52.4	37.6**	39.1	46.5	43.1	47.1	44.9	369
"A couple should discuss contraceptive before having sex."	81.5	72.5**	79.9	74.9	76.3**	79.9	77.0*	74.7	81.2*	77.6	638
"Good boys carry condoms."	74.4	67.5**	73.5	69.7	67.7	68.4	72.2**	66.6	77.4**	71.4	587
"Unmarried men should be encouraged to use contraceptives if they are having sex."	71.4	60.2**	67.8	64.5	67.7	69.0	5.9**	64.2	69.5**	66.5	547
"It is a woman's responsibility to provide and use contraceptives."	35.7	25.8**	37.9	26.1	19.4**	33.9	30.7	28.8	34.6	31.4	258
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey
Note: 1. ** p<0.01, * p<0.05
2. N/c - not committed

Conditional approval for premarital sex is significantly influenced by age, religiosity, education and childhood residence although there is one statement that is not significantly influenced by religiosity and childhood residence, and two statements for education. Young men at older aged are less likely to given conditional approval to premarital sex once they agree that premarital sex is never right as compared the those age 15-19. Those with urban childhood residence are less likely to give conditional approval to premarital sex as compared to those of rural childhood residence. Education has a negative relationship to conditional approval. The more educated the young men are the less likely they are to agree to the statements on premarital sex. Religiosity has a significantly positive influence on agreeing to the statements.

Religiosity, education and area of childhood residence as discussed also have a significant influence on the attitude to premarital sex if contraceptive is used. Half of the young men with lower education attainment agreed with the statement while only a quarter of those of higher education attainment agreed. Young men with a background of childhood upbringing in the rural area also have a significant higher percentage agreeing with the statement as compared to those brought up in urban areas.

Table 7.6b shows that attitude for two thirds of the young men have been positive attitude towards premarital sex. More than half of these men agree with premarital sex if contraception is used, as long as it is based on love, if marriage proposal was approved, and if the couple are engaged and marriage date set while 18.9 per cent agreed with the statement that premarital sex is all right if they do it with a prostitution. Religiosity having a negative significant influence on the proportion agreeing while education has a positive significant influence that is the higher the educational attainment the more likely young men are to agree to premarital sex with contraceptive use.

Religion could influence young men's attitude to premarital sex as it is a Christian belief that premarital coitus is a sin and traditional culture stating that premarital sex is not acceptable and coitus is a function of marriage where premarital coitus in acceptable or not. Also they know that it is not acceptable in society they assume that it can be accommodated under some conditions as mentioned in education attainment and area of childhood upbringing. There is a clear indication that young men are more likely to agree to accept premarital coitus if certain conditions are met. These are contraceptive use during coitus, coitus must be based on love, and marriage proposal from parents was approved.

7.8 ATTITUDE TO CONTRACEPTIVE USE

Statements and questions on contraceptive use asked to young men during the questionnaire interviews are outlined in Table 7.7. The first three items in Table 7.7 are indicators of contraceptive use. Items 1 and 3 had *Yes/No/Do not know* response. The yes responses are accounted for as agreeing to the statements. Item two was modified and the statement is shown in the table. The percentage agreeing to item two included those choosing option 2 and option 3 (males, and both males and female). Below are the questions, as extracted from the questionnaire, for the three items. Items 4-7 are part of Question 43. A ranking scale from 1 to 5 (denoting strongly agree, agree, neither agree or disagree, disagree, and strongly disagree) was used. As in Table 7.6, strongly agree and agree were classified under "agree" and neither agree or disagree, disagree, and strongly disagree were under "disagree" in Table 7.7.

Q 37	Is vasectomy commonly used amongst men in your society?				
	1.	Yes	2.	No	3. Do not know
Q38.	Who in your society usually (commonly/mostly) use birth controls?				
	1.	Females	2.	Males	3. Both
Q40.	Is the use of condoms common in your community?				
	1.	Yes	2.	No	3. Do not know

The attitude to contraceptive use influence contraceptive use of individuals and their partner. Young men are perceived to have a negative attitude to contraception (birth controls). About nine per cent of young men agreed that vasectomy is not commonly used in Fijian communities. Only 10 per cent agree with the statement that males in the society usually use birth controls. This indicates the contraceptive use among men in not perceived to be a common practice. Less than half (44.9 per cent) of young men stated that condom use is common in their community. This indicated that some young men do not see condom as a birth control method, they see it as a STI/HIV/AIDS preventative measure.

On the statement *"A couples should discuss contraceptive use before sex"*, more than three quarters of young men agreed with the statement. This is conforming to society's expectation today. Religiosity, education, and area of childhood residence have significant influences on young men's responses to the items in Table 7.7. Although there is little difference young men brought up in rural areas are more likely to agree with the statement as compared to those brought up in urban areas. Young men with only a junior secondary education (or below) are more likely to agree with the statement compared to those with higher education qualification.

About seventy one per cent of young men agreed with the statement *"Good boys carry condoms"*. This shows that young men have a positive attitude to condom use and they perceive that they should always carry condoms. Age, education and area of childhood upbringing have a significant influence on the perception to this statement. A slightly higher proportion of those with rural upbringing agree to the statement as compared to those with urban upbringing. Young men with higher secondary education are slightly more likely to agree with the statement as compared to those with junior secondary education. Young men age 20-24 are less likely to agree with the statement as compared to those aged 15-19. More than 60 per cent of the young men stated that unmarried men should be encouraged to use contraception if they are having coitus. Age has a significant influence on young men's responses to the statement as a higher percentage of those 15-19 agreed with the statement as compared to those 20-24 years of age.

Fijian men are assumed to have little knowledge of female contraception. Contraceptive use is a woman's responsibility because they become pregnant. With an increase in awareness on condom use and contraceptive use men have been informed about contraceptive methods and attitude to contraceptive use has changed in the last three decades with 31 per cent of the young men thinking that it is the woman's responsibility, therefore men are becoming more aware of female contraceptives. Little respect is given to older men who have a vasectomy because they can no longer have any children. This shows the negative attitude the Fijian communities have toward men who have had vasectomy. Below is an experience of a man who had vasectomy:

> *Jese had a vasectomy six years ago. He stated that he had the choice to have a vasectomy because his wife was sickly and they had four children. He did not inform anyone except his wife, about the choice he made. The reason why he did not want anyone else to know was because his friends were going to joke about his decision to have a vasectomy. He finally had a vasectomy, but was unlucky because he got infected the next day and was hospitalised for one week. The operation became common knowledge to everyone and people joked about him from then till today. His advise is that if a Fijian man chose to have a vasectomy they must never let anyone know because they can be joked about by their friends and by the community as a whole.*

The statement above shows how the public's attitude to vasectomy can influence a man's attitude to the use of this method of contraceptive. Although it is a good example of virility, it shows that the public needs to be educated to accept this contraceptive method and not to joke about an individual's choice of the contraceptive method they wish to use.

Table 7.8: Percentage of respondents agreeing with perceived statements on gender roles by age, religiosity, education, and area of childhood residence

	Socio-demographic variables										
	Age		Religiosity			Education		Childhood residence		ALL	TOTAL
Statements on gender role	*15-19*	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Girls are expected to look after their younger brothers and sisters."	62.4	46.8**	59.5	57.3	32.3**	65.5	52.9**	54.9	56.4	55.6	457
"At ages 5-12 boys do less domestic duties than girls."	47.3	42.9	45.3	50.5	29.0**	52.3	43.5*	44.2	46.9	45.4	373
"Males in rural or village communities do more household duties when compared to those in urban areas."	70.5	42.9**	57.8	62.2	49.5	67.2	56.2**	53.2	65.1**	58.5	481
"Men have more free time than women do."	58.1	46.8**	54.5	52.1	50.5	56.9	52.2	50.1	56.9*	53.2	437
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey
Note: ** $p<0.01$, * $p<0.05$

Table 7.9: Percentage of respondents agreeing with statements on perceived gay relationships and prostitution in the society by age, religiosity, education, and area of childhood residence

Statements on gay relationships and prostitution,	Socio-demographic variables									ALL	TOTAL
	Age		Religiosity			Education		Childhood residence			
	15-19	*20-24*	*Com.*	*Mod*	*N/Com*	*Jnr sec*	*High+*	*Urban*	*Rural*		
"Are gay people accepted in society?"	35.3	30.0	36.5	28.7	31.2	24.7	35.2**	24.2	43.9**	33.0	271
"Do gay people normally have more than one partner? "	71.2	66.7	71.6	65.8	69.9	71.3	68.7	65.3	74.1**	69.2	569
"Is prostitution common in your society"	40.4	71.7**	45.5	58.0	79.6**	37.4	58.5**	63.7	42.0**	54.0	444
"Is it common for men in your community to visit prostitutes?"	23.4	38.9**	20.6	40.4	39.8**	20.7	32.7**	33.6	25.9*	30.2	248
Total number of respondents (N)	465	357	422	307	93	174	648	455	367	822	822

Source: Computed from the 2001 RSHKB survey
Note: ** p<0.01, * p<0.05

7.9 GENDER ROLES

In the Fijian society males and females have well defined roles from early childhood to old age. Young men and young women are expected to play different roles in society. Men are the decision makers in society, they are the head of the family and women are expected to concede to the demands of their men in almost any situation that prevails. However cultural expectations have changed over time and with Western influence and changing status of women, in society gender equity and gender equality becoming big issues of development. These concepts in many ways contradict with the traditional and cultural expectation of the Fijian society. Although Pacific Island planners agree that culture does not discriminate between men and women (Secretariat of Pacific Community 2001), however it must be noted that culture is gender-based and there are norms and roles specific to each sex.

Four statements, as shown in Table 7.8 were posed to young men to determine their experiences in relation to some gender roles. The statements are part of Question 55 of the questionnaire (Appendix 1). A ranking scale from 1 to 5 (denoting strongly agree, agree, neither agree or disagree, disagree, and strongly disagree) was used, strongly agree and agree were classified under "agree" and neither agree or disagree, disagree, and strongly disagree were under "disagree" in Table 7.8.

Table 7.8 shows that more that half of the young men agreed that young men and women have different gender roles. As shown in Table 7.8 young men's age, religiosity and education attainment have a significant influence on agreeing with this. While more than 60 per cent of the young men aged 15 to 19 agreed with the statement only about one third of those aged 20 to 24 also agreed. This could be because at 20-24 they are more responsible and are also expected to play the role of looking after their younger brothers and sisters if there is no other older person in the family apart of their parents. Less than half of the young men agreed with the statement about boys doing less domestic duties than girls.

More than half of the young men agreed with the third statement indicating that society's expectation of men's role is also different according to the environmental setting. Education

attainment and area of childhood upbringing have significant influence on the responses given by the young men with a slightly higher proportion of those with rural childhood upbringing agreeing with the statement as compared to those with urban childhood residence. This could be because those with rural childhood residence are able to compare the difference when they now live in an urban area. Age has a negative significant relationship with statement three. Seventy one per cent of young men 15-19 agree with the statement while 42.9 per cent of those aged 20-24 also agreed. The fourth statement on men having more free time then women is agreed by 53.2 per cent of young men. This is positively related to area of childhood residence, showing that those in rural area are more likely to agree as compared to those in urban areas. Age has a statistically significant negative relationship to the statement for those aged 15-19 years are more likely to agree with the statement as compared to those aged 20-24years.

7.10 ATTITUDE TO GAYS AND COMMERCIAL SEX WORKERS IN THE COMMUNITY

The homosexual or 'gay' community in Fiji is a new and fast growing sub-group in society. Unlike Samoa the Fijians do not appreciate men been gay. The group is of great concern as the society associates them with HIV/AIDS and it is a common perception in society that it is one of the groups that is involved in the transmission of HIV/AIDS. The second sub-group that is a growing concern today are the commercial sex workers. The growing number of commercial sex workers, both female and males and mostly Fijian is a manager concern in the Fijian society.

Attitude to the gay community

> *" Joanna, a gay men who prefers to be given a female name, related some of his experiences in society. He stated that his being gay is not accepted by the men from his village and in particular not accepted by his male relatives. However his brothers do not openly declare their disapproval of his behaviour. His being gay is acknowledged by many of his female relatives and friends. He stated that when going around Suva he must always be on the alert because some of his male relatives from the village always punch him whenever they meet in the city. He stated that he could no longer survive in the village because the villagers do not approve of him being gay and feminine in nature. He related how one late Friday afternoon he was punched by one of his cousins while he was shopping with two other gay friends in the Suva market. He run to the nearest police officer he could find hoping to be protected by the officer. Little did he realise that the officer was also one of his relatives. When reaching the officer he was shocked when the officer gave slapped. He looked up and saw that he was also a close relative. He than ran to the nearest taxi and made his escape. "*

The above indicate most Fijian men's attitude to the gay community in Fiji. Gay relationships are not acceptable in the Fijian culture. In the Fijian context the homosexual or gay individuals are mainly refers to transvestite men. They can easily be identified in the community, as they tend to be very feminine in nature. Some dress up as females while others do not but have feminine features such as the way they talk and their voice, and their gestures could easily identify them. The gay community in Fiji is fast increasing in urban Suva. Young men are openly declaring that they are gay and this was observed in the in-depth interviews and focus group discussions. Gay prostitution in Suva is also well established.

Young men's perception of the gay community is assessed in the first two statements in Table 7.9. It shows that about two thirds of the young men disagree that gay people are accepted in society. This attitude is significantly influenced by education attainment and by area of childhood upbringing. The higher the education attainment the more likely it is for young men to agree with the first statement and those with rural childhood upbringing are more likely to agree that gay people are accepted in society as compared to those with urban childhood upbringing. In the Fijian society it is generally assumed that gay people do not have a steady relationship and normally have more than one partner. This is clearly indicated in the analysis as about 70 per cent of young men agreed with the statement that gay people normally have more than one partner. This could indicate that gay men are perceived as not practicing safe sex.

7.10.1 Commercial sex workers

The presence of commercial sex workers (CSW) or prostitution in Fiji is becoming a major social issue to the Fiji government. Female prostitution has existed in Fiji for decades. Prostitution is not acceptable in the Fijian culture and is an illegal activity in Fiji. Although prostitution is visible in and urban Suva and is entertained in society Fijians do not formally publicise its existence. In October 2000 the United Nations (UN) Geneva office released a report on Fiji stating that child prostitution is increasing in Fiji (Fijilive 2000). The Fiji government have recently been trying to curb prostitution in urban Suva by arresting and fining sex workers in the streets of Suva. The current Prime Minister of Fiji, Laisenia Qarase

rejects the proposal for prostitution to be legalised in Fiji. He stated that prostitution is morally wrong (Fijilive 2000).

Prostitution is mostly associated with females but the new trend in Fiji today includes gay men in the profession. The last two statements in Table 7.9 address prostitution. The study observed that more than half of the young men stated that prostitution, including women and gay, is common in their society. Age, religiosity, education attainment, and area of childhood upbringing all have a significant influence on young men's response to the statement *'Is prostitution common in your society'*. While more than 70 per cent of young men aged 20-24 agreed that prostitution is common in society less than half of those age 15-19 years also agreed. This could be due to the younger age groups' little exposure to nightlife as they are perceived as not old enough to visit nightspots and as prostitution flourishes in the evenings the young generation would not be exposed to their existence. About 64 per cent of the young men brought up in urban areas stated that prostitution is common in society while half than half of those with rural upbringing agreed likewise. This could indicate the conservative attitude of those with rural upbringing deciding to ignore that existence of something that is not acceptable in society. It also indicates that prostitution is far more obvious in Suva as Suva attracts prostitutes.

During interviews with female and male commercial sex workers, they stated that they do not like Fijian male clients because they do not respect the CSW and some clients physical abuse the CSW. These prostitutes are both Fijian and Indian prostitutes. Two other common reasons the CSW identified include some Fijian men not paying for the services provided and secondly Fijian men always expect coitus and prefer not to use condoms. The CSW also stated that they are always reluctant to have Fijian male clients, and not many Fijian men come to CSWs because the workers choose to services and they mostly service Indian and expatriate men. This is supported by young men's perception about men in their community visiting prostitutes. Only 30 per cent agreed that men commonly visit prostitutes. Religiosity has a significant influence the perception on men visiting prostitution or not. While 20.6 per cent of those committed agree with the statement, about 40 per cent of those moderately committed and those not committed agreed with the statement. This indicates the influence of religious beliefs on the exposure and the ability to judge the extent

of prostitution, for in Christianity it is a sin to be a prostitute and men must not be involved with prostitutions.

7.11 SUMMARY

Attitude to sexual behaviour have changed over time. Traditional norms before European contact and before the missionaries arrived in the early nineteenth century has changed. As discussed in Chapter Five young men were separated from young women and slept in the men's house under the supervision of older men. Women were kept under the supervision of their family. Attitudes to reproductive and sexual behaviour were different as there was a lot of restriction and traditional sanctions in place to prevent and disallow any form of premarital sexual conquest and sexual encounter.

Religion has played a major role in changing the society's attitude to reproductive and sexual behaviour since the introduction of Christianity into the Fijian society in the early nineteenth century. Religious influence on attitude to sexual behaviour had already made its effect by the early twentieth century. Although Fijian young men do know that premarital sexual relationships and behaviour is not culturally acceptable and has been so since before European contact, cultural norms have changed by the beginning of the last century and so attitudes have also changed.

Although dating is not a cultural behaviour it has become a norm of the Fijian society today. The study noted that young men's attitude to first date is conforming to the acceptable pattern of behaviour in that first dates ensure that the couples come to know each other, therefore less intensive sexual behaviour would be more acceptable, and this is the attitude young men also have towards first dates. However the findings reveal that attitude toward regular dates does not conform to the cultural norm. Although premarital sex in a cultural taboo most young men perceive that very intensive sexual behaviours including coitus would occur after dating for some time (regular date).

A woman maintaining virginity till marriage is not important today. This cultural norm is fast disappearing, therefore although some men want to marry women who are still virgins, young men do know that this is difficult to find. Although some studies have noted that the

age of sexual initiation for young men in Fiji in age group 9-13 years (Chandra 2000; Kaitani 2000; Price 2002), this study reveals that most young men perceive that the age of sexual initiation for both young men and women in age group 15-19 years.

The ideal age of first marriage conforms to society. Over the last five decades the mean age of first marriage for Fijian men and women has been almost stable at about with men having a mean age at marriage (SMAM) of between 25 and 27 years and women have a SMAM of between 22 and 23 years (Statistics 1989; Statistics 1998). The survey showed similar result indicating that young men's perception and attitude to age of marriage is conforming to the social and cultural norms of late marriage.

Premarital coitus is culturally a taboo in the Fijian society. A woman would never publicly declare that she has had premarital sex but a man could do so because it is a masculinity act and macho and real men engage in sexual encounter with women. The study showed that also some young men understand that premarital coitus is not acceptable most of them do agree that it is acceptable under some circumstances and not others. This indicates that attitude to premarital sex has changed and young men perceive that it is acceptable under some conditions relating to the relationship between the two partners involved.

Most young men perceive that men should be encouraged to use contraception and that there should be a dialogue between partners on contraception use. These perceptions are significantly influenced by education status and area of childhood upbringing. However young men perceive that the current norm of contraceptive use among men in Fiji is very low. Young men's attitude to gender role is highly influence by education. Some young men do not accept the existence of a gay community in Fiji. This is significantly influence by the religious, education and area of childhood upbringing status. Most young men also do not perceive that Fijian men using the sex industry, that is visiting commercial sex worker, as common practice. This was supported by the CSW during interviews, stating that most of their clients were Indians or expatriates.

CHAPTER 8

REPRODUCTIVE AND SEXUAL BEHAVIOUR

8.1 INTRODUCTION

The reproductive and sexual behaviour of young men differs in many ways. Some young men are heterosexual, some bisexual, while others are homosexuals. Some initiate sexual coitus at an early age while others do so at an older age. Young men's behaviour is influenced by different factors, as discussed in Chapter 3. These factors include education, religiosity, peer influence, their childhood experiences, and exposure to different social environments.

This chapter examines the factors that influence the behaviour of young Fijian men. First the dating experiences of young men are discussed, followed by the coital experiences and romance in the Fijian context is also discussed. In discussing the dating behaviour of the respondents we only consider those that have dated a partner and excluded those that have had coital experience. It is therefore assumed that those who have had coitus must have dated someone before and after coitus. Finally other sexual behaviour including masturbation is discussed.

8.2 PRECOITAL SEXUAL EXPOSURE

In the Fijian society it is generally assumed that once dating takes place, sexual coitus is also assume to have taken place at the same time. In the Fijian culture dating and courting is not a cultural or traditional norm. Courtship is restricted and must take place in public areas only, that is in the presence of another relative, mostly the younger brother in the case of young men or younger sister in the case of young women or one of the cousins in both cases. This restricts behaviour as holding hand is forbidden and kissing in public is not accepted in society. Showing any affection for one another is not acceptable in public. It must be done in private or in secret only.

Dating in the Fijian society is forbidden and young men and women see it as a behaviour that is to be hidden from the public eyes. It is conducted in secret and dating couples seldom publicly show that they are dating each other. The community generally perceive that coitus is a dating behaviour therefore dating is not encouraged in the community. This could be a factor that could influence dating behaviour to become an initiation process of coitus.

In the Fijian community the general perception is that coitus can only takes place after marriage. As mentioned in Chapter 5, premarital coitus was not acceptable even before European contact. However since European contact there had been records of premarital coitus and although culturally not acceptable it is practiced in society today. Although traditional and religious norms in many societies demand premarital virginity and does not approve of premarital coitus some people argue that today this is only a guiding principle that may be modified by circumstances (Orubuloye et al. 1991; Malungo 2000).

Another perception in the community is that any form of sexual related behaviour must be forbidden until the child has completed his formal education. This indicates that parents associate the beginning sexually related behaviour with the end of the formal education system. One of the main reasons for this association is because it is assumed that engaging in sexual relationships will deteriorate the academic performance hence sexual relationships are discouraged. This is a common attitude of older people.

The cultural separation between men and women, as discussed in Chapter Five, has dramatically affected the way dating has evolved among young people. Young people are advised by the schools, churches, families, and community members that they are not allowed to have extensive contact with the opposite sex until they are over twenty-one. Though culture has forbidden the relationship, young people are still having relationships.

Age is an important factor is influencing and determining the sexual behaviour of males. As a young man gets older he is likely to develop the skills to interact and communicate with those from the opposite sex. He is likely to start establishing dating partners and to establish relationships with the opposite sex. Physical maturity also develops with age and as a man gets older he learns the sexual knowledge and experiences he is likely to obtain. This knowledge can be obtained through different sources such as their friends and through the media as discussed in Chapter 6.

Education has a great influence in determining the sexual behaviour of Fijian males. A young man's age and stages of maturity is also partially determined by the level of education they a currently in. Young men are not encouraged to have interpersonal relationships while they are in the school system. It is generally assumed that they are too young and are not expected to

have their thought diverted to an intimate relationship, as this would affect their academic performance. These relationships are expected to start after young men leave the school system, regardless of their age group.

Some aspects of coital behaviour could also be related to each other. The type of coital partner could be influenced by how long the individual has been sexually active. The type of precoital contact could also be influenced by the type of dating partners an individual has. The general use of condom could be influenced by the type of dating partner an individual has. For when having coital with the girlfriend the man is less expected to use condoms, while having casual sex or having sex with a CSW the individual is more likely to use condoms.

Table 8.1: List of variables

Dependent	*Independent*	*Independent for all dependent variables*
Sexual exposure	Attitude to premarital sex Attitude to dating behaviour	– Age – Education status – Religiosity – Area of childhood upbringing – Residential status – Mother's occupation – Father's occupation – Source of useful information
Type of dating partner (one partner or more)	Age at first date Attitude to dating behaviour and types of partners	
Precoital contact	Age at first date Type of first dating partner Attitude to dating behaviour	
Type of coital partner	Age of first coitus Attitude to types of coitus partner	
Type of coital partner mostly had	Attitude to premarital sex Length of coital lifetime Knowledge of reproductive health. Age at first coitus Type of first coitus partner	

With the above possibilities in mind the analysis both bi-variate and multivariate are conducted. The Chi-squared (X^2) was used to examine the direction of the bi-variate analysis. A significance test was conducted to see if the relationships between the dependent and the independent variables were statistically significant. Table 8.1 shows the dependent and independent variables used in the analysis.

Variable for the analysis were selected on the basis of their theoretical applicability as reflected in prior research and on the availability of data. Therefore factors that were not available in the

data could not be used in the analysis. The study investigated the background characteristics of those who engage in precoital dating and premarital sexual behaviour. Logistic regression was applied because of the dependent variables are dichotomous. Bi-variate logistic analyses are performed by regressing each of the independent variables on each of the dependent variables (as shown in Table 8.1). This shows that individual strength and direction of the variable in addition to estimating its statistical significance.

In addition to the bi-variate analysis, multivariate analysis are carried out and presented as Model II in the same tables. Logistic regression was used to identify the factors that influence sexual behaviour. The multivariate models all the variables are entered simultaneously. This shows the individual strength and direction of the variables in relation to other variables. No interaction or multi-co linearity or correlation was revealed between and among variables.

8.2.1 Marriage and sexual exposure

The Fijian culture closely associates sexual exposure and marriage. As mentioned in Chapter 5, social control existed in the past to prevent premarital coitus. This study shows that the average age at first sexual exposure, including dating and coitus, for Fijian men is lower than the national age at first marriage. The 1996 census showed that the average age of first marriage for Fijian men was 25 years while for women it was 23 years. This survey showed that more that 90 percent of the young men between the age of 15 and 24 were never married. The low proportion of Fijian men married by the age of 24 years is a norm in the Fijian culture because it is believed that a man must be able to look after a family and be the breadwinner before ever getting married. Booth (2003) observed that late marriage has been a trend in the Fijian society since the last 50 years. This indicated that sexual exposure for young Fijian men occur long before they are married.

This survey however showed that more than 90 percent of young Fijian men are not married, while only 5.4 percent belonging to other category including those who are married, divorces, separated, and those having a de facto relationship at the time of the interview. This is because most of the respondents in the survey interview were still in the school system, therefore not married, at the time of the interview. The data is biased towards unmarried men because the main areas of data collection are the formal education institutions.

As mentioned above the Fijian culture does not accept any form of intimate sexual behaviour to be exposed in public places. Young lovers meet in secret and their relationship is not publicly announce although known. Common meeting places are hideouts, the bushes, empty homes, and the streets. While common meeting times are during social and religious gatherings. Below is a discussion with Tevita a 44 years old man talking about his experience as a young man.

> As a young man I recall that the common practise of adolescents and young adults was to be piping Toms and to secretly observe lovers when they are making love. We could look through small gaps and holes between the walls of the houses or follow them into the bushes and observe what they do. Most of the time we explain what we imagine to have seen to others in the group but these are mostly imaginations and assumptions. We would build up on the little we see and exaggerate the actions we observe.

These imaginations are mostly knowledge from friends, televisions, magazines, and movies that young men are exposed to and are able to obtain ideas from. The practise is still common today. As discussion during the FGDs and interviews showed that young men and women spy on each other when partners date in isolated places, away from the public.

Although premarital sex is not acceptable in the Fijian culture Table 8.2 shows that more than half of the young men had had coitus indicating that the taboo against premarital sex have not been observed by many young men. Of the 822 respondents, 62.8 percent have had sexual intercourse (this is defined as having penetrative penile-vaginal intercourse or penile-anal intercourse). Less than one quater have dated a female or another male but have had no penetrative sexual intercourse, while 12.9 percent of the respondents have neither had a date nor penetrative sexual intercourse. The high percentage of young men stating that they have had coitus indicated that premarital coitus is becoming a common practice although it is not traditional acceptable.

Table 8.2 shows that there is not significant relationship between the current age and sexual exposure. Education status however has a significant relationship with sexual exposure. While more than one quarter of those who have an education status of high school and above stated that they have dated only a slightly lower percentage, 17.8 percent, indicated likewise for those with Junior Secondary or below. This indicates that some young men are dating their partners without coitus. This perspective of a date contradicts with society's assumption. In the Fijian society it is generally assumed that when two people date each other coitus takes place. The

behaviour of dating without coitus is a western concept and this is filtering into society through exposure to Western cultures.

Table 8.2: Cross-tabulation analysis of percentage distribution of the sexual exposure by age at first date and education status of respondents

Dependent Variables	*Independent Variables*			*Results and significants*
	Age at interview		**Percent (total)**	
Sexual exposure	*15-19*	*20-24*		X^2 : 2.85;
Had dated only	23.9	24.9	24.3 (200)	Cramer's V:
Had ever had sex	61.5	64.4	62.8 (516)	0.59;
Had neither dated nor coitus	14.6	10.6	12.9 (106)	d.o.f: 2;
Percent	56.6	43.4	100.0 (822)	not significant
	Education status at interview		**Percent(total)**	
Sexual exposure	*Jnr sec. or less*	*High school & above*		
				X^2 : 8.08;
Had dated only	17.8	26.1	24.3 (200)	Cramer's V:
Had ever had sex	64.4	62.3	62.8 (516)	0.099;
Had neither dated nor coitus	17.8	11.6	12.9 (106)	d.o.f: 2;
Percent	21.2	78.8	100.0 (822)	$p<0.05$

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Young men stated in interviews that they have observed that premarital coitus is a common practice in society today. Young men are challenged and criticised by their colleagues if they have never had sex. They could be excluded from the group if they are still virgins. This is a big challenge to young Fijian men, so to be part of the group or to be accepted as a group member some explained how they are dared by their mates to perform certain acts and behaviour, especially to date a young woman or to take part in a group sex called the convoy, which is discussed in Chapter nine.

8.2.2 Dating experience

Western concept of dating, as discussed in chapter five, contradicts with the traditional concept of dating. In the Fijian culture there are highly restrictive rules on relationships between opposite sex. Adolescents are told that they are not allowed to have extensive contact with the opposite sex by their schools, churches, families, and members of their community. These regulations exist until the person is twenty-one. Although the culture has forbidden it, young people are still having relationships. Data collected from the survey showed that most have significant other and some have more than one. This is discussed is this chapter and in Chapter Nine.

8.2.3 Development of relationships

Cultural separation between men and women, as discussed in Chapter Five, has dramatically affected the way dating has evolved among adolescents in Fiji. Young men are trying to combine two ideals. The first is their culture telling them not to associate and the second is from their contact with Western culture through television, songs and magazines and is very limited to most. Young men are trying to incorporate what they see of Western ideals, through these media, into their own culture. Therefore adolescents and young adults have applied the ideals of romantic love to relationships with very little contact. However in Western culture the concept of love is usually accompanied by the idea that it is a gradual process that evolves over long period of time spent together.

The Fijian concept of love serves a symbolic function and creates a symbolic relationship. It is the idea of needing to be in a love relationship that dominates the way relationships have evolved. The fact that they are not able to spend time together has supported the evolution of symbolic relationships and created an underlying theme of people having relationships just for the sake of being in a relationship. This can be seen in the fact that Fijian men and women are known for cheating on each other and it is clearly illustrated in the writing of love letters that dominates the field of communication. In an interview Max explained how he met his wife through his sister. Max is a soldier and during one of his tour of duty to Sinai in the Middle East that he came to communicate with his wife. She worked with his sister and on one occasion she sent him a parcel through his sister. This was how their relationship developed. They had never met but communicated through love letters for nine months and on his return they got married.

People meet their significant others in different ways. These include school, friend of the family, sporting event, religious gatherings, in towns or in the village. Looks are often the attracting component although young men also said that they also want their partners to be kind, have good personalities and so on. In a FGD some of the qualities of the partners that young men look for are honesty, have a good attitude to their family, a girl with a good job, parental approval, faithful, religious, and a virgin. Below are some of the ways some of the young men interviewed stated that they use to approach someone they want to date.

> *When I fix a girl I always have a goal to achieve and I work very hard to make sure I get the goal. There are a lot of sweet and wise words used and I make sure I am never too drunk. However my friends what they do they drink with the girls or they give them drugs and than have sex with them. (Saro, 17 year old male)*

Men approach me when there is no female around. We do not date we just have sex. (24 yr old gay).

I approach a girl by calling her by name or I just whistle to her. (Jone, 18 yr old male)

For my current girlfriend I met her at the "bean cart" after school. I went up to her and chat her up. I found her to be interesting because she was very pretty. (Paula 19 yrs old).

For my current girlfriend we met at a workshop. We are from different schools. She was sitting beside me during the workshop. After the workshop she came and introduced herself to me. When we met later I approached her and asked her whether she has a boyfriend and she said no so I asked her to be my girlfriend. (Dan, 17yrs old).

If I see a girl I like I go up to her and create a conversion or I just ask straight out if I could talk to her. (Filipe, 18yrs old).

I always ask the girl straight out if I am attracted to one. I also do it when one of my friends dares me. I ask the girl if she has time to talk to me, if she has time, I look for a place to sit and talk. (Inia, 23 yrs old male).

With my latest partner I did not approach her. She approached me. It was after school and I was washing the boys toilet. She was washing the girls toilet at the other side. She came and told me that she wanted me. I asked her why. She said because I was handsome, so we had sex in the toilet. (James, 22 yrs old)

Some of the ways men use to approach their partners are shown above. Some created conversations, some call on the girls on the streets, others can only approach women when they are drunk. Creating a conversation and talking using *sweet words*, words that indicate that you love and like her and just coming to know her is important for the second time you meet you can than start a special relationship. However women or other males also ask some men for a date.

It is common for a man to ask a woman to go around with him the second time they meet and once two people are a couple it is not long before they say that they love each other.

8.2.4 Precoital influences

Factors influencing an individual to engage in precoital dates are discussed in Table 8.3. Analysis was conducted on the socio cultural factors that influence a young man to engage in precoital dates. In conducting the analysis only those who had had a date but had no coital experiences were used in the sample subset. Various aspects of dating experience among those that have dated but have had no coital experience are show in Table 8.3. Of the 200 young men who have dated only with no coital experience, about two thirds had their first date before they were 16 years old. About 45 percent stated that their first dating partners were their girlfriends. Table 8.3 shows that 32 percent of the respondents had their first date with friends, these are those that they had known for sometimes but not their girlfriends.

Table 8.3 shows that having first dates are mostly with individuals that the respondents know this includes friends and girlfriends. The other category making up 24 percent included the 6.5 percent of the respondents who had their first date with other males and a further 6.5 percent who had their first date with commercial sex workers. This also included respondents who had their first date with newly-met individuals whom they do not know or have just known commercial sex workers indicate that young Fijian males tend to have first dates with individual that they have known for sometimes.

Table 8.3: Percentage distribution of type of first dating partner by Age at first date

Dependent Variables	*Independent Variables*					*Results and significants*
	Age at first date				**Percent (total)**	
Type of first dating partner	*15 & under*	*15-16*	*17-18*	*19 & over*		X^2 :
Girlfriend	36.6	53.6	41.6	39.5	43.7 (313)	Cramer's V:
Friend	34.8	26.0	38.9	28.9	32.3 (230)	
Others	28.6	20.4	19.5	31.6	24.0 (172)	d.o.f: 2
Percent	39.0	34.9	20.8	5.3	100.0 (716)	$p<0.01$

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note: Others includes newly–met, CSWs, and other males.

Establishing relationship was discussed during in-depth interview and focus group discussions. Relationship between Fijian men and women usually start before the people have spent a significant amount of time together. Young men meet their significant others in a variety of ways. These include schools, friends of the family, sporting events, town, or in the village. Looks are often the attracting component although young men and women also stated that they also want their partners to be kind, have good personality, honest, and other good qualities.

Having relationships with individuals from the same sex is not acceptable in the Fijian culture. It is however interesting to note that some respondents stated that their first dating partners were other males. This finding is also substantiated with information from focus group discussions and in-depth interviews.

In the four weeks prior to the interview 30.5 percent of the respondents who have had dating experience but no coital experience did not have any date. Table 8.4 shows that that 26.0 percent, of the respondents had two dates, in the last four week, while 23.0 percent had three or more dating events in the last four weeks.

Of the 139 respondents with dating experience but no coital experience and had dated in the last four weeks, 69.8 percent had only one dating partner while 30.2 percent had two or more dating partners in the last four weeks before the interview. This indicated that young Fijian males do change dating partners or are likely to be dating two individuals at one time.

Table 8.4: Aspects of dating activity in the last four weeks prior to the interview among those with no coital experience

Dating activity	*Dated only*	*Coital experience*
Number of dating events		
None	30.5 (61)	8.3 (44)
One	20.5 (41)	21.1 (109)
Two	26.0 (52)	29.1 (150)
Three	13.5 (27)	12.2 (63)
Four	4.5 (9)	7.4 (38)
More than four	5.0 (10)	21.7 (112)
Total	*200*	*516*
Number of female/male partners		
One	69.8 (97)	47.7 (225)
Two	21.6 (30)	34.1 (161)
Three or more	8.6 (12)	18.2 (86)
Total	*139*	*472*
Types of partners for those with one partner		
Newly met	9.3 (9)	11.0 (12)
Girlfriend	41.2 (40)	46.8 (51)
Friend	34.0 (33)	25.7 (28)
CSW	5.2 (5)	5.5 (6)
Male	8.2 (8)	11.0 (12)
Unreported	2.1 (2)	.....
Total	*97*	*109*

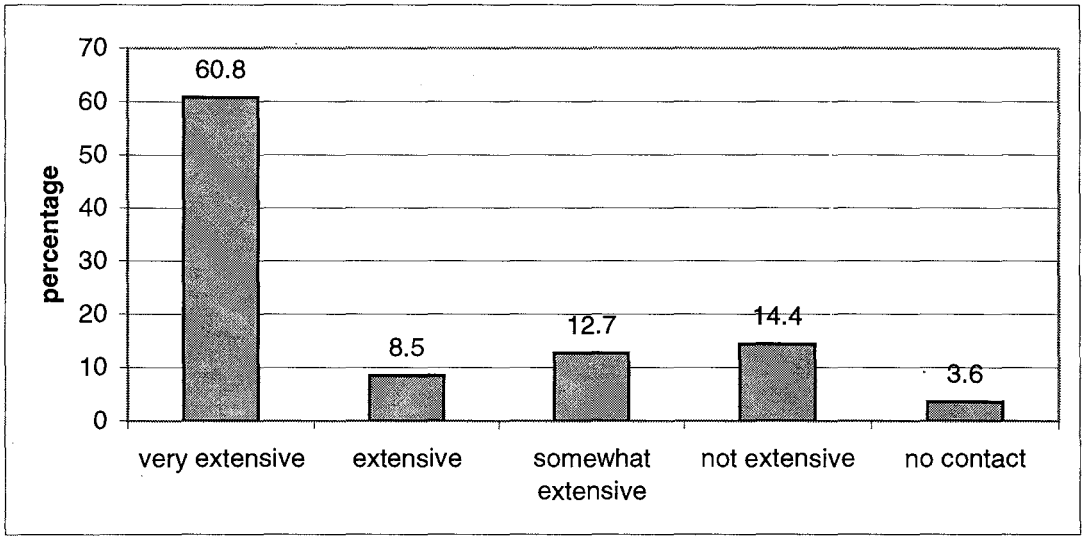
Source: Computed from 2001 RSHKB Survey of Men in Fiji.

The two most common types of dating partners for those with only one dating partner in the four weeks prior to the interview were dating the girlfriends, that is 41.2 percent of those with one dating partner, and dating a friend, making up 34.0 percent of those with one dating partner. Having dates with CSWs is less likely to occur amongst young Fijian males. This is indicated in Table 8.4, as 5.2 percent of the respondents stated that their dating partner for the single date they had in the four week prior to the interview were CSWs.

The dating behaviour has being classified into very extensive, extensive, somewhat extensive and not extensive. The extent of expected dating behaviour among those with no coital

experience is shown in Figure 8.1. Very extensive dating behaviour includes petting with full penetration, petting with full penetration, petting with ejaculation, and penetrative intercourse.

Figure 8.1: Extend of pre-coital experiences amongst those with no coital experience



Source: Computed from 2001 RSHKB Survey of Men in Fiji.
(N=306)

Table 8.5: Percentage distribution of the extensiveness of precoital contact in the last four week by age at first date and types of dating partner for respondents with dating experience but no coital experience

Dependent Variables	*Independent Variables*					*Results and significants*
	Age at first date			**Percent (total)**		X^2:
Pre-coital contact	*15 & under*	*15-16*	*17 & over*			Cramer'sV:
Very Extensive	80.2	64.7	77.8	74.5	(149)	0.163
Not very extensive	19.8	35.3	22.2	25.5	(51)	d.o.f: 2
Percent	*48.0*	*34.0*	*18.0*	*100.0*	*(200)*	not significant
	Type of dating partner					X^2:
Pre-coital contact	girlfriend	Not girlfriend	No dates	Percent (total)		Cramer'sV
Very Extensive	77.2	64.6	85.2	74.5	(149)	:0.202
Not very extensive	22.8	35.4	14.8	25.5	(51)	d.f.o.: 2
Percent	*28.5*	*41.0*	*30.5*	*100.0*	*(200)*	*p< 0.05*

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Extensive behaviour includes breast fondling and genital fondling. Somewhat extensive include lips kissing, and intensive hugging are somewhat not extensive while holding hands, hugging, and cheek kissing are classified as not extensive. Figure 8.1 shows that about 61 per cent of the young men who have no coital experience have had very extensive pre coital experience. Only

4 per cent of the respondents with no coital experience had no contact with any partners. This indicates that young men engaged in very extensive precoital experience with their dating partners.

Young men in Fiji knows that dating a woman is important, however what to do during a date and their partner's expectation of a date may differ in many ways. Some young men stated that when dating they take their partners to the cinema, or they walk around in the city. Young men's perception of what happens during a date is what they see from movies and videos. This includes short-term dates that finally result in very extensive dating behaviour. Young Fijian men do not realise that these are not the dating behaviour of the Western society. In the Western society dating enables partners to come to know each other better before becoming very involved and having very extensive dating behaviour. Fijian men do not realise that partners must know each other better before having intimate relationships and that one major process in knowing your partner is communicating with each other regularly and talking about one's self to allow your partner to know you better. Below is a statement from a young man who was dating a young Australian woman and found it difficult and boring to be sharing with the woman.

> *I had to break up with my girlfriend because she does nothing but talk about herself and her family. She also asks me a lot of question about my family. She would talk for hours and I sometimes get bored with it. She just wants to know too much about my family. I have now run out of things to talk about with her. When we are together the only things we do is talk about our families and about each other's past. There is very little physical contact during our dates. We would only kiss each other and she would start the stories. (Bole, 23 years old)*

The above statement indicates that the partners have different perceptions of having a date. While the woman sees that they need to come to know each other better, the young man assumed that a lot of physical contact is important and this is lacking in their relationship. He later stated that this was the reason why he broke up with the young woman. Young Fijian men associate love with a lot of physical affections. This is clearly shown in the above example where the young man feels that his girlfriend should be involved in more extensive dating behaviour.

The survey investigated factors that influence young men's dating experiences. The bi-variant (Model I) and multivariate (Model II) analysis is presented in Table 8.5. In assessing the factors which influence dating experiences, that is if the young men have had a dating experience or not, the dependent variable was a dichotomous variable. The question format is shown below.

Q 65. Have you ever dated a person (by dating I mean an activity where a male and a female without blood relationship go out together all alone, for example, to watch a movie or to stroll)?

1. Yes 2. No (If no go to question 70)

In Fiji tradition does not encourage having sexual relationships with relatives unless they are cross cousins. Therefore when young people who are related go out together they are not perceived or assumed to be dating. A date in Fiji is understood as going out with another person that you have a love and an intimate feeling for and that the common understanding is that you create a relationship that include sexual relationship. This understanding is established from the beginning of the relationship.

In the analysis many independent variables used when doing the bi-variant analysis and in running the regression, however only a selected few are shown in Table 8.5. These are the variables that have a significant influence on the dating experiences of young men, in the multivariate analysis. The variable indicating the numbers of years that the respondents have spent living in Suva has no significant relationship to their dating experiences but the multivariate analysis showed that those who have lived in Suva for more that 10 years have a significant influence on dating experience.

Logistic regression analysis is used to identify the relationship between dating experience and the factors influence the decision to go on a date. Education has a significant influence on dating. Young men with 9-10 years of education and those with 11-12 years of education are less likely to have dating experience as compared to those with 1-8 years of education. While those with more than 13-15 years of education are 1.5 times more likely to have dated and those with more than 15 years of education are 2 times more likely to have dated. It is noted that most of the young men with 9-10 years of education and those with 11-12 years of eduction are still in the school system while most of those with more then 13 years of school experience are not in the school system. Therefore the more years they have in the school system the older they are and the more likely it is for them to have dating experience.

Table 8.6: Logistic Regression Coefficient Parameter estimates of selected explanatory variables on whether respondents had had dating experiences

	MODEL I				MODEL II				
	B	*S.E*	*Sig.*	*Exp(B)*	*B*	*S.E*	*Sig.*	*Exp(B)*	*n*
Age					.337	.073	.000	1.400	822
Years of Education			**.000**				**.007**		
1-8yrs				1.000				1.000	13
9-10yrs	-.254	.694	.714	.776	-1.205	.857	.160	.300	104
11-12yrs	.723	.686	.292	2.061	-.419	.565	.458	.658	244
13-15yrs	1.250	.690	.070	3.492	.457	.488	.349	1.580	316
> 15 yrs	.750	.705	.287	2.117	.708	.416	.089	2.030	145
Religiosity			**.007**				**.014**		
Committed				1.000				1.000	422
Moderate	-.417	.214	.052	.659	-1.448	.604	.016	.235	307
Not committed	1.092	.532	.040	2.981	-1.719	.594	.004	.179	93
Years lived in Suva			**.536**				**.107**		
Life time				1.000				1.000	112
<3 yrs	-.055	.339	.871	.946	-.123	.390	.140	1.646	187
3-5yrs	.144	.393	.714	1.155	.499	.338	.140	1.646	111
6-10yrs	.517	.382	.176	1.678	.677	.394	.086	1.968	166
10+ yrs	.073	.329	.824	1.076	.912	.415	.028	2.490	246
Religion			**.070**				**.028**		
Catholic				1.000				1.000	128
Methodist	.627	.282	.026	1.871	-.683	.444	.124	.505	331
Seven day Adventist	.781	.434	.072	2.184	-.026	.406	.905	.975	80
AOG	.285	.318	.370	1.330	.360	.536	.502	1.433	149
Others	.903	.376	.016	4.120	-.926	.474	.051	.396	134
Fathers Occupation			**.001**				**000**		
Professional				1.000				1.000	278
Service	1.241	.348	.000	3.460	-1.521	.611	.013	.218	189
Others	.188	.230	.412	1.207	-.062	.695	.929	.940	279
Unemployed	1.347	.537	.012	3.847	-1.496	.624	.016	.224	76
Mothers occupation			**.001**				**.005**		
Professional				1.000				1.000	133
Service	.916	.322	.004	2.499	-.749	.314	.017	.473	160
Others	1.289	.374	.001	3.629	-.365	.338	.281	.694	137
Unemployed/decease	.893	.257	.001	2.443	.799	.418	.056	2.224	392
CONSTANT					*-1.900*	*1.845*	*.303*		

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note: The adjusted odds ratio for the reference category is 1.

Religiosity has a negative significant effect on dating experience. Young men with moderate religious commitment and those not committed are less likely to have dating experience. This is not a norm but it could be attributed to religious youths having a lot of unsupervised social gatherings. From experience during the fieldwork I observed that a particular religious group had the youth kept in the church until 12 midnight rehearsing action song and their performance for the Sunday services. This social gathering could result in the youths have date with each other.

Young men whose fathers have professional occupations are about 80 percent more likely to have dating experience as compared to those whose father are unemployed and those whose father work in the service sector. Mothers' occupation has a significant influence on dating behaviour. Young men whose mothers are unemployed or deceased are twice more likely to have dating experience than those whose mother have professional occupation. However those whose mothers are in service occupation are about 50 percent less likely to have dating experience.

8.3 COITAL EXPERIENCE

Many reasons have been advanced for premarital sexual relations among young people including peer pressure, enjoyment of life, economic reasons, fun and curiosity. Chapter three outlined some of the social, cultural, and economic factors that influence young men and adolescents to engage in premarital sex. This section analyses factors that influence coitus among young Fijian men. Both bi-variant and multivariate analysis is conducted and findings are discussed below.

As shown in Table 8.1 of the 822 respondents 62.8 percent (516) had ever had coitus before the interview. The 516 respondents who have had coitus were asked about their coital experiences. The data indicates that respondents had first coitus at different ages. The age at first coitus ranges from 10 to 24 years of age. About one quarter (27.1 percent) first had coitus before the age of 15 and marginally a lesser proportion had first experienced intercourse when they were 16 (21.9 percent). Others experience first intercourse when they were 15 (15.5 percent), when they were 17 (13 percent), when they were 18 (9.7 percent), and when they were over 18 (12.9 percent), as shown in Table 8.4.

First coitus partners were classified into five categories. Those they just met (newly met), commercial sex workers (CSW), girlfriend, girls they had known for sometimes but not their girlfriends (friends), other males. The data indicated that the majority of the respondents had first coitus with friends (38.6 percent). About one third (33.7 percent) of those sexually active had first sexual intercourse with their girlfriends, while other had first coitus with commercial sex workers (15.5), with another male (10.1 percent), or with those they newly met (2.1 percent).

Table 8.7: Cross-tabulation analysis showing percentage of some aspects of first dating and coitus experience among coitally experienced respondents

Dependent Variables	Independent Variables					Results and significants
	Age at first coitus				Percent (total)	
Type of first coital partner	15 & under	15-16	17-18	19 & over		X^2:
Girlfriend	8.6	26.1	6.0	14.8	15.5 (80)	Cramer's V:
Friend	16.5	34.2	46.2	47.5	33.7 (174)	
Others	74.8	39.7	47.9	37.7	50.8 (262)	d.o.f: 2
Percent	26.9	38.6	22.7	11.8	100.0 (516)	$p<0.01$

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Others includes newly –met, CSWs, and other males.

Age at first coitus has a significant influence on the type of first coitus partners that young men have. Young men who had their first coitus experience below the age of 15 are less likely to have a friend or their girlfriend as their first coitus partners. They are more likely to have other partners such as newly met, CSWs, or other males. Those who have first coitus after the age of 17 are more likely to have their friends or someone they have known as their first coitus partner.

The significant influence of age at first coitus on the type of first coital partner shows that to encourage safe sex and to ensure that young men know their partners better, young men should be encouraged to delay the age at first coitus. However some young men however have their first coitus during child molesting and incest. These are mostly with relatives. Below is a case of a young man relating his first sexual experience.

> *"When I was a child I had my first sexual encounter with a woman much older than me. She came home and we were talking for a while. I suddenly realised when I woke up in the night that this woman was fondling my private part. And then she carried on from there. She is a cousin of mine. I was only 7 years old then. She started kissing me and did all other things to me. I was frightened to tell anyone at home. (17 yr old)*

This is a case of a child sexually abused by a relative, one is a case of an informant who was abused by his sister's girlfriend, she was about 10 years older than him, another by a woman who was his mother's friend. These are only a few examples of the reality of what is happening to young boys. This young man had his first experience without realising it took place. When asked at what age did he have his first coitus he stated that at 16.

Child molesting and child sexual abuse has been a recent issue in Fiji. Incidences of sexual abuse of children have been reported in the news regulars but almost all this cases since 2000 have been of female children and youth being sexually abused. Sexual abuse of young men and

boys are not reported because men are perceived to enjoy sexual intercourse and if reported the community would judge them as abnormal because of not enjoying the sexual act.

Table 8.8: Coital activity in the last six months prior to the interviews among respondents with coital experience.

Coital activity	Number	Per cent
Number of coital events		
1	90	17.4
2	110	21.3
3	67	13.0
4	65	12.6
5	53	10.3
6	18	3.5
More than 6	113	21.9
Total	516	100.0
Number of coital partners		
1	140	27.1
2	189	36.6
3	69	13.4
4	36	7.0
More than 4	58	11.2
No response	24	4.7
Total	516	100.0

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Table 8.8 shows the current sexual activity of those that had sexual intercourse experience was measured according to their sexual activity in the six months prior to the interview. All the sexually active respondents (516) stated that they engaged in one or more coital events in the last six months. About one fifth of the sexually active respondents stated that they had two (21.3 percent) coital events and a similar proportion had more than six (21.9 percent) coital events in the last six months. The next highest number of respondents had had sexual intercourse on one (17.4 percent) occasion in the six months prior to the interview, this was followed by those that had had three (13.0 percent), those that had had four (12.6 percent) and finally those that had had five or six had a cumulative percentage of 13.8 percent.

As for the number of coital partners most had two (36.6 percent) coital partners in the last six months before the interview while a further 27.1 percent had only one coital partner. Table 8.7 shows that a further 13.4 percent have had three coital partners in the last six months, followed by those with more than four coital partners (11.2 percent), and finally those with four coital partners (7.0 percent).

Table 8.9: Cross-tabulation analysis of percentage distribution of the most common type of coital partner by age at interview, education status, and length of lifetime coitus, for the respondents with coital experience.

Dependent Variables	*Independent Variables*			Results and
Most common coital partner	**Age at interview**		Percent (total)	significants
	15 19	*20-24*		
Girlfriend	34.3	38.3	36.0 (186)	X^2 : 8.40
Female I know	38.8	28.7	34.3 (177)	Cramer'sV
Female have not known	17.5	17.3	17.4 (90)	0.128
No response	9.4	15.7	12.2 (63)	d.o.f: 3
Percent	55.4	44.6	100.0 (516)	p<0.05
Most common coital partner	**Education status**			
	Jnr sec. or less	*High school & above*	Percent (total)	
Girlfriend	33.0	36.9	36.0 (186)	X^2 :2.26
Female I know	40.2	32.7	34.3 (177)	Cramer'sV:
Female have not known	15.2	18.1	17.4 (90)	0.066
No response	11.6	12.4	12.2 (63)	d.f.o.: 3
Percent	*21.7*	*78.3*	*100.0 (516)*	not significant
Most common coital partner	**Length of lifetime coitus**		Percent (total)	
	2yrs or less	*3-5yrs*	*6yrs or more*	
Girlfriend	43.8	32.4	25.1	36.0 (186)	X^2 :24.65
Female I know	33.0	31.8	41.3	34.3 (177)	Cramer'sV:
Female have not known	12.9	25.2	14.4	17.4 (90)	0.219
No response	10.3	10.6	19.2	12.2 (63)	d.f.o.: 6
Percent	*45.2*	*34.7*	*20.1*	*100.0 (516)*	p< 0.01

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Table 8.9 shows bi-variate analysis of the influence of age, education status, and length of lifetime coitus on the most common type of coitus partner. There is a significant relationship between the respondents' age at interview and the most common type of coital partner. Young men aged 15-19 years are more likely to have female they knew (38.8 per cent) and their most common coital partner followed by their girlfriends (34.3 per cent) while those at the older age, 20-24, are more likely to have their girlfriends (38.3 per cent) followed by females they knew (28.7 per cent). This indicates that at older age most young men could have established their relationships with their girlfriends and premarital sex occur.

Education status has no significant influence on the most common type of coitus partner young men have. While the length of lifetime coitus has a significant influence on the most common type of coitus partner. About 40 per cent of young men with more than six years of coitus experience stated that the most common type of coitus partners are females they know but not their girlfriends. However 43.8 per cent of young men with less than three years of coitus experience stated that their most common coital partners are their girlfriends. This

indicates that the more years of sexual experience a young man has the more likely it is that they have more coitus with women they know but not their partners.

Logistic Regression analysis in Table 8.10 is used to examine the factors that influence the coitus experience. Controlling for age, it is noted that only a selection of the independent variable is shown on Table 8.9. Variables that have no statistically significant influence on the coitus experience are not shown in the analysis although they have been run in the regression.

The number of years of education has a significant influence on coitus experience. Young men with 9-10yrs and 11-12 years of education are less likely to have had coitus as compared to those with 1-8 years of education. Young men with 13-15 years of education and those with more than 15 years of education have respectively 39 and 18 per cent more chance of having coitus experience. A contributing factor to this result is because most of those with 9 to 12 years of education are still in the school system while those with 1-8 years of education have left the formal schooling system and are no longer student therefore increasing their chance of having coitus experience.

Religion has a statistically significant influence on coital experience. The Assembles of God (AOG) are more likely than the Catholics to have coitus experience and the Seven Days Adventists (SDAs) are 41 per cent more likely to have coitus experience. The Methodists however are less likely to have coitus experience compared to the Catholics. Although religious teaching specifies that coitus must only take place after marriage and that premarital coitus is a sin the analysis results indicate that religiosity has an interesting effect on coitus experience, those who are committed Christians are more likely to have had coitus as compared to those who are moderately committed and those not committed. Therefore the less committed a young man is to religion the less likely it is that they have had coitus.

In analysing the effect of knowledge received on coitus experience three variables have significant influence on coitus experience. These are received useful information from friends, received useful information from schools and teachers, and thirdly how often do you discuss reproductive and sexual health at home. It is observed that young men who stated that they received useful information from friends have about 61 per cent more chance of having coitus than those that did not find the information useful. Young men who stated that they receive

Table 8.10: Logistic Regression Coefficient Parameter estimates of selected explanatory variables on whether respondents had had coitus experiences

	MODEL I				MODEL II				
	B	*S.E*	*Sig.*	*Exp(B)*	*B*	*S.E*	*Sig.*	*Exp(B)*	*n*
Age					.136	.045	.003	1.145	822
Years of Education			**.000**				**.000**		
1-8yrs				1.000				1.000	13
9-10yrs	-.736	.583	.207	.479	-1.069	.632	.091	.343	104
11-12yrs	-1.133	.267	.000	.322	-1.241	.388	.001	.289	244
13-15yrs	.231	.222	.298	1.260	.331	.313	.290	1.393	316
> 15 yrs	.102	.210	.626	1.108	.170	.258	.511	1.185	145
Religiosity			**.183**				**.030**		
Committed				1.000				1.000	422
Moderate	-.147	.244	.548	.864	-.092	.273	.735	.912	307
Not committed	.350	.250	.129	.684	-.526	.276	.057	.591	93
Religion			**.140**				**.006**		
Catholic				1.000				1.000	128
Methodist	.016	.251	.950	1.016	-.272	.292	.350	.762	331
Seven day Adventist	.407	.211	.053	1.503	.346	.249	.164	1.414	80
AOG	.208	.293	.326	1.333	.668	.337	.048	1.950	149
Others	.007	.241	.975	1.007	-.276	.278	.321	.759	134
Mothers occupation			**.000**				**.009**		
Professional				1.000				1.000	133
Service	-.901	.194	.000	.406	-.497	.235	.034	.609	160
Others	.866	.210	.000	.421	-.659	.215	.002	.517	137
Unemployed/decease	.362	.112	.084	.696	-.082	.231	.723	.922	392
Receive useful information from friend			**.005**				**.000**		
No				1.000				1.000	240
Yes	.450	.164	.006	1.569	.477	.198	.016	1.611	282
Receive useful information from Schools and teachers			**.000**						
No				1.000				1.000	348
Yes	-.400	.148	.007	1.492	-.466	.178	.009	.627	474
Coitus is a proper behaviour dating couple engage in.			**.000**				**.000**		
Yes to first & regular date				1.000				1.000	141
Yes first/ no regular date	.486	.246	.048	1.625	.278	.296	.347	1.320	23
No first/ yes regular date	-.787	.442	.075	.455	-.746	.491	.129	.474	441
No, to both	-.412	.173	.017	.662	-.692	.200	.001	.501	217
Premarital sex is never right			**.000**				**.010**		
Agree				1.000				1.000	267
Disagree	-.151	.191	.427	.860	-.039	.230	.866	.962	362
Neither agree/nor disagree	.598	.187	.001	1.819	.548	.227	.016	1.729	193
A boy should be a virgin till married							**.001**		
Agree				1.000				1.000	371
Disagree	-.971	.201	.000	.379	-.902	.231	.000	.406	270
Neither agree/nor disagree	-.379	.215	.078	.684	-.601	.244	.014	.548	181

Conti.

How often do you discuss reproductive and sexual issues at home?			**.062**				**.001**		
Often				1.000				1.000	117
Sometimes	.026	.222	.908	1.026	-.016	.255	.949	.984	276
When there is trouble	.437	.175	.013	1.547	.794	.212	.000	2.212	125
Never	.373	.117	.880	1.033	.292	.258	.259	1.339	304
CONSTANT					-1.588	1.043	.128		

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

useful information from schools and teacher have a 37 per cent less chance of having coitus experience. This indicated that useful information received from friends engages coitus while useful information received from schools and teachers discourages coitus experience.

Information obtained from interviews and observations support the above finding. During an in-depth interview a young man explained how young men in their group compete for sexual coitus and how the winner is the young man who has the most coitus partner in the week. A person with no coitus experience will not be able to be part of the group. Among peers young men talk about how to prevent being infected with STI. They also discuss how to prevent pregnancy. Although some information received is useful, most are myths or incorrect information on sexual health behaviour.

Discussing reproductive and sexual issues at home has a significant influence on coitus experience. Those who only have discussions when there is trouble are twice more likely to have coitus experience than those who often discuss the issue at home. Those who do not discuss the issue at home have about 34 per cent more chance of having coitus than those who often discuss the issues at home. The analysis indicated that the frequency of discussing the issues at home and the situation in which the discussion is held is important in influencing coital experience among young men.

Attitude to coitus experience have a significant influence in the young men's perception of premarital sex. Young men who neither agree nor disagree with premarital sex are about 70 per cent more likely to have coitus as compared to those who agree that premarital sex is never right. Young men who agree that men must remain virgins until marriage are more likely to have coitus experience than those who disagree and those who neither agree nor disagree. This indicates that attitude and practice contradict.

8.4 CONTRACEPTIVE USE

Contraceptive use in Fiji is more focused toward married women. This perception is slowly changing and men are today being encouraged to use contraceptives. Two types of modern contraceptive methods are available in Fiji. The most common one of the two is condom, which will be discussed in the later part of this Chapter, and the second type vasectomy is less common in society. Two types of natural methods are used in Fiji they are the rhythm, and the withdrawal methods.

Contraceptives are only used by people who are sexually active therefore the analysis includes only the 516 young men who have coitus experience. Table 8.11 shown the proportion of the sexually active who have ever used contraceptive. The most commonly used contraceptive is condom with about 74 per cent stating that they have ever used the contraceptive, while only 1.6 per cent have ever used vasectomy.

Table 8.11: Contraceptive use among coitus experienced respondents

Type of contraceptive		Number	Percent
Condom			
	Yes	383	74.2
	No	133	25.8
Vasectomy			
	Yes	8	1.6
	No	508	98.4
Withdrawal			
	Yes	116	22.5
	No	400	77.5
Rhythm			
	Yes	90	17.4
	No	426	82.6
Total		516	**100.0**

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

8.4.1 Vasectomy

Vasectomy is the least common type of contraceptive used by Fijian men. It has been available in Fiji since the late 1960s but has not been promoted because of traditional values. In the Fijian tradition a man is admired, respected, and attains higher status in society if they have more children. Men therefore are expected to have children. A man without a child is criticised by his peers and is not an image of 'a real or macho man'. Vasectomy stops men from children and this is not valued in society. As a result vasectomy has not been widely acceptable in society.

Vasectomy is known to 45.7 percent of the respondents. Age has a statistically significant positive relation with knowledge of vasectomy as a contraceptive method. It was only in the late 1990s that it has become general knowledge to the public. The 1974 Fiji Fertility Survey reported only two (2) cases of vasectomy (Bureau of statistics, 1976). Only 25.2 percent of those brought up in villages know of vasectomy, while about 50 percent of respondents in other areas of childhood upbringing know of vasectomy. This showed that knowledge of vasectomy has not been well disseminated to the village communities. In the early 1990s the Ministry of Health in a joint promoted Health awareness, including awareness on vasectomy as a contraceptive method. Interview with one of the members of the Health promotion team in the early to mid 1990s revealed that the awareness program, including an advertisement on television and newspapers, was not a total success.

Table 8.12: Percentage distribution of general use of vasectomy by age at interview, by education status, by type of coital partner and by length of lifetime coitus, for the respondents with coital experience

Dependent Variables	*Independent Variables*				*Results and significants*
	Age at interview				X^2 :10.104
Ever used condom	*15 19*	*20-24*	*Percent (total)*		Cramer'sV:
Yes	0	3.5	1.6		0.140
No	100	96.5	98.4		d.o.f: 1
Percent	55.4	44.6	100.0 (516)		p<0.01
	Education status				
Ever used condom	*Jnr sec. or less*	*High sch. & above*	*Percent (total)*		X^2 :0.405 Cramer'sV:
Yes	0.9	1.7	1.6		0.028
No	99.1	98.3	98.4		d.f.o.: 1
Percent	21.7	78.3	100.0 (516)		not significant
	Most common coital partner				
Ever used condom	*girlfriend*	*Female I know*	*female I don know*	*No response*	*Percent (total)*	X^2 :2.888 Cramer'sV:
Yes	2.7	1.1	1.1	0	1.6	0.075
No	97.3	98.9	98.9	100	98.4	d.f.o.: 3
Percent	36.0	34.3	17.4	12.2	100 (516)	not significant
	Length of lifetime coitus					
Ever used condom	*2yrs or less*	*3-5yrs*	*6yrs or more*	*Percent (total)*		X^2 :19.017 Cramer'sV:
Yes	0	1.1	5.8	1.6		0.176
No	100	98.9	94.4	98.4		d.f.o.: 2
Percent	45.2	34.7	20.2	100.0 (516)		p<0.01

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Bi-variate analysis shows that the age at interview and the length of lifetime coitus have a significant influence on using vasectomy. This however cannot be totally conclusive because of the small number of individuals who stated that they have used vasectomy. Young men at older age, 20-24 years, are more likely to use vasectomy as compared to those aged 15-19. The longer the length of lifetime coitus the more like it is for young men to use vasectomy.

During an interview a 46 years old man related his story of how he had a vasectomy in 1979. He explained that he was dared and challenged by his friends so he had a vasectomy. Two years later he got married and to this date he has regretted his actions because they cannot have any children. They have adopted a son but he stated that this action he took in 1979 was his biggest mistake in life.

Vasectomy is used in society but men do not openly discuss that they have had a vasectomy. A 48 years old man related to me how his family, his wife's family and his friends make big jokes about him when he had the vasectomy operation. Most men are stigmatised when they have a vasectomy therefore this discourages men from using this method of modern contraceptive.

8.4.2 Natural Method

Young men do not commonly use the natural method of contraceptive however in Fiji Catholics are discouraged from using modern contraceptive methods so they resort to the natural methods. Table 8.12 shows that age at interview and length of lifetime coitus have statistically significant influence on young men ever using withdrawal method. Although less than a quarter have ever use the withdrawal method, young men age 20-24 are more likely to use the method as compared to those aged 15-19.

Young men have little knowledge of the natural method of contraceptives. During in-depth interviews and after the questionnaire interview I was on three occasions approached by young men and asked to explain the withdrawal and the rhythm method of contraceptive. Some young men stated that they have heard of the withdrawal method but do not know the purpose it service. This indicated that these young men are in search of knowledge and there is limited reliable source because of the cultural taboo of open discussion on sex.

Table 8.13: Percentage distribution of use of withdrawal method by age, education, coital partner, and length of lifetime coitus, of respondents with coital experience

Dependent Variables	*Independent Variables*				*Results and significants*
	Age at interview				X2 :3.889
Ever used condom	*15 19*	*20-24*	*Percent (total)*		Cramer'sV:
Yes	19.2	26.5	22.5		0.0.087
No	80.8	73.5	77.5		d.o.f: 1
Percent	55.4	44.6	100.0 (516)		p<0.05
	Education status				
Ever used condom	*Jnr sec. or less*	*High sch. & above*	Percent (total)		X2 :0.661 Cramer'sV:
Yes	19.6	23.3	22.5		0.036
No	80.4	76.7	77.5		d.f.o.: 1
Percent	21.7	78.3	100.0 (516)		not significant
	Most common coital partner				
Ever used condom	*girl-friend*	*female I know*	*female don't know*	*No response*	*Percent (total)*	X2 :0.814 Cramer'sV:
Yes	21.0	24.9	22.2	20.6	22.5	0.043
No	79.0	75.1	77.8	79.4	77.5	d.f.o.: 3
Percent	36.0	34.3	17.4	12.2	100.0 (516)	not significant
	Length of lifetime coitus					
Ever used condom	*2yrs or less*	*3-5yrs*	*6yrs or more*		*Percent (total)*	X2 :10.486 Cramer'sV:
Yes	16.7	30.2	22.1		22.5	0.143
No	83.3	69.8	77.9		77.5	d.f.o.: 2
Percent	45.2	34.7	20.2		100.0 (516)	p<0.01

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

The rhythm method is not commonly used by young men in Fiji however using it is encouraged by the Catholic religion in Fiji. Most young men do not understand the rhythm method. This was observed during the questionnaire service when young men requested that I explain the rhythm method and the menstrual cycle with them. These young men were eager to know the cycle and how the rhythm method could be used as a contraceptive method.

8.4.3 Condom Use

Condom is the most common type of male contraceptive use in Fiji. Knowledge of condom, as discussed in Chapter Six shows that more than 90 per cent of young men in Suva know about condom. Table 8.13 shows some of the independent variables used in analysing the factors that influence condom use among young men.

Table 8.14: Dependent and Independent Variables used in analysing condom use

Dependent Variables	*Independent variables*
Frequency of condom use	Age at interview Education status at interview Type of coital partner mostly had Length of coital lifetime Attitude to condom use "Boy boys carry condom"

The analysis in table 8.15 showed that age at interview, most common coital partner, and length of lifetime coitus have statistically significant influence on the frequency of condom use among young Fijian men. About 57 per cent of young men aged 20-24 years stated that they sometimes use condoms and a slightly lower proportion of 45.5 per cent of those in the young age group stated likewise. Slightly less than one quarter of the young men in both age group stated that they always use condoms. This indicated that condom use is not a common practice among young Fijian men in urban Suva.

Young men who most commonly have females they do not know as their coital partners are more likely to sometimes use condoms as compared to those who most commonly have girlfriends and females they know as their most common coital partner. The longer the length of young men's lifetime coital experience the more likely they are to sometimes use condom. Young men do not always use condoms for many reasons. When asked why they prefer not to use condoms they had different reasons, some reasons given are as follows:

'they prefer skin to skin';
'the condom is not reliable';
'I trust my girlfriend so there is no point in using it';
'I was too drunk';
'Some men stated that using condoms does not give the feeling of sexual satisfaction to both partners'.

Multivariate analysis was done to identify factors that influence condom use. It must be noted that only a selection of the variables used in the analysis is listed in Table 8.14. Socio-demographic variables that influence condom use are discussed below. Young men's mothers' occupation has a significant influence on condom use. Young men whose mother are in service occupation are 2.4 times more likely to ever use condoms as compared to those whose mothers have professional occupation, and young men whose mothers are unemployed or deceased are 1.8 times more likely to ever used condoms.

Table 8.15: How frequent respondents used condom during coitus by age at interview, by education status, by type of coital partner and by length of lifetime coitus, for the respondents with coital experience

Dependent Variables	Independent Variables				Results and significants
	Age at interview				
Frequency of condom use	*15 19*	*20-24*	*Percent (total)*		X^2: 7.800
Always	24.5	23.0	23.8		Cramer'sV:
sometimes	45.5	56.5	50.4		0.123
never	30.1	20.5	25.8		d.o.f: 2
Percent	55.4	44.6	100.0 (516)		p<0.05
	Most common coital partner				
Frequency of condom use	*girl-friend*	*female I know*	*female don't know*	*No response*	*Percent (total)*	X^2 :17.421
always	24.7	29.9	10.0	23.8	23.8	Cramer'sV:
sometimes	52.2	41.2	63.3	52.4	50.4	0.130
never	23.1	28.8	26.7	23.8	25.8	d.f.o.: 6
Percent	36.0	34.3	17.4	12.2	100.0 (516)	p<0.01
	Length of lifetime coitus				
Frequency of condom use	*2yrs or less*	*3-5yrs*	*6yrs or more*	*Percent (total)*	X^2 :14.689
always	26.2	24.6	17.3	23.8	Cramer'sV:
sometimes	42.1	55.9	59.6	50.4	0.169
never	31.8	19.6	23.1	25.8	d.f.o.: 4
Percent	45.2	34.7	20.2	100.0 (516)	p<0.01

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

The analysis shows that who the young men are residing with have a significant influence on whether young men have ever used condom. Young men who reside with their parents and those who live in their own home have about an equal change of ever using condoms. Those residing with friends are four times more likely to ever use condoms and young men residing with relatives are seven times more likely to ever use condoms as compared to those living with their parents. While those leaving in the hostels/boarding have an almost zero change of ever using condoms. This could be because they do not get assess to the service that distributes free condoms. Young men brought up in rural areas are less likely to have ever used condoms compared to those brought up in urban areas.

Table 8.16: Logistic Regression Coefficient. Parameter estimates of selected explanatory variables on whether respondents have ever used condom

	MODEL I				MODEL II				
	B	*S.E*	*Sig.*	*Exp(B)*	*B*	*S.E*	*Sig.*	*Exp(B)*	*n*
Age					-.802	.098	.399	.921	516
Years of Education			**.015**				**.057**		
1-10yrs				1.000				1.000	44
11-12yrs	1.354	.430	.002	3.872	1.659	.789	.035	5.252	169
13-15yrs	.833	.345	.016	2.300	1.711	.625	.006	5.533	210
> 15 yrs	.829	.337	.014	2.291	1.202	.522	.021	3.326	93
Mother's occupation			.000				.006		
Professional				1.000				1.000	67
Service	.845	.293	.004	2.329	.878	.444	.048	2.405	82
Others	.540	.282	.056	1.716	1.340	.409	.001	3.820	87
Unemployed/decease	.511	.277	.065	1.667	.621	.402	.123	1.860	280
Who are you currently residing with?			**.005**				**.000**		
Parents				1.000				1.000	241
Own home	-.115	.277	.679	.891	.086	.439	.845	1.090	25
Friends	-.211	.550	.702	.810	1.412	.788	.073	4.103	17
Hostel/boarding	-.837	.786	.287	.433	-2.608	1.431	.068	.074	127
Relatives	.711	.293	.015	2.035	1.993	.486	.000	7.341	106
Area of childhood upbringing									
Urban					1.000			1.000	295
Rural	-.453	.202	.025	.636	-1.160	.395	.003	.314	221
Category you belong to?									
Heterosexual				1.000				1.000	478
Homosexual	.657	.457	.150	1.929	1.465	.683	.032	4.327	38
Length of lifetime coitus			**.016**				**.038**		
Two years or less				1.000				1.000	233
3-5 years	.439	.272	.106	1.551	.571	.477	.231	1.771	179
6 or more years	-.210	.299	.482	.810	-.370	.440	.402	.691	104
First sexual partner			.010				.000		
Girlfriend				1.000				1.000	80
Female I know	-.380	.295	.197	.684	-.794	.401	.048	.452	174
Female I do not know	-.704	.237	.003	.495	-1.398	.365	.000	.247	262
Usefulness of information from counsellors and religious leaders			**.019**				**.000**		
Not a source				1.000				1.000	163
Not useful at all	.594	.280	.034	1.812	1.260	.465	.007	3.525	44
Not useful	.665	.390	.088	1.945	1.320	.582	.023	3.742	57
Useful	-.640	.462	.166	.527	-1.200	.638	.060	.301	133
Very useful	.216	.302	.474	1.241	1.041	.415	.012	2.832	119
Taken family life education in school									
No				1.000				1.000	325
Yes	-.542	.205	.008	.582	-.888	.310	.004	.412	191

Conti

How often do you discuss reproductive and sexual issues at home				**.000**			**.000**		
Often					1.000			1.000	70
Sometimes	-1.036	.364	.004	.355	-2.505	.566	.000	.082	191
When there is trouble	-.623	.235	.008	.536	-1.480	.389	.000	.228	75
Never	-.509	.313	.103	.601	-1.346	.484	.005	.260	180
Ever received family planning information.									
Yes				1.000				1.000	274
No	.056	.202	.781	1.058	.463	.361	.200	1.588	242
Ever heard of Condom			.004						
Yes				1.000				1.000	468
No	-.905	.310	.004	.404	-.787	.509	.122	.455	48
Premarital sex is never right			**.002**				**.004**		
Agree				1.000				1.000	145
Disagree	.645	.283	.022	1.906	.807	.436	.064	2.240	259
Neither agree/nor disagree	-.138	.271	.611	.871	-.396	.426	.353	.673	112
Unmarried men should be encouraged to use contraceptives.			**.033**				**.012**		
Agree				1.000				1.000	340
Disagree	.756	.298	.011	2.131	1.155	.425	.007	3.175	77
Neither agree nor disagree	.459	.383	.231	1.582	.367	.537	.495	1.443	99
Is condoms use common in your community			**.001**				**.122**		
Yes				1.000				1.000	244
No	-.740	.228	.001	.477	-.988	.334	.003	.372	117
Do not know	-.866	.286	.002	.421	-1.512	.407	.000	.220	155
Good boys carry condom			**.020**				**.011**		
Agree				1.000				1.000	386
Disagree	-.753	.270	.005	.471	-1.304	.433	.003	.272	58
Neither agree nor disagree	-513	.380	.177	.599	-1.075	.557	.054	.341	72
CONSTANT					.924	2.734	.736		

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Homosexuals are four times more likely to have ever used condoms as compared to heterosexuals. The type of first sexual partner has a statistically significant influence on condom use. Young men who had their girlfriends as their first sexual partner are more likely to have ever used condoms as compared to those who had first sexual coitus with a female they know or a female they do not know. Therefore in establishing a relationship before having coitus have encourage young men to ever use condom.

Knowledge and the source of knowledge of reproductive and sexual health behaviour and knowledge of condom availability and condom use are important factors influencing condom use. Young men who take Family Life education at school are less likely to have ever used condoms as compared to those who did not take family life. The analysis shows that discussing reproductive and sexual issues more often at home can increase the change of ever using condom. Knowledge of family planning and knowledge of condom has no significant influence on condom use. This indicates that knowledge alone does not influence behaviour.

Some of the attitude factors that influence condom use include the attitude to encouraging young men to use contraceptives. Young men are three times more likely to have ever used condom. Positive attitude to condom use have a significant influence on ever use contraception. This shows that to encourage young men to use condoms, the society must have a positive attitude to condom use.

8.5 MASTURBATION

Masturbation in the Fijian culture is assumed to be an unhealthy behaviour. When a person is seen masturbating the community jokes him about. Men therefore do not openly declare that they masturbate. Masturbating is not masculinity behaviour, and one who does masturbate is assumed to be unable to get a woman as a sexual partner. Fijian women are never associated with masturbation.

Masturbation is a taboo topic in the Fijian. When translated into Fijian it is a swear word. Symbolic words are used when talking about masturbation. Some of the words used are as follows: *Masi dakai-* in English this is interpreted as wiping the gun. The penis is referred to as the gun*; waliwali* – oiling oneself is the English interpretation, and it refers to massaging the penis when masturbating, as oil is used for massaging. Thirdly, *yavu sovu-* finishing the soap, it symbolises that men masturbate in the shower. These phrases are commonly used through out Fiji. A new phrase that has been introduced in the last decade is *"tuki yadre"*- meaning slapping the forehead. The phase is used or the action performed and the youth community understands what it means.

> *"A young female doctor whom I had an informal discussion with was surprised to know that the above also referred to masturbation. She related to me how when conducting a health check in the rural areas of Fiji in 2001, she wrongly interpreted the word as many males who visited the mobile health check centre were using the word. She thought they were talking about something to do with their foreheads."*

Focus group discussion with male youths indicated that they used this sign language to tell other friends that they had just been to the toilets to masturbate as they sometimes ejaculate when some of their female teachers come in to teach.

Asking the question on whether the respondents masturbate or not was difficult in its own ways. When asked what do we mean by the word masturbation, symbolic terms had to be used. The research team used the phase *masi dakai* meaning cleaning the gun. This was the common phrase used for masturbation. During the fieldwork, a new term for masturbation was introduced, *tavi adre*, meaning slapping your forehead. This as explained by some individuals during a focus group discuss is a symbolic gesture that boys use to indicate that they had been masturbating or had returned from masturbating in the cloakroom. Table 8.17 show that a high percentage of those aged 20-24 stated that they do masturbate. Age has a statistically significant relationship with masturbation. For those age 15-19 about half of the responded stated that they do masturbate and only 3.5 percent did not respond to the question.

Table 8.17: Percentage distribution those stating they ever masturbated by age

	Responses			
Age	Yes	No	No response	Total
15-19	48.9	47.7	3.3	100 (465)
20-24	63.3	27.2	9.5	100 (357)
Total	55.1	38.8	6.1	100 (822)

Source: Computed from 2001 RSHKB Survey of Men in Fiji. ($p<.01$)

The number of times the respondents masturbated was also asked. For the respondents from both the age group, the majority stated that they masturbated only in the past that is 16.6 per cent of the age 15-19 and 18.5 per cent of those aged 20-24. Only 3.2 per cent of those aged 15-19 stated that they masturbated more than 7 times a week while a higher percentage of those 20-24 (15.1 per cent) stated likewise. The table shows that there is a statistically significant relationship between age and the number of times the respondents masturbate.

Table 8.18: Percentage distribution of number of times masturbated by age

	2-7times wkly	*>7times wkly*	*Wkly*	*Mthly*	*Past only*	*Never*	*Total*
15-19	10.1	3.2	8.8	10.3	16.6	51.0	100 (465)
20-24	12.3	15.1	9.6	7.0	18.5	37.4	100 (357)
Total	11.1	8.4	9.2	8.9	17.4	45.0	100 (822)

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note: ($p<.01$)

Fijian men regard circumcision as a necessary for a man. Below is part of an interview with a father and his views on having his son circumcised. The discussion is an indication that the parents decide on the child getting circumcised.

A father/interviewer

I will send my son to the village this holidays to be circumcised
Why?
Because I do not what my son to blame me for not having him circumcised when he grows older.
What is so important about circumcising your son?
Well it is the natural thing to do. It is traditional and for him to be a "man" he must be circumcised.

The Fijian society today still associated masturbation with uncomfortable and disapproval, unfortunate and unnecessary guilt. It is done in secrecy. Although a normal and natural process most feel a shame or guilty about it. The social perceptive of masturbation is that it is an immature process and a real man would be able to find a partner to have sex with rather than being left to his own device.

8.5.1 Wet dreams

Young men have wet dreams at the early stage of their youth development. This is a biological development and is an important stage of development to young men. In the Fijian society however it is believed to be an unnatural act associated with evil spirits. Having wet dreams is believed to be a result of the men being sexually abused by female evil spirits. Young men do not discuss their experience in public but mostly share the experience with their friends. This is because having wet dreams is associated with being a sex maniac. Wet dreams are therefore not a common knowledge to young men. Below is a young man's experience of his first wet dream.

> *I have had wet dreams. The first was when I was 14 years old. My pants got wet when I was asleep. I hid the pants and burnt it the next morning because I thought I peed on my pants, I did not know that it was a wet dream. (Mike 21 years old).*

The above quote indicate that knowledge of wet dream is not universal to all young men. During the questionnaire interview I was asked by a group of 16 year olds to explain what the term wet dreams meant. I explained it in Fijian but because there was no Fijian word for wet dream I explained the experience to them. While explaining one of the young men quickly related to the others that 'Wet dreams is when you are asleep and a female evil spirit comes and have sex with you'. This is how wet dream is perceived in the Fijian context.

8.6 SUMMARY

This chapter has shown that premarital sex intercourse is not uncommon among young Fijian men in Fiji. The various reasons for the increase identified in this chapter include peer pressure; prevailing myth that favour sex among young people especially men; the need to show sexual prowess among young men; and the tolerance of such sexual behaviour among young men. As a result young men indicate that they often have premarital sex. Premarital sex was reported to begin at very young age, some men reported that they first had sex before the age of ten. This is high- risk behaviour in the era of HIV/AIDS.

The regression model showed that young men who are committed to their religion are more likely to be discouraged from having dated. They are however more likely to be engaged in premarital coitus. It is important to note that young men who are still in the formal secondary (high school) education system tend to have a reduced rate of premarital sexual activity. The schools and teacher give information that influence young men not to have coitus while useful information obtained from friends encourage the onset of premarital sex. Most knowledge of premarital risk behaviour and attitudes had no significant influence on the dating and coital behaviour of young men.

Contraceptive use among young Fijian males is not very common. Although knowledge of condom as a safe sex method is high, the proportion that had ever used condoms is very low but high among homosexual males. Knowledge of condom and source of information are important influence to condom use and safe sex practice. Obtaining information from religious leaders and counsellors increase the chance of condom use.

This chapter shows that sexual behaviour among young men is changing with respect to such behaviour as dating behaviour and postponement of premarital sexual acts on the one end and the increase in premarital coitus on the other, and condom use is increasing. These developments can be attributed to many institutions involved in articulating programs aimed at reducing sexual behaviour risks. Such organizations include religious organizations, NGO, and health promotion services. What is required to consolidate and expand these programs include some of the finding in this analysis. The government should further train and use the schools to educate young men on reproductive sexual health behaviours. Religion and religiosity are influential factors therefore religious leader must be involved in implementing programs on sexual behaviour to their youth. Social environment that religious groups have and social

meetings for their youths need to be reviewed as these could be influencing factors to encourage premarital coitus.

It is not only the knowledge and attitude that is important, as most have not significant influence on behaviour. The social environment and family background have an important role in influencing sexual behaviour. Parents therefore need to be advised to encourage discussions on sexual issues with their children. Most organizations addressing the issues in Fiji are only promoting information dissemination, counselling centres and service provider friendly environment must be provided. Programs for teacher, parents, religious leader and young men must be encouraged.

CHAPTER 9

RISK BEHAVIOURS

9.1 INTRODUCTION

The growing concern about sexual issues such as STI including HIV/AIDS, and teenage pregnancy has increased the importance of understanding reproductive health behaviour and identifying the factors that influence risk behaviours. Reported HIV/AIDS cases have more than doubled in Fiji in the last decade and reported incidence of STI continues to increase among the Fijian male population. This is shown on Table 2.4 and 2.4 in Chapter 2.

It is very important to understand why some individuals do not protect themselves against infections and to also understand why some men engage in risk-taking sexual behaviour. In an effort to provide an understanding on the risks involved in contacting STI including HIV/AIDS and in practicing unsafe sex in Fiji, this chapter examines the factors that influence risk-taking behaviours. Risk behaviours discussed in this chapter include casual sex, having multiple partners, having coitus with prostitutes, and sexual assaults including incest and child molesting, rape, and the 'convoy'.

9.2 CASUAL SEX

Casual sex is a common practice in Fiji today. The younger age at maturity, the decreasing age of first sexual intercourse, and the increase in age at first marriage contributes to increase in incidence of casual sex. As discussed on Chapter Five, casual sex was not encouraged in the Fijian community before European contact. It was only acceptable for chiefs to engage in such sexual endeavours and it was prestigious to bear a child for the chief even if out of wedlock. Today this perception extends to economic wealth and not only chiefly status.

Although there is a general assumption that first sexual intercourse occurs after marriage, my survey last year showed that about 60 per cent of the young men have premarital coitus experience. Involving in casual sex is secretive because once known that a man is having an affair with a young woman, the woman's relative, especially the males, can force him into marrying the woman. This is due to the shame the woman's family can have, for the woman would be seen as a loose girl and assumed to be available for any men. The institution that

tries to force a man into marrying a young woman, is less practical today, allowing Fijian men to have premarital sex with little chance of being forced by their partner's relative into marrying her.

Fijians in urban areas are no longer in the closed village communities they once lived in. What a girl does in another suburban area has a low possibility of filtering to her immediate family. As a result adolescents and young adults engage in premarital sex without the knowledge of their parents and their immediate relatives. Parents are ignorant of their children's sexual relationships and assume that because of the cultural and religious taboos, their children can never fail them, and will never have premarital sex. Parents and household heads also play a double standard; they would never allow their children to have premarital sex or to bring their dates home, but would allow their relatives to bring casual date to their homes and sleep for the night or spend the weekends with them.

Having a steady girlfriend is not very common amongst Fijian adolescents. Casual sex is very common. The most common meeting place to get a partner for casual sex, or one nightstand off, is at nightclubs. To some men the sole purpose for going into nightclubs is to try and get girls for one-night affairs.

"I go to the night club for the three F (FFF)" (22yr old)

The three 'Fs' is a common slogan in Fiji and I was told that it stands for 'fix, fuck, and forget'. During a FGD I asked the group who are in their 11th grade- or Form 5 and whose age ranged between 16 and 18, if they knew the meaning of the three Fs. They stated that they did and that some refer to it as 'F cube' or 'F^3'. They see the behaviour as a normative behaviour and thought that it is an accepted behaviour and that is one of the main reason for going to nightclubs is to have casual sex and friend one night affair partners.

Incidence of casual sex is common amongst STI patients. Interviews with some patients who attended the Suva clinic showed that most of those infected were infected through casual, unprotected sex. Some of the informants did not even know the names of their partners. Those who knew their partners stated that their affairs were mostly one night's affair and they were not regular partners. My survey showed 72 per cent of the young men who have

had coitus do not have a partner. This could reflect the high percentage of casual sex taking place amongst indigenous Fijians.

In analysing the survey data having casual sex is defined as having sex with some you do not know, and having sex with a friend who is not your girlfriend. In the analysis the behaviour is classified as current behaviour, this is because it took place in the last six months prior to the interview. The analysis is a subset of the total data. It only includes young men who are sexually active. This is because these young men are at risk of being involve in risk behaviour in the six months before the interview.

Table 9.1: Cross-tabulation analysis of percentage distribution of those currently engage in casual sex by selected socio- demographic status of respondents

Dependent Variables	Independent Variables					Results and significants
	Age at interview				*Percent(total)*	
Engage in casual sex	15-19		20-24			X^2 :10.927 ;
Yes	64.0		36.0		41.5 (214)	
No	49.3		50.7		58.5 (302)	d.o.f: 1;
Percent	55.4		44.5		100 (516)	P<0.01
	Education status at interview					
Engage in casual sex	*Jnr sec. or less*		*High school & above*		*Percent(total)*	
Yes	27.1		72.9		41.5 (214)	X^2 : 6.268;
No	17.9		82.1		58.5 (302)	d.o.f: 1;
Percent	21.7		78.3		100 (516)	p<0.01
	Age at first sex					
Engage in Casual sex	<15	15-16	17-18	19 yrs+		X^2 : 35.111;
Yes	29.9	49.1	16.8	4.2	41.5 (214)	d.o.f: 3;
No	24.8	31.1	26.8	17.2	58.5 (302)	p<0.01
Percentage	26.9	38.6	22.7	11.8	100 (516)	
	Area of childhood upbringing					
Engage in Casual sex	*Urban*		*Rural*			
Yes	51.9		48.1		41.5 (214)	X^2 : 4.197;
No	60.9		39.1		58.5 (302)	d.o.f: 1;
Percentage	57.2		42.8		100 (516)	p<0.025

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Table 9.2: Logistic Regression Coefficient Parameter estimates of selected explanatory variables on currently engaged in casual sex

	MODEL I				MODEL II				
	B	*S.E*	*Sig.*	*Exp(B)*	*B*	*S.E*	*Sig.*	*Exp(B)*	*N*
Age					-.188	.163	.248	.829	516
Years of Education			**.220**				**.059**		
1-8yrs				1.000				1.000	13
9-10yrs	1.244	.892	.163	3.470	4.315	1.653	.009	74.793	104
11-12yrs	.233	.393	.554	1.262	-.514	1.026	.617	.598	244
13-15yrs	.445	.265	.093	1.560	-.724	.661	.262	.476	316
> 15 yrs	.066	.258	.799	1.068	-.592	.533	.267	.553	145
Are you currently a student									
Yes				1.000				1.000	435
No	-.344	.089	.000	.709	1.070	.591	.070	2.916	81
Years lived in Suva			**.157**				**.011**		
Life time				1.000				1.000	112
<3 yrs	-.083	.297	.780	.920	1.713	.605	.005	5.545	187
3-5yrs	-.156	.258	.545	.855	.243	.558	.663	1.275	111
6-10yrs	.443	.293	.130	1.557	.904	.624	.148	2.468	166
10+ yrs	.372	.250	.138	1.450	-.394	.500	.430	.674	246
Mothers occupation			**.011**				**.044**		
Professional				1.000				1.000	133
Service	-.131	.275	.635	.877	-.587	.534	.272	.556	160
Others	.054	.252	.830	1.056	-.195	.433	.652	.823	137
Unemployed/decease	-.883	.274	.001	.414	-1.368	.491	.005	.255	392
Age at first coitus			**.000**				**.049**		
<15 yrs				1.000				1.000	139
15-16years	1.595	.399	.000	4.928	1.975	1.089	.070	7.205	199
17-18 years	1.864	.388	.000	6.451	2.284	.9150	.013	9.818	117
19 years and over	.943	.413	.022	2.567	1.406	.802	.080	4.080	61
Received useful info. from counsel./rel. leaders									
No				1.000				1.000	264
Yes	.144	.179	.420	1.155	.672	.391	.085	1.959	252
Received useful info. from the media									
No				1.000				1.000	117
Yes	.832	.214	.000	2.297	1.040	.478	.029	2.830	399
It's a man's right to have sex with his wife/partner			**.002**				**.016**		
Strongly agree				1.000				1.000	175
Agree	-.679	.384	.077	.507	-1.388	.692	.046	.250	95
Neither	.653	.340	.055	1.922	1.104	.679	.104	3.016	101
Disagree	.707	.248	.004	2.028	.654	.561	.250	1.906	68
Strongly disagree	-.149	.287	.602	.661	-.684	.498	.170	.505	77

Conti.

Men should make their own decision on choosing a partner			**.000**				**.005**		
Strongly agree				1.000				1.000	218
Agree	1.648	.475	.001	5.197	2.393	.726	.001	10.946	171
Neither	.681	.483	.159	1.976	2.508	.814	.002	12.285	67
Disagree	.844	.521	.105	2.325	1.407	.889	.113	4.085	29
Strongly disagree	.462	.616	.453	1.587	2.890	1.064	.007	17.991	31
A girl should be a virgin till marriage			**.168**				**.009**		
Agree				1.000				1.000	279
Disagree	-.052	.209	.062	.949	1.705	.566	.003	5.502	97
Neither	-.479	.275	.804	.619	1.038	.647	.109	2.822	140
Premarital sex is okay if with a prostitute			**.209**				**.000**		
Agree				1.000				1.000	101
Disagree	-.259	.310	.403	.772	-1.363	.640	.033	.256	343
Neither	-.444	.260	.088	.641	-2.541	.617	.000	.076	72
Premarital sex is okay if both partners agree but don't have love.			**.001**				**.002**		
Agree				1.000				1.000	160
Disagree	-.919	.257	.000	.399	-1.924	.545	.000	.146	249
Neither	-.643	.234	.006	.526	-1.521	.554	.006	.219	107
Premarital sex is okay if based on love			**.007**				**.005**		
Agree				1.000				1.000	220
Disagree	.668	.228	.003	1.950	1.568	.497	.009	4.796	163
Neither agree nor disagree	.216	.245	.377	1.242	1.501	.573	.009	4.486	133
CONSTANT					-9.995	22.82	.662	.000	

Source: Computed from 2001 RSHKB Survey of Men in Fiji.
Note:: The adjusted odds ratio for the reference category is 1.

Bi-variate analysis on Table 9.1 showed that younger men (64 per cent) aged 15-19 are more likely to be engaged in casual sex as compared to their older counterparts (36 per cent) aged 20-24. This could be because men at older ages have a more steady relationship with their girlfriends therefore are less likely to be having coitus with women who are not their girlfriend.

Education status has a significant influence on engaging in casual sex. About 73 per cent of the young men who stated that they had engaged in casual sex in the six months before the interview had high school or tertiary education. This result could have been influence by the proportional distribution of the education status of the respondents.

Logistic regression is used to analyse and identify the factors that influence young men to engage in casual sex. Analysis. Table 9.2 shows a selection of variable that have been regressed against the dependent variable. The variables not shown in Table 9.2 have no significant influence on engaging in casual sex. Logistic regression is used because the dependent variable is a dichotomous variable. Using the significance level of $p \leq 0.05$ the analysis shows that the number of years a young man has spent in Suva has a significant influence of his practising casual sex. Young men who have lived in Suva for less than 3 years are about five times more likely to currently engage in casual sex compared to those who were brought up in Suva. This could be a result of these young men getting exposed to the new culture and wrongly interpret that it is a norm.

It is common practice among young Fijian men to talk about their sexual adventures and discuss it with the village boys when they visit their villages. Young men normally talk about how easy it is to get 'beautiful' girls in the city. Young men moving into Suva would think that such behaviour is acceptable in Suva and so practice what they have learnt from the relative who are also their peer.

Other socio-demographic factors that significantly influence engaging in casual sex include mother's occupation, and age at first coitus. Young men whose mothers have professional occupation are more likely to be involved in casual sex than those who are unemployed and those in all other categories of occupation. Young men whose mothers are unemployed or have passed away have about 75 per cent less chance of having casual sex as compared to those whose mothers are in professional occupation. Unemployed mothers spend more time with their children and supervise their children while professionally employed women spent less time at home but more at work and there is less supervision for their children. This is one reason, why, as stated by a young man during informal discussion, children of professional mothers engage in risk taking behaviour.

The age at first coitus influences young men to engaging in casual sex. Young men who stated that they had first coitus before the age of 15 are less likely to be engaging in casual sex as compared to those who had first coitus at older age. It must be noted that these young men are within the expected age at first and some have had coital experience of between 1-2

years. This could be a reason why those who had first coitus at age 17-18 years are seven times more likely to be engaged in casual sex than those that had coitus before the age of 15.

Variables assessing young men's knowledge of risk behaviour and their knowledge of safe sex have no significant influence on their engaging in casual sex. However the source of useful information has a significant influence on the practice of casual sex. Young men who stated that they received useful information from the media are about three times more likely to engage in casual sex than those who stated that they did not receive useful information from the media. This indicated that information young men assume are useful reproductive and sexual health behaviour information obtained from the media encourages young men to engage in risk taking behaviour.

The attitude variables that have a significant influence on young men's sexual behaviour and influence engaging in casual sex are shown in Table 9.2. Attitudes are measured with statement questions. Some statements on premarital sex influence behaviour while others do not. Young men who agree that premarital sex should be based on love are about four times less likely to be engaged in casual sex compared to those who disagree and to those who neither agree nor disagree. Those who agree that premarital sex is okay if both partners agree but do not love each other have about 80 per cent more chance in engaging in casual sex compared to those who disagree. Young men who agree that premarital sex with prostitutes is okay are more likely to engage in casual sex.

As discussed in Chapter Five casual sex has been practiced in Fiji for more than a century (Thompson 1908). Today with the changing social environment young people have more social events together encouraging the development of intimate relationships. Social gathering for the family, the church, sports, schools, and evening outings to watch movies, and go dancing encourage young men to engage in casual sex when the opportunity is there. The factors discussed above are some of the factors that influence young men to engage in casual sex. To decrease the risk these influences should be addressed.

9.3 MULTIPLE PARTNERS

In the era of HIV/AIDS having multiple partners is a sexually risk behaviour because HIV can be spread through sexual intercourse. In Fiji blood testing is not common and although incidence of STI infection is rapidly increasing, known cases of HIV infection is not well established and monitoring and addressing the needs of infected individuals is not established.

Below is a case that could justify why having multiple partners in Fiji is risk behaviour.

> *'In February 2001 a young women in her mid 20s was diagnosed to be HIV positive. She was asked to identify her partner. Her partner was a soldier. The two are from the same village and when the man was contacted it was realised that he was very sick in hospital. It was not known than that he was HIV positive. His test result arrives a few days before he died and on his death bed, he informed the medical team that in the last six months he had prior to his death to had had seven different female sexual partners. The medical team tried to identify the six women and traced the young man's movement six months before his death. Non of the six women one was able to be identified.'*

The above case indicates that there are people at large in the community who could be HIV positive but have never been tested and the practice of having multiple partners can increase the risk. Below is a summary of an interview with a STI patient at the Suva STI Clinic.

> *Mosese a Fiji Institute of Technology student related how his group have sexual adventures during the weekends. This is a group of young men aged between 19-26 years, leaving in a suburb at the outskirt of Suva. The group is made up of about 15 young men. Every evening they would meet outside the community shop and discuss their sexual adventures the week before. They compete for leadership in the group. The individual who have sex with the most number of women would lead the group for the week. An n empty house in the suburb was used for accommodating their sexual partners for the night. He related that on some occasions they would 'convoy' (gang sex) the woman if her male partner agrees. The group's motto is to have a change of partner every time and that was seen by Mosese to be an achievement.*

The above example shows that young Fijian men engage in having multiple sexual partners and some see this as proving to others that they are macho man. When young Fijian men gather and talk the most common topic of discussion is their sexual adventures and women. Peers do encourage young men to engage in sexual adventure but the extent of the influence will be assessed in the bi-variate and logistic regression analysis discussed below.

Table 9.3: Cross-tabulation analysis of percentage distribution of those currently engage in having multiple sexual partners by selected socio- demographic status

Dependent Variables	Independent Variables					Results and significants
	Age at interview				*Percent(total)*	
Engage in multiple partners	*15-19*		*20-24*			X^2 :1.348. ;
Yes	52.8		47.1		50.2(259)	
No	58.0		42.0		49.8(257)	d.o.f: 1;
Percent	55.4		44.6		100 (516)	Not significant
	Education status at interview					
Engage in casual sex	*Jnr sec. or less*		*High school & above*		*Percent(total)*	
						X^2 : .028;
Yes	50.9		50		50.2(259)	
No	49.1		50		49.8(257)	d.o.f: 1;
Percent	21.7		78.3		100 (516)	Not significant
	Age at first sex					
Engage in Casual sex	*<15*	*15-16*	*17-18*	*19 yrs+*		
						X^2 : 3.732;
Yes	30.5	37.5	21.6	10.4	50.2(259)	d.o.f: 3;
No	23.3	39.7	23.7	13.2	49.8(257)	Not significant
Percentage	26.9	38.6	22.7	11.8	100 (516)	
	Area of childhood upbringing					
Engage in Casual sex	*Urban*		*Rural*			
Yes	56.0		44.0		50.2(259)	X^2 :.299;
No	58.4		41.6		49.8(257)	d.o.f: 1;
Percentage	57.2		42.8		100 (516)	Not significant

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

More that 50 per cent of the young men who are sexually active stated that they are currently engaging in having multiple partners. This is measured as young men having more than one sexual partner in the last six months prior to the interview. This includes for men who might change girlfriends in the last six months and those who have two or more partners at one given time. The bi-variate analysis shows that age at the time of interview, age at first coitus, education status and area of childhood upbringing have no significant influence on young men's engaging in having multiple sexual partners.

Table 9.4: Logistic Regression Coefficient Parameter estimates of selected explanatory variables why respondents have multiple partners.

	MODEL I				MODEL II				
	B	*S.E*	*Sig.*	*Exp(B)*	*B*	*S.E*	*Sig.*	*Exp(B)*	*n*
Age					.387	.174	.026	1.472	516
Years of Education			**.642**				**.001**		
1-8yrs				1.000				1.000	6
9-10yrs	-.455	.891	.609	.634	2.069	2.451	.399	7.918	38
11-12yrs	.343	.386	.374	1.409	1.087	1.159	.348	2.965	169
13-15yrs	.226	.259	.384	1.253	2.271	.843	.007	9.692	210
> 15 yrs	.333	.250	.184	1.395	2.763	.705	.000	15.84	93
Religiosity							**.001**		
Committed				1.000				1.000	272
Moderate	-.633	.287	.027	.531	-1.40	.656	.000	.091	181
Not committed	-.452	.299	.130	.636	-1.77	.660	.007	.170	63
Religion			**.013**				**.000**		
Catholic				1.000				1.000	75
Methodist	.881	.332	.008	2.413	3.278	.765	.000	26.51	224
Seven day Adventist	.166	.266	.534	1.180	2.669	.635	.000	14.43	52
AOG	.286	.361	.428	1.331	.846	.774	.275	2.330	87
Others	.759	.317	.017	2.136	2.916	.772	.000	18.48	78
Mother's occupation			**.002**				**.029**		
Professional				1.000				1.000	67
Service	.144	.272	.596	1.155	.841	.579	.146	2.318	82
Others	.881	.266	.001	2.414	1.622	.576	.005	5.063	87
Unemployed/decease	-.281	.249	.259	.755	.128	.546	.814	1.137	280
Father's occupation			**.000**				**.004**		
Professional				1.000				1.000	166
Service	1.529	.333	.000	4.613	.675	.782	.388	1.963	118
Others	.634	.347	.067	1.886	-1.19	.880	.176	.304	172
Unemployed/decease	1.081	.329	.001	2.949	-.181	.786	.818	.835	60
Who you currently reside with?			**.050**				**.086**		
Parents				1.000				1.000	241
Own home	.252	.236	.285	1.286	-.542	.541	.317	.582	25
Friends	1.097	.472	.020	2.994	1.450	.941	.123	4.261	17
Hostel/boarding	.225	.524	.668	1.253	.031	1.135	.978	1.032	127
Relatives	.644	.267	.016	1.905	925	.561	.099	.397	106
No. of years lived in Suva			**.000**				**.000**		
Lifetime				1.000				1.000	70
<3 years	.435	.290	.133	1.546	1.780	.604	.003	5.930	110
3-5 years	1.141	.266	.000	3.131	2.857	.637	.000	17.41	68
6-10 years	-.212	.296	.473	.809	.680	.637	.285	1.975	112
More than 10 years	-.305	.253	.228	.737	.674	.569	.237	1.962	156
Receive useful information from relatives									
No				1.000				1.000	266
Yes	-.264	.177	.135	.768	-1.72	.463	.000	.178	250
Receive useful information from the media									
No				1.000				1.000	117
Yes	.254	.211	.229	1.289	1.393	.556	.012	4.027	399

Conti.

Do you discuss repro. and sexual health issues at home			**.014**				**.001**		
Often				1.000				1.000	70
Sometimes	.635	.285	.026	1.887	2.116	.610	.001	8.294	191
Only when there is trouble	.584	.210	.006	1.793	1.748	.514	.001	5.745	75
Never	.647	.278	.020	1.909	1.866	.585	.001	6.461	180
Premarital sex is if both agree but do not love each other			**.002**				**.004**		
Agree				1.000				1.000	160
Disagree	.456	.256	.075	1.577	.011	.595	.985	1.011	249
Neither agree/nor disagree	.839	.238	.000	2.314	1.500	.593	.011	4.483	107
Premarital sex is okay if it is with a prostitute			**.922**				**.013**		
Agree				1.000				1.000	101
Disagree	.115	.309	.709	1.122	-.859	.682	.208	.423	343
Neither agree/nor disagree	.038	.259	.883	1.039	-1.76	.624	.005	.170	72
Premarital sex is never right			**.142**				**.091**		
Agree				1.000				1.000	145
Disagree	-.393	.254	.121	.675	-1.12	.585	.054	.323	259
Neither agree/nor disagree	-.440	.228	.054	.644	-1.11	.549	.042	.327	112
Men should chose their own partners			**.001**				**.025**		
Strongly Agree				1.000				1.000	218
Agree	-.139	.386	.791	.870	.690	.711	.332	1.995	171
Neither agree nor disagree	.561	.393	.154	1.752	.265	.760	.727	1.304	67
Disagree	.713	.441	.106	2.040	2.254	.861	.009	9.528	29
Strongly disagree	-.604	.540	.263	.547	.034	1.119	.975	1.035	31
It is okay for a man to have extramarital affair			**.080**				**.006**		
Strongly Agree				1.000				1.000	41
Agree	.508	.339	.134	1.662	1.626	.734	.027	5.085	40
Neither agree nor disagree	.364	.339	.284	1.438	2.268	.768	.003	9.657	87
Disagree	.002	.246	.995	1.002	-.353	.569	.535	.703	65
Strongly disagree	.698	.283	.014	2.011	1.213	.540	.025	3.364	283
Is having more than one partner acceptable in society			**.013**				**.008**		
Yes				1.000				1.000	81
No	-.752	.281	.007	.471	-1.81	.582	.002	.164	285
Do not know	-.483	.204	.018	.617	-.840	.433	.052	.432	150
CONSTANT					-10.83	22.99	.638		

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

Logistic regression analysis was used to identify the factors that influence young men to engage in having multiple sexual partners because the dependent variable is a dichotomous variable. A number of variables including socio-demographic variables, knowledge variables and attitude statements on sexual behaviour were up into the analysis. Variables on Table 9.4 are selected variables that after the regression have a significant influence on the decision to

engage in having multiple partners. The variables are divided into three categories namely the socio-demographic variables, the knowledge variables and the attitude factors. The number of years of education young men have has a significant influence on their having multiple partners. Those with 9-10 of education are nine times more likely to engage in having multiple partners as compared to the reference category of 1-8 years of education. Young men with 13-15 years of education are about 10 times more likely to engage in having multiple partners than those with 1-8 of schooling.

Table 9.4 shows that the age at first date has no significant influence on the dating behaviour of young men. However the type of dating partner in the four weeks prior to the interview do have a significant influence on dating behaviour. About 85 per cent of those who had no dates in the last four weeks stated that they have very extensive precoital contact with their dating partners. However those whose dating partners are not their girlfriend are less likely to state that they have very extensive precoital contact. The analysis shows that more that 60 per cent of the young men who have dated but had no coital experience engage in very extensive precoital contact regardless what of the type of dating partner.

Other factors that influence behaviour on having multiple partners is religiosity, the more religious young men are the more likely it is that they engage in having multiple partners. This is contradictory to the general assumption where religiosity reduces the likelihood of engaging in risk taking behaviour. Religion has a significant influence on having multiple partners. Methodists are most likely to have multiple partners followed by Seventh Day Adventists, AOGs then Catholics.

Parents' occupation has a significant influence on having multiple partners. Young men whose mothers have professional occupation are less likely to have multiple partners compared to those in the service sector (2.3 time more likely) and mothers who are unemployed (1.3 time more). Those who live with other relatives and those having own homes are less likely to have multiple partners compared to those living with their parents, while those living with friend are 4 times more likely to have multiple partners. This could be because when living with their relative young men have restriction but with friend they

are free and there is no older individual to counsel or advise them on the moral value and to ensure that they behave as expected in society.

Useful knowledge received from two sources is observed to have significant influence on having multiple partners. Young men who receive useful information from relatives are less likely to engage in having multiple partners while those receiving useful information from the media are more likely to engage in having multiple partners. This indicates that the types of useful information received from the two sources are different as one encourages having multiple partners while the other do not. Discussing sexual issues at home also reduces the chances of having multiple partners.

Attitude to premarital sex influence the chance of having multiple partners. Those who agree that premarital sex with a prostitute are more likely to have many partners while those who agree that premarital sex is okay if both partners agree but do not love each other are less like to engage in having many partners. Young men who agree that the behaviour is acceptable in society are more likely to practice it. This shows that a change in some attitude to premarital sex can reduce the problem of having many sexual partners.

9.4 COMMERCIAL SEX WORKERS

There are different classes of commercial sex worker in Suva. There are female and male CSW. Female CSW have the *'unders'* or the under age, that is those below the age of 16. These are mostly street girls, referred to by some CSW as *'kalavo ni Viti'* or *'the Fiji rats'*. They provide service for about $10 to $15 a night. Some CSW stated that these are the group mostly servicing Fijian men. One reason is because they are cheap and at an affordable rate. The second group are those who parade the streets and are picked up by their clients from the streets. There are two particular streets in Suva where CSW parade. The two sexes have different areas of operation. Each worker has a defined boundary and no other sex worker can cross the boundary. About 90 per cent of male sex workers are Fijian men. These are homosexual men who mostly service Indian businessmen and expatriates. These street parading CSW have a rate of between $50-$60 per session or per client. The session could last the whole night or could last less than an hour. The third group are nightspot CSW and the final are professional call girls who are the most expensive of the group.

Table 9.5: Cross-tabulation analysis of percentage distribution of those have engage in sexual relationship with a prostitute by selected socio- demographic status

Dependent Variables	Independent Variables					Results and significants
	Age at interview				*Percent(total)*	
Had coitus with a prostitute	*15-19*		*20-24*			X^2 :1.018 ;
Yes	11.9		9.1	11.9	10.7(55)	
No	88.1		90.9	88.1	89.3(461)	d.o.f: 1;
Percent	55.4		44.6	55.4	100 (516)	Not significant
	Education status at interview					
Had coitus with a prostitute	*Jnr sec. or less*		*High school & above*		*Percent(total)*	
						X^2 : 4.401;
Yes	16.1		9.2		10.7(55)	
No	83.9		90.8		89.3(461)	d.o.f: 1;
Percent	21.7		78.3		100 (516)	p<0.05
	Age at first sex					
Had coitus with a prostitute	*<15*	*15-16*	*17-18*	*19 yrs+*		
						X^2 : 2.411;
Yes	11.5	11.6	11.1	4.9	10.7(55)	d.o.f: 3;
No	88.5	88.4	88.9	95.1	89.3(461)	Not significant
Percentage	26.9	38.6	22.7	11.8	100 (516)	
	Area of childhood upbringing					
Had coitus with a prostitute	*Urban*		*Rural*			
Yes	51.9		48.1		10.7(55)	X^2 : 4.197;
No	60.9		39.1		89.3(461)	d.o.f: 1;
Percentage	57.2		42.8		100 (516)	p<0.025

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

CSW do not like Fijian male clients. They explained that most Fijian men are too abusive and too forceful during their business encounter. Some do not pay for the service and in return would physically assault and abuse them. Although Fijians have a negative stigma towards CSW the STI Clinic reported that these CSW frequently visit the clinic for their condom supply and for medical check ups. This indicates that they are aware of the risks they take in engaging in the commercial sex business.

Table 9.6: Logistic Regression Coefficient Parameter estimates of selected explanatory variables on why respondents have sexual relationship with a prostitute

	MODEL I				MODEL II				
	B	S.E	Sig.	Exp(B)	B	S.E	Sig.	Exp(B)	n
Age					.468	.535	.382	1.597	516
Years of Education			**.099**				**.014**		
1-8yrs				1.000				1.000	6
9-10=yrs	-.754	1.156	.514	.471	-14.48	4.804	.003	.000	38
11-12yrs	-1.193	.531	.025	.303	-12.30	3.938	.002	.000	169
13-15yrs	-.297	.443	.502	.743	-4.490	2.302	.051	.011	210
> 15 yrs	.004	.444	.993	1.004	-2.468	1.723	.152	.085	93
Religiosity			**.082**				**.085**		
Committed				1.000				1.000	272
Moderate	-.029	.444	.949	.972	2.332	1.361	.087	10.30	181
Not committed	.187	.475	.694	1.206	4.407	2.044	.031	82.01	63
Mother's occupation			**.178**				**.061**		
Professional				1.000				1.000	67
Service	.084	.417	.839	1.088	.559	1.808	.757	1.748	82
Others	.458	.434	.291	1.581	.417	1.409	.768	1.517	87
Unemployed/decease	1.116	.542	.039	3.054	6.173	2.274	.007	479.6	280
Father's occupation			**.029**				**.034**		
Professional				1.000				1.000	166
Service	-.2436	1.029	.018	.088	-.626	2.772	.024	.002	118
Others	-1.799	1.056	.088	.165	-4.49	2.584	.082	.011	172
Unemployed/decease	-1.797	1.041	.084	.166	-7.86	2.795	.005	.000	60
Are use currently a student									
Yes				1.000				1.000	435
No	.199	.373	.593	1.221	-3.76	1.892	.047	0.23	81
Safe sex is having one sexual partner			**.365**				**.003**		
Yes				1.000				1.000	81
No	-2.987	13.50	.825	.050	13.52	164.4	.934	74833	285
Do not know	-3.498	13.53	.796	.030	5.657	1642	.973	286.2	150
Receive useful information from counsellor/rel. leaders									
No				1.000				1.000	112
Yes	.677	.295	.022	1.968	2.719	1.366	.046	15.16	156
Receive useful information from relatives									
No				1.000				1.000	266
Yes	.192	.286	.502	1.211	3.044	1.227	.013	20.98	250
Can a person get STI/HIV thru sexual intercourse with an infected person									
No				1.000				1.000	117
Yes	1.739	1.021	.089	5.694	10.55	3.028	.000	38431	399
Premarital sex okay if contraceptive is used			**.018**				**.058**		
Agree				1.000				1.000	160
Disagree	-1.688	.616	.006	.185	-6.294	2.725	.021	.002	249
Neither agree/nor disagree	-1.728	.630	.006	.178	-6.076	2.673	.023	.002	107

Conti.

Premarital sex is okay if both partners agree but no love			**.269**				**.048**		
Agree				1.000				1.000	101
Disagree	-.247	.457	.589	.781	-3.93	2.174	.070	.020	343
Neither agree/nor disagree	-.601	.413	.146	.548	-5.54	2.257	.014	.004	72
It is okay for a man to have extramarital affair			**.041**				**.011**		
Strongly Agree				1.000				1.000	41
Agree	-.723	.419	.085	.485	-5.17	2.075	.013	.006	40
Neither agree nor disagree	.206	.558	.712	1.229	3.042	2.460	.216	20.939	87
Disagree	.612	.461	.185	1.843	-.719	1.663	.665	.487	65
Strongly disagree	1.459	.741	.049	4.301	6.075	3.346	.069	434.6	283
Is having more than one partner acceptable in society			**.017**				**.016**		
Yes				1.000				1.000	81
No	-1.362	.491	.006	.256	-5.79	2.092	.006	.003	285
Do not know	-1.051	.427	.014	.350	-2.26	1.681	.178	.104	150
CONSTANT					-5.354	165.6	.974		

Source: Computed from 2001 RSHKB Survey of Men in Fiji.

The Fijian society does not encourage men to visit CSW. In assessing the current behaviour of young men they were asked if they visited a prostitute in the six months prior to the interview. About 11 per cent of the respondent stated that they did visit a prostitute. Education status and area of childhood upbringing have significant influence on young men to have coitus with prostitutes. A slightly higher proportion of young men brought up in urban areas (51.9 per cent) are likely to engage in coitus with CSW as compared to those brought up in the rural areas (48.1 per cent). The different is however very small.

Logistic regression was conducted to explain what factors influence socio-demographic variables that influence the men to have sexual intercourse with CSW include the years of education. Model I explain the effect of the independent variable before controlling for other factors while Model II controls age. Young men who had only eight or less years of education have a 99 per cent more chance to engage in sexual relationship with CSW as compared to those with more than 8 years of education. Father's occupation has a significant influence on the behaviour to engage in sexual relationship with a CSW. Young men whose fathers have professional occupation have a 99 per cent more chance of engaging in sexual intercourse with a CSW compared to those whose fathers are unemployed and those whose father are employed in the service sector.

The information received and the sources of information significantly influence men's behaviour. Young men who received useful information from counsellors and religious leaders and those receiving information from relatives are more likely to have sexual relationship with CSW as compared to those who do not receive information from these sources of information. This indicated that some information that young men assume are useful could be influencing them to engage in risk taking sexual behaviour. Men who know that safe sex is having one sexual partner have very little chance of having sexual relationship with a prostitute. Knowledge at this point can influence sexual behaviour.

Attitude to premarital sexual behaviour has a significant influence on young men and they are more like to engage in sexual relationship with CSW if they agree that premarital sex is okay if contraceptive is used and if they agree that premarital sex is okay if both partners agree but do not love each other. Men who stated that having more than one partner is acceptable in society have a 90 per cent more chance of having a CSW sexual partner. This indicates that to influence young men not to be involved with CSW, as it is a risk taking behaviour, different approaches must be taken with regards to knowledge and attitude.

9.5 SEXUAL ABUSE

The scope of sexual abuse in Fiji is unknown. However many service providers assert that the actual incidence is much higher than reported. Given the cultural tendency to hide sexual abuse from others, it is difficult to ascertain the accuracy of sexual abuse in Fiji. Sexual abuse discussed below includes incest and child molesting, rape, and the 'convoy'.

Child abuse and sexual molesting seemed to be common. There are a lot of reported cases of sexual abuse, incest, and promiscuity in Fiji today. These cases are of females being sexually abused. There is not one case of incest or sexual assault on young males. My research has revealed that this is also happening to young males and it is kept a secret to both the abused and the abuser. The following are some experiences of some of my informant in my fieldwork this year.

> *" When I was a child I had my first sexual encounter with a woman much older than me. She came home and we were talking for a while. I suddenly realised when I woke up in the night that this woman was fondling my private part. And then she carried on from there. She is a cousin of mine. I was only 7 years old then. She started kissing me and did all other things to me. I was frightened to tell anyone at home. (17 yr old)*

This is a case of a child sexually abused by a relative, one is a case of an informant who was abused by his sister's girlfriend, she was about 10 years older than him, another by a policewoman who was his mother's friend. These are only a few examples of the reality of what is happening to young boys.

This indicates an institutional break down in the traditional Fijian system of looking after the children. The traditional framework of childhood upbringing and the shared responsibility where the extended family is the institution that looks after the children is no longer applicable or safe in the urban Fijian society. It leaves us with the question on what institution can be formulated to replace the extended family that used to care for a child's upbringing and where no sexual abuse can take place. It is at the adolescent stage, peer groups have great influence on the individual's behaviour. Researches have found that peer pressure plays a great role in influencing an individual's behaviour. One of the major influences is the challenge given to young men, by their peer group members. Below is a quote from one of the informants.

> *"I was 12 years old when my friend, who were much older than me told me that if I do not take part in the convoy, than I was a pufta (gay)." (18 year old)*

The case above clearly indicates that pressure has been put on the informant to participate in group-sex, or else he would not be regarded as a man. This indirectly indicates that he will not be accepted in the group. The informant had to take part in-order to be accepted, and to remain in the group. Some boys however reported that they had refused to take part in group-sex with their friends, but they were mere observers. In discussing group sex I observed that most of my informants do not see group or gang sex, convoy, as an indecent act. They see it as an act or a process that all boys take part in or do have to witness in life. It is a process of growing up into manhood. Some are proud of the experience that they went through, because males in the community pride themselves in talking about their experiences during a convoy in the weekend.

The act is called a convoy because men have to line up and take turns in having sexual intercourse with the woman. It is like a convoy of trucks enrooting to a common destination. The convoy is not a new behaviour it existed 30 years ago when I was a university student. A young man would bring a woman and in most cases, against the

woman's will allow his friends to have sexual intercourse with her. As discussed in Chapter Five Fijian women are subject to this abuse because traditionally they have to be passive receivers in society.

Men have different interpretations of this type of behaviour. Some see it as an acceptable behaviour, although it is conducted in secrecy and out of the public. Boys are challenged by their friends to date, or fix a particular girl. They also compete for who dates the highest number of girls in a week.

> *"There are 11 of us in a group. We always compete for who gets the highest number of girl... One particular boy is winning, he wins most of the time.....We take the girls to this house.....some times everyone will have sex with a girl...CONVOY". (20 years old).*

This is a clear indication of the influence that the peer group has on an individual. Competition for multiple partners and group sex is seen as greatly influenced by the peer group.

It is generally assumed and as most of my informants agreed, when a group of males sit together in a casual or informal group, the most common topic of conversation will be women and sex. If a woman walks in their direction flirting comments may be passed to her when walking by, or shared by the group admiring her built and how attractive she is.

When discussion about sex is conducted in groups, the group talked in a symbolic manner and joke about it. As an informant stated in describing a beautiful woman walk pass

> *"I would refer to a car parking at the car park, and how beautiful it looks..... She could never tell that we were talking about her...."*

This young man has a steady girlfriend who is a high school student. They do not have sexual intercourse as he feels she should remain a virgin till they get married.

Men are commonly reported as instigators of rape while women are mostly referred to as victims of rape. Men who are victims of rape are mostly homosexual males. There is therefore very little report on rape.

9.6 SUMMARY

This chapter has shown that there are different factors that influence men to engage in risk taking behaviour. Different socio-demographic factors play different role in influencing

behaviour. There is a changing behaviour pattern and society need to identify the different factors that influence behaviour. Notable is the increase in incidence of risk taking behaviour and the increase in number of CSW.

Knowledge has little influence on practicing risk-taking behaviours. There is also contradicting finding on the effect of the useful information received from different sources. What young men perceive to be useful information from the media is the information that encourages risk taking sexual behaviour. While useful information from relatives discourage them to engage in having multiple partners, useful information from the media on the other hand encourage them to engage in having multiple partners. The different types of information received from different sources therefore influence young men's behaviour in different ways. The source of information must therefore be addressed and the information they disseminate must be accessed to influence young men in a positive way.

Attitude to premarital sex has a lot of significant influence on behaviour. Influencing young men's attitude can influence their behaviour in different ways. Service providers and policy makers must therefore be familiar with the different reaction each attitude can encourage when trying to ensure that young men do not practice sexual risk behaviours.

The study also found out that men are still stereotype and do not report cases of child abuse, incest and sexual rape for fear of being regarded as a person who is not man enough because he does not enjoy the sexual pleasure that is a process of sexual intercourse. This needs to be addressed and young men must learn to share their problem and their sexual assault experiences.

Although this is the first ever study conducted to try and explain the factors that influence young men's behaviour. There are a lot of questions that still needs to be answered in order to obtain a clear view of the different factors that influence sexual risk behaviours. indicated that young men engage in very extensive precoital experiences with their dating partners.

CHAPTER 10

CONCLUSION

10.1 INTRODUCTION

This thesis has examined and explored the factors that influence the reproductive and sexual behaviour of young Fijian men. It has expanded the understanding of young men's reproductive and sexual behaviour and broadened the scope for further research work on reproductive and sexual behaviour among Pacific Island cultures.

Most studies of reproductive health in Fiji have been focused on women and adolescents (Chandra 2000; Bureau of Statistics 1976; Chung 1991; Laquian and Naroba 1990; Naroba 1990; Price 2002; Secretariat of the Pacific Community 2001; Seniloli 1996; 1992; 1990). As observed in Chapter One and Two, there has been a gap in understanding the factors that influence young Fijian men's reproductive and sexual behaviour. This study attempts to bridge this gap by addressing the following three objectives:

1. To provide a historical overview of men's reproductive and sexual behaviour (Chapter Five).
2. To explore the reproductive and sexual health knowledge, attitudes and behaviour of young Fijian men and their use of the available services (Chapter Six, Seven, Eight).
3. To identify the factors that influence young men's risk-taking behaviour (Chapter Nine).

This chapter reviews the findings for each of the objectives above and makes recommendations on future approaches to addressing reproductive and sexual health issues of young men in Fiji.

10.2 SUMMARY OF THE FINDINGS

10.2.1 General overview

In addressing the objectives of the thesis, the study has offered insights into the historical and current sexual behaviour of young Fijian men that have never before been explored. The cultural taboo of discussing sexual behaviour with the opposite sex has been broken because the researcher was an indigenous Fijian female. Highlighted in this study are the changing traditional norms in Fijian society and the factors that currently influence the reproductive and sexual behaviour of young Fijian men.

Most studies have examined adolescents' and women's reproductive behaviour and/or conducted bi-variate analysis to identify the factors influencing sexual behaviour and used only one type of research method, that is using either qualitative or quantitative research methods (see 1.3, 2.9, 2.10). This study has taken a step further and has used both qualitative and quantitative data and has employed multivariate analysis to identify the factors that influence the reproductive and sexual behaviour of young men. A highlight of this approach is the diverse and in-depth information obtained and analysed in the findings (see 4.8.6 and 4.11).

In understanding the historical perspective of young Fijian men's expected reproductive and sexual behaviour since before European contact, this study has shown that most of the sexual norms and values had changed by the beginning of the twentieth century. The changes in traditional norms and values were brought about through the early missionaries (see 5.7), however most Fijians do not realise that what Fijians identify as traditional norms and values of reproductive and sexual behaviour had changed since European contact in the early nineteenth century. Traditional norms that influence reproductive and sexual behaviours are discussed and a comparison of past and present cultural norms are highlighted (see 5.3.1, 5.3.2).

Most young Fijian men are well informed about different expected sexual behaviour norms and values. This study shows that young Fijian men do not perceive parents as an agent for disseminating useful information on reproductive and sexual health behaviours (see 6.2.1). Other sources including mass media, friends, and schools (see 6.2.2) were identified as the main sources of useful information. Myths were also found to influence attitudes and behaviour (see 6.4.1). Available services are not common knowledge so not many young men have ever used the services.

10.2.2 Specific Objectives

Objective 1: *To provide a historical overview of men's reproductive and sexual behaviour*

More research should be conducted to try to identify the factors that influence men's reproductive and sexual behaviours. There is very little research work done in Fiji on reproductive and sexual health behaviour of men and women in general. Very little is known about the historical perspective of the reproductive and sexual behaviours of indigenous Fijians. Behavioural trends and patterns need to be identified in-order to try to address behavioural changes.

As discussed in chapter five, reproductive and sexual culture has evolved over time. The arrival of the missionaries and colonisation was the turning point. Western concepts and values were introduced into a society where reproductive and sexual behaviour were appreciated. The initiation of young boys to become young men was ceremonial. The first incidence of sexual intercourse for women was appreciated and celebrated by the community. This appreciation disappeared and was replaced by social restriction.

Some of the sexual norms in the Fijian society that have existed over the last one and a half centuries are identified in chapter five (see 5.3.2, 5.5, 5.5.1, 5.6.1). Others also discussed have been eliminated from society including the existence of the men's house and the practice of polygamy (see 5.4, 5.5.2). This shows that sexual norms in the Fijian society have changed over the last one hundred and fifty years and it could be concluded that they will continue to change in the future.

The taboo on discussing the topic in public was introduced by the missionaries because of the assumption that sexual acts are sinful acts. The concept of sexuality as a taboo topic in the Fijian culture has been challenged in this thesis. As a female researcher, I was able to discuss the topic with Fijian men. The cultural taboo has been broken and new grounds for open discussion have been established. As a policy adviser stated:

> *Sex is a difficult topic to talk about and it is difficult to get people to open up to you and give you a rough idea of what is happening. Peer members know how to get to the bottom line of every thing. There are counsellors who are there with ideas.*

In a communal village the existence of the 'men's house' shows that sexual activities of young men are monitored by the older men in the community (5.4). The men's house influences fertility control. It controls premarital sexual relationships. The community also has a kinship system that allows respect for certain females in the family. There is a taboo on men and women speaking to each other or being in the same place at one time. The kinship system and structure control socialization. These social controls prevent premarital sex, incest and child abuse (see chapter 5).

Traditional social controls exist in the local communities and have a positive approach to reproductive and sexual health. Thus this is not a new phenomenon as it has been in place in the past. To improve reproductive health, these controls can be reviewed and introduced into the community. As society wants to maintain its traditional values, traditional social controls could be reinforced in communities.

The changing culture has influenced behaviour in different ways. Women have become more restrictive in their understanding of men and men have become more adventurous in their efforts to keep up with the change. Adoption of a mixture of traditional and western values is the underlying problem. Some traditional social controls have disappeared and new controls have been established. But Fijian men still are caught between the past and the future and to acknowledge men's sexual behaviour, we must study the past and also appreciate the new Western values that have been introduced into our culture.

Objective 2: *To explore the reproductive and sexual health knowledge, attitude and behaviour of young Fijian men and their use of the available services*

Although young Fijian men are well informed about some aspects of the issues of reproductive and sexual behaviour, they do not obtain a holistic understanding of the issues. Sources of information are generally available and the public has access to most sources of information. The two main sources of information for young men are friends and mass media. Types of information received differ according to the source of information. This was explored in chapters 8-9.

Although a lot of public services are available, young men do not make a lot of use of the available services. There is still a stigma that the services are for women only and young men are afraid of using the services. Some of them do not know that the services are available. The centres providing free condoms were not known to some of them. The type of knowledge that is passed on to young men is important. This must be explored as knowledge from the media is not censored and can provide the wrong message to young men (see 6.4, 6.5, 6.6).

Parents were identified as poor sources of useful information (see 6.2.1). Young men do not see information from their parents as being useful. Parents therefore need to re-examine the type of information they are relating to their sons and the environment in which the knowledge is disseminated. Young men are well versed with information on STIs including HIV/AIDS (see 6.8), but they have a limited understanding of how the infection is spread and their attitude to practising safe sex is negative in most cases.

Because grandparents were traditionally responsible for educating children on sexual norms in society, the disappearance of the extended family has led to a breakdown in the system (see 5.2.1). Children are not knowledgeable and are not well informed about sexuality. This

is clearly shown through the increase in sexual abuse, incest and promiscuity in Fiji (see 6.4.1, 6.4.2).

The four issues discussed above reflect the evolution of the Fijian traditional and cultural values. It is therefore recommended that sexual and reproductive health education begin at primary level. At the same time, public awareness programs must continue at all levels of society. Secondly visual aids, such as soap operas must be encouraged and shown through the only available free television station. Educating the public through this means will be more effective than the charts and pamphlets used today (see 6.2.2).

Young men's attitudes to reproductive and sexual behaviour have been greatly influenced by religion since European contact and this continues to be so. Most young men conditionally approve premarital sex although it contradicts with their religious belief (see 7.4, 7.4.1, 7.7, 8.2.4). A positive attitude to premarital sex is not culturally acceptable. There is also a changing attitude to dating behaviour. Attitudes to dating are very different from the Western concept of dating (see 7.2, 7.3, 7.3.1, 8.2.2). This contradiction has negative implications on reproductive and sexual behaviour.

The analysis shows that men need to be encouraged to use contraceptives. Young men do not commonly know the natural methods of contraception and there is a need to educate them to have a positive attitude to contraceptive use (see 8.4, 8.4.1, 8.4.2, 8.4.3). The stereotype of the macho man is prominent (see 7.8). This has influenced their attitude to different gender roles (see 7.9).

Objective 3: *To identify the factors that influence young men's risk-taking behaviour*

Most young Fijian men have the attitude that they go to nightspots for the 'three Fs' meaning casual sex (see 9.2). The social setting encourages casual sex, as nightspots are accessible to young people. The second risk behaviour, the convoy is a common practice of young men, where a girl has sexual intercourse with a group of boys (see 9.3). Boys do not see it as rape. It is also a process of sexual initiation to some boys. Young women on the other hand are willing partners of casual sex but they do not agree with the 'convoy'. Risk behaviour programs in Fiji are mostly IEC programs that do little to influence behaviour.

Factors influencing behaviour should be identified and addressed when implementing programs for adolescent men. The age limits for entry into nightclubs and for alcohol consumption is not restricted allowing men as young as twelve to socialise in these places and to consume alcohol. Factors influencing the different risk taking behaviours are different for each behaviour type. The data show that socio-demographic factors influence young men to engage in sex with CSW (see 9.4) as compared to casual sex and having multiple partners (see 9.2, 9.3).

Attitudes and beliefs have a strong influence on risk-taking behaviours. Young men's attitude to premarital sex is a common factor influencing sexual risk-taking behaviour. A policy adviser at a government ministry stated:

There is a need for a policy to be formulated encouraging future couples to have pre-marital counselling.

It is suggested that in trying to educate young men to stop engaging in risk-taking behaviour, one approach that can be taken is to influence their attitude to premarital sex, making them accept that premarital sex is not encouraged and not an accepted norm in Fijian society.

10.3 FUTURE PROSPECTS AND RECOMMENDATIONS

The following quotes are from interviews with two reproductive health specialists working for an international organization with a regional office in Fiji:

1. *We cannot identify the factors that influence the behaviour. It is the behaviour that makes the difference. What are the factors that promote risk-taking behaviour? What works and what does not. (NB)*
2. *A lot is unknown about the Pacific and these needs to be known in order for preventive action to be implemented. This is largely related to sexual network. It is the interaction in different parts of society. (MO)*

The quotes show that there are important unknown factors influencing sexuality that need to be identified. Findings from this study have identified some of these factors, as discussed in previous chapters and below are recommendations for future approaches to address issues of sexuality.

The traditional system responsible for the education of young people, the extended family, is fast vanishing. Society today takes little responsibility to look after the behaviour of the extended family members including young men. This has resulted in young people obtaining misinformation on sexual and reproductive health behaviours. Knowledge is therefore limited due to the narrow sources of information and, as discussed in chapter 6, young men are sometimes misinformed on this taboo topic. This has disrupted the traditional means of controlling sexual behaviour and disseminating human sexuality knowledge. The absence of the 'props' that enforce sexual taboos results in an increase in

risk behaviours. This leads to an increase in casual sex. Two end results are the high incidence of teenage pregnancy and the high incidence of STIs among the indigenous Fijian population. To address these issues, the institutional link that has been broken needs to be replaced. This has disrupted the traditional means of controlling sexual behaviour and disseminating human sexuality knowledge.

Institutions could be designed and reconstructed to educate young men and women about healthy sexuality to replace the wanning practices of traditional ceremony, norms, and education. Traditional institutions can be reconstructed or new model institutions constructed to replace the traditional institutions that have been discussed earlier. This includes the construction of an institution, such as the formal education system and religious youth groups, to replace the extended family structure and one to replace the grandparents, who were the media for transferring knowledge to the children. Currently the school or the education sector as an institution is not replacing the extended family members and the grandparents in educating the children on reproductive and sexual health behaviours because the school system and the school curriculum mostly do not allow this to happen.

Policies could be structured to regulate and control behaviour. Given the current situation in Fiji with no age restriction on alcohol consumption and entry into bars and nightclubs, government policies on enforcing an age limit for entry into nightclubs and for alcohol consumption should be introduced. The age of entry into nightspots and the age approved for liquor consumption should be aged twenty-one. Young men are at high risk of casual sex and as observed in this study most young men go to nightclubs for casual sex, and when drunk young men have an excuse to practice risky behaviours. This recommendation will control young men between the ages of fifteen and twenty from entering social environments where risk-taking activities, including casual sex, are encouraged.

There is a double standard on values and behaviour because men cannot differentiate between religious values and cultural values of sexuality. This problem could be resolved through the process of breaking the barriers of cultural and religious taboos. Cultural and religious values must be differentiated, as these are two important institutions that influence sexual beliefs, attitudes and behaviour of young Fijian men today. A step forward in reproductive health could be possible if the message is addressed to the population as a whole including young and old, not just to the high-risk groups when educating people on the changing sexuality norms in society.

In addressing risk behaviours, different approaches must be taken. These include the use of different sources of knowledge such as the media, schools, religious groups and relatives to disseminate knowledge. Service providers must go out to the communities and encourage young men to use the different services available. This could include mobile services available to provide services at different socialising areas including sports grounds, youth centres, nightspots, bar and pubs, and youth rallies. Support from the government and from the Great Council of Chiefs could encourage young Fijian men to use the available services.

This thesis has explored the reproductive and sexual behaviour of young men and observed that although the government is addressing youth by establishing reproductive and sexual health counselling centres within the structure of the Ministry of Health, the needs of youth are not well met. Below is a statement from a female peer educator who is a youth counsellor at the centre:

> *In my experience I found that many youth take the education process very lightly. They joke about it and pass comments about sex to us. Being in a clinic like this is stigma to the youth. It prevents people coming in for counselling. We cannot run discussion with the youth as we work according to the clinic...we cannot make the centre a youth friendly clinic such as having music to attracting the youth because the office space is shared with the STI clinic.*

The quote shows that educating young men using peer educators is not always a success. The research showed that young men prefer men to educate them on some topics and they accept older women to educate them on other topics such as contraceptives, and menstruation period. However young female peer educators, although knowledgeable, are not an acceptable source of information. This indicated that more research is needed to clearly understand other factors that influence reproductive and sexual behaviours of young men. These include the role of the government and the service providers in influencing behaviour, in-depth studies on the types of information received from different sources and how the information is disseminated. A nationwide research project on young men's sexual behaviour is needed.

In reproductive health education and promotion the balance between short-term motivational approaches and long term social changes is a complex and contested one. But in either case, strategies directed at young men will require a thorough understanding of their sexual lives, to which I hope this study has contributed.

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APPENDIX 1

QUESTIONNAIRE

Code No.			

SURVEY QUESTIONNAIRE

The Reproductive and Sexual Health Knowledge and Behaviour of Men in Fiji.

This research is conducted to try and identify the social and cultural factors that influence the reproductive and sexual behaviours of males aged 15 to 24 years in Fiji. The aim of the study is to identify the factors influencing the reproductive and sexual behaviours of adolescent and young males in Fiji. In identifying the factors that influence the behaviour of males, the study can be used to plan related programs and to identify the needs relating to reproductive and sexual health services.

The findings from this research will help to improve and better the standard of reproductive health services available to men. It will help to improve the general understanding of how is the reproductive and sexual behaviours of men determined and why different social groups may have different reproductive and sexual behaviour.

I would like to inform you that all of your responses will be treated confidentially and **you should not put your name in the questionnaire**. Your participation and honesty is appreciated in anticipation of the success of this study.

Thank you for taking the time to complete this questionnaire.

A Questionnaire Identification

Questionnaire Number; _____
Date: _____
Interviewer / Self-administered: _____

Prepared by Mili Kaitani, DemographyProgram, RSSS, The Australian National University, Canberra Australia.

PART I. ***Respondent's demographic characteristics. Please write your responses in the spaces provided. For multiple choice questions please circle the answer of your response.***

1. Where do you live in Suva.

1	Samabula	7	Tamavua
2	Nabua	8	Lami/Delainavesi
3	Raiwai/Raiwaqa	9	Valelevu/Kinoya
4	Nasinu	10	Nadera/Nepani
5	Vatuwaqa	11	Other area. Name:
6	Nasese		_____

2. Who are you currently residing with?

1.	Staying at my parent's home	4.	Living in a hostel or boarding house
2.	Staying at my own home or renting a house.	5.	Staying with my relatives
3.	Living with friends	6.	Others (specify) _____

3. How old are you? _____years

4. Ethnicity.
   1. Fijian (including Rotumans)
   2. Indian

5. Marital Status

1.	Never married	4.	Separated
2.	Married and together	5.	De facto union
3.	Divorced		

6. If ever-married, at what age were you first married? _____years

7. Religion

1.	Catholic	5.	Hindu
2.	Methodist	6.	Muslim
3.	Seventh Days Adventist	7.	No religion
4.	Other Christian denominations (identify) _____	8.	Others (identify) _____

8. How often do you go to church or to religious gatherings?

1.	Every day	4.	Sometime
2.	Every Sunday	5.	Rarely
3.	I go to every religious gathering	6.	Never

9. How many years of education have/did you received? _____years

10. Are you currently a student?
    1. Yes *(if yes go to Q11)* 2. No *(if no go to Q14)*

11. Name of the school or institution you attend. _____

12. What form or level of education are you in? _____

13. What is your area of study (subject majors)

    1. General, all subjects
    2. Science
    3. Arts (Geo/History)
    4. Commerce
    5. Technology
    6. Others: Specify: _____

14. What was your highest education level attained
    1 Primary (class 1-6)
    2 Junior secondary (fm1-4)
    3 Higher secondary (fm5-7)
    5 Tertiary education
    6. None
    7 Others (specify)_____

15. Occupation
    1. Farmer/ Fisherman
    2. Labourer/ Casual worker
    3. Service worker
    4 Student
    5. Sales person
    6. Government worker
    7. Businessman/self employed
    8. Manager/Administrator
    9. Unemployed
    10. Others (specify) _____

16. Parent's marital status.
    1. Never married
    2. Married
    3. Separated
    4. Divorced
    5. Widowed
    6. De Facto Union

17. Father's occupation
    1. Farmer/Fisherman
    2. Labourer/Casual worker
    3. Service worker
    4. Teacher
    5. Sales person
    6. Government worker
    7. Businessman/self employed
    8. Manager/Administrator
    9. Unemployed
    10. Others (specify)_____
    11. Deceased

18. Mother's occupation
    1. Labourer/ Casual worker
    2. Service worker
    3. Manager/Administrator
    4. Government worker
    5. Self employed
    6. Unemployed
    7. Others _____
    8 Deceased

19. How much money does your household (family) earn in a week?

1. Less than $50.
2. $51 - $100
3. $101 - $300
4. $301 - $500
5. More than $500.

20. Where were you brought up as a child?
1. In the village
2. In a farm/rural settlement.
3. In town/city.

21 For how long have you been residing or schooling in Suva? _____

22. How many brothers do you have? _____

23. How many sisters do you have? _____

PART II KNOWLEDGE OF REPRODUCTIVE HEALTH

24. Have you ever received any educational information on reproductive and sexual health?
1. Yes 2. No

25. The statements below mention several sources of information that you might have used to get information on reproductive and sexual health. *Please answer this by circling the score of your choice for each of the following sources, according to the key scores mentioned below.*

Key

1 = *Not useful at all* *3* = *Useful*
2 = *Not useful* *4* = *Very useful*

		Use this source Yes(Y)/No(N)	If YES, usefulness of information (Score)
1.	Girlfriend	_____	1 2 3 4
2.	Mother	_____	1 2 3 4
3.	Father	_____	1 2 3 4
4.	Other family members	_____	1 2 3 4
5.	Friends (peer)	_____	1 2 3 4
6.	Counsellor/religious leaders	_____	1 2 3 4
7.	Newspapers/magazines/books	_____	1 2 3 4
8.	Radio/ TV/film	_____	1 2 3 4
9.	School, (Teacher)	_____	1 2 3 4

26. Is/was Family Life Education offered at your Primary/High school?
1. Yes
2. No **(go to Q29).**
3. Do not know **(go to Q29)**

27. If yes, have you taken the subject?
    1. Yes 2. No

28. If yes, is/was the subject compulsory?
    1. Yes 2. No

29. Have you ever heard about STDs mentioned below? *Please tick (✔) your answer..*

		Yes	No
0.	Syphilis	____	____
1.	Gonorrhoea (Tona)	____	____
2.	HIV/AIDS	____	____

30. How can a person get STDs and HIV/AIDS? *(please tick your choices).*

		Yes (1)	No (2)
0.	Kissing	_____	_____
1.	Holding hands	_____	_____
2.	Sexual intercourse with an infected person	_____	_____
3.	Sexual intercourse with multiple partners	_____	_____
4.	Sexual intercourse with prostitutes	_____	_____
5.	Not using a condom during intercourse	_____	_____
6.	Homosexual sex	_____	_____
7.	Blood transfusion	_____	_____
8.	Sharing razor blades with infected person.	_____	_____

31. Have you ever received any information on family planning?
    1. Yes,
       from where did you get the information, _____
    2. No (**go to no.33**)

32. What kind of information or services did you receive? *Please circle your answer.*

		Key:	*Yes –(1)*	*No(2)*
0.	Education on family relationships		1	2
1.	Counselling and guidance on family	planning	1	2
2.	Family planning service		1	2
3.	Medication for STDs		1	2
4.	Others, please specify_____			

33. When a couple has sex together, who normally decides if they should use contraceptives?
    1. Man 3. Both decide.
    2. Woman

34. This question addresses how familiar you are with the Reproductive health services available. Answer yes or no to the following questions. (Please put the number 1 (for Yes) or 2 (for No).

Type of service	Do you know of the available service? *(Y =1/N=2)* ***If No, do not answer column 2,3and 4..***	Is the service free? *(Y=1/N=2)*	Have you ever used the service? *(Y=1/N=2)*
Family Planning clinic			
Women's crisis centre			
STD clinic			
Reproductive health unit			

35. The question below is based on your knowledge of contraceptive methods. Please put the numbers in the spaces provided to indicate your choice of answer.

Contraceptive methods	Ever heard of the method *Yes=1, No=2*	**If yes**, where can method be obtained? ***(1=hospital/health clinics, 2= retail shops, 3=friends, 4= chemist)***	Is the method freely available *Y=1, N=2*	Ever used the method? *Y=1, N=2*
Pills				
IUD (Loop)				
Injectables				
Condom				
Vasectomy				
Withdrawal				
Rhythm (calendar)				

36. Vasectomy is an operation performed on a man which prevents him from fathering children but does not prevent him from normal sexual activity.
1. True 2. False 3. Do not know

37. Is vasectomy commonly used amongst men in your society?
1. Yes 2. No 3. Do not know.

38. Who in your society usually (commonly/mostly) use birth controls?
1. Females
2. Males.
3. Both, males and females.

39. What is safe sex? (*Please circle your choice of answers)*

	Yes, safe.	**No, not safe.**
a. Using any form of contraception during coitus.	1	2
b. Using a condom during coitus	1	2
c. Sexual abstinence	1	2
d. Having one a sexual partner	1	2
e. Preventing pregnancy	1	2
f. Oral sex.	1	2
g. Having sex with a girl when not having her period	1	2

40. Is the use of condoms common in your community?
    1. Yes 3. Do not know.
    2. No

PART III. GENDER RELATIONSHIPS.

41. In general, among people you know well from your ethnic group, who has higher status?
    1. Men 2. Women 3. Both have equal right

42. If you could only have one child, which would you prefer?
    1. Son 2. Daughter. 3.No preference

43. How much do you agree with the following statements? *(Please tick.)*
    Key
    1. Strongly agree *3. Neither agree nor disagree* *4. Disagree*
    2. Agree *5. Strongly disagree*

	1	2	3	4	5
a) Becoming a mother is the most important thing a woman can do.					
b). It is a woman's responsibility to provide and use contraception					
c). A couple should discuss contraception before having sex					
d). Good boys carry condoms.					
e) It is a woman's right to choose whether she wants an abortion.					
f). It is best for a girl to be a virgin until she is marriage.					
g). Men should decide on the number of children they can have.					
h). Unmarried men should use contraception if they are having sex.					
i). It is a man's right to have sexual intercourse with his wife/partner.					
j). It is okay for men to have extra-marital affairs.					
k). Women should not have extra-marital affairs.					
l) Men should make their own decision on choosing a partner					
m) A man should be free to have more than one partner.					
n) Dating a person from another race is acceptable.					
o) A Fijian dating an Indian is acceptable.					
p) Marrying someone from another race is not good.					
q) Dating someone of a different religion is not right.					
r) Marrying someone from another religious group is not acceptable.					

44. Teenage girls should be allowed to do out dating without supervision.
    1. Yes 2. No
45. Drinking alcohol can influence a person to behave in an unacceptable manner.
    1. Yes 2. No
46. Violence in a relationship usually occur because of sexual matters
    1. Yes 2. No

PART V DATING AND PRE COITAL BEHAVIOURS

47. If someone is dating, what do you think is proper sexual behaviours that the dating couple can engage in? *Please circle your answer for each of the following behaviours.*

	First date		**Regular partner**	
	Yes	*No*	*Yes*	*No*
0. Holding hands	1	2	1	2
1. Hugging	1	2	1	2
2. Intense hugging	1	2	1	2
3. Cheek kissing	1	2	1	2
4. Lips kissing	1	2	1	2
5. Breast fondling	1	2	1	2
6. Genital fondling	1	2	1	2
7. Petting with full penetration.	1	2	1	2
8. Petting to ejaculation/orgasm	1	2	1	2
9. Penetrative sexual intercourse.	1	2	1	2

48. What is the ideal age for a girl to get married? _____years.

49. What is the ideal age for a boy to get married? _____years

50. How much do you agree with the following statement about boys engaging in premarital sexual intercourse? *Please tick your choice for each item.*
    1. Strongly agree *3. Neither agree nor disagree* *4. Disagree* *5. Strongly disagree*
    2. Agree

	1	2	3	4	5
a) Premarital sex is all right if you use contraceptives.					
b) Premarital sex is all right if both partners agree but do not love each other.					
c) Premarital sex is all right as long as it is based on love					
d) Premarital sex is okay if a marriage proposal from parents was approved.					
e) Premarital sex is all right if the couple are engaged and marriage date set.					
f) Premarital sex is never right					
g) Premarital sex is all right if you do it with a prostitute					
h) A girl should be a virgin till marriage.					
i) A boy should be a virgin till marriage.					
j) Males should be responsible for preventing teenage pregnancy.					

PART VI CULTURE AND REPRODUCTIVE HEALTH

51. Who is the head of your family?

0.	My father	3.	Myself
1.	Mother	4.	Others (specify)
2.	Grandfather		_____

52. Who in the family is mostly responsible for looking after the children?

1.	Women/young girls	3.	Fathers/Men/boys
2.	Both parents	4.	All the grown up in the family.

53. Who in most cases determine the number of children a couple should have?

1.	The man's parents	3.	The couple themselves
2.	The whole extended family	4.	The wife
		5.	The husband.

54. In a family where domestic violence occurs, who is most often the victim?

1.	The man	4.	The men and the children
2.	The woman	5.	The women and the children.
3.	The children		

55. The following statements relate to your lifetime experiences and cultural experiences. How much do you agree with the following statement?

Key

1.	*Strongly agree*	*3. Neither agree*	*4. Disagree*
2.	*Agree*	*nor disagree*	*5. Strongly disagree*

	1	2	3	4	5
a) Girls are expected to look after their young brothers and sisters.					
b) At age 5-12 years, boys do less domestic duties than girls.					
c). Males in rural or village communities do more household duties when compared to those in urban areas.					
d). Men have more free time than women do.					
e). Knowledge on reproductive and sexual health is passed on to the children through their parent and the elderly in the community.					
f). An extended family,(father, mother, children with other relatives living together is common in the rural areas.					
g). Most urban families are made up of the nuclear family (parent and children with no other relatives)).					
h). Young children normally share the same rooms with their parents.					
i). A private room for a married couple is common in the homes.					

56. How can pregnancy be prevented? (multiple response)

1.	Abstaining from sex	4.	Using traditional medicines
2.	Using condoms	5.	Using contraception
3.	Having one sex partner		

57. Is abortion legal in Fiji?
1. Yes 2. No 3. Do not know

58. Is arranged or fixed marriage still practised in your community?
1. Yes 2. No. 3. Do not know

PART VII PRACTICES IN RELATION TO REPRODUCTIVE HEALTH

59. Generally, at what age do females in your society become sexually active?
1. Less than 10yrs 3. 15 - 19yrs 5. 25+yrs
2. 10 - 14yrs 4. 20 - 24yrs

60. At what age do males in your society, generally, become sexually active?
1. 9yrs or younger 3. 15 - 19yrs 5. 25+ yrs
2. 10 - 14yrs 4. 20 - 24yrs

61. Did/will you choose your own partner?
1. Yes 2. No
If no, who did/will? _____

62. How often do you discuss reproductive and sexual health issues at home?
0. Often 2. When there is trouble
1. Sometimes 3. Never **(go to Q64)**

63. Who do you most often discuss reproductive and sexual health issues with?
0. Whole family 3. Father 6. Cousins
1. Both Parents 4. Sister 7. Friends
2. Mother 5. Brother

64. Would you go to a reproductive and sexual health clinic to get advise in reproductive or sexual health matters?
1. Yes 2. No

PART V REPRODUCTIVE AND SEXUAL BEHAVIOR

65. On the whole, which of the following have you experienced with the opposite sex?
(Please tick 1 for Yes or 2 for No).

		1	*2*
0.	I have had no physical contact with a female	____	____
1.	I have held hands with a female	____	____
2.	I have embraced a female	____	____
3	I have embraced another male	____	____
4.	I have kissed another male on the lips.	____	____
5.	I have kissed a female on the lips	____	____
6.	I have fondled a female's breast while she had her clothes on.	____	____

		1	2
7	I have fondled a female's breast while she had her clothes off.	____	____
8	I have fondled a female sex organ.	____	____
9	I have had my sex organ fondled by a female	____	____
10	I have reached orgasm when having physical contact with a female, but no penile-vaginal penetration	____	____
11.	I have dated a other male.	____	____
12.	I have reached orgasm when having physical contact with a female, but no penile-vaginal penetration	____	____
13.	I have had sexual intercourse with full penetration with a woman.	____	____
14.	I have had penetrative sexual intercourse with another male.	____	____

66. Have you ever dated a person (by dating, I mean, an activity where a male and a female with an intimate relationship, go out together all alone, for example, to watch a movie or to stroll).
    1. Yes 2. No **(if no, go to Q# 71)**

67. Which of the following categories do you belong to?
    1. Heterosexual (having female partners only)
    2. Bisexual (both male and female partners)
    3. Homosexual (male partners only)

68. How old were you when you first dated a female? _____years old.

69. In which of the following categories was your first date?
    1. A female whom you had just met, but was not a prostitute.
    2. My girlfriend
    3. A female whom you had known for some time, but was not a 'girl friend'.
    4. A female prostitute.
    5. Another male
    6. Others (please specify)_____

70. In the last four weeks, how many times have you dated?

0.	None	2.	Twice	4.	Four times
1.	Once	3.	Three times	5.	More than four times

71. Do/ have you ever masturbated?
    1. Yes 2. No **(go to Q73 or Q85)**

72. How often do you masturbate?

1.	2-7 times a week	2.	More that 7 times a week
3.	Weekly	4.	Monthly
5	Never	6.	Only in the past.

<u>If you have not had any dating activity in the past four weeks, please go to Question # 85.</u>

73. In the last four weeks, how many females/males have you dated?

1	One	4.	Four
2	Two	5.	More than four
3.	Three		

74. In the last four weeks, which category best describe your dating.
1. I dated a prostitute
2. I dated a girlfriend
3 I dated a female friend whom I had known for some time, but was not a girlfriend
4 A male companion
5 I dated a female I had just met.

75. In your whole life have you ever had full penetration sexual intercourse with another person?
1. Yes 2. No **(go to Q86)**

76. How old were you when you first had sexual intercourse with another person?
_____years old.

77. With which of the following categories of females did you first experience sexual intercourse?
1 A female prostitute
2 A female whom I had just met but not a prostitute
3 A girlfriend/ wife
4 A female whom I had known for some time, but was not a girlfriend
5 A male companion
6 A male prostitute

<u>If you have not had any sexual intercourse in the past six months, please go to Q #.82</u>

78. In the last six months, how many times have you had intercourse with female?

1	Once	4	Four times	6.	Six times
2	Twice	5	Five times	7.	More than six times
3	Three times				

79. Was this with one partner ?
1. Yes 2. No

80. In the last six months, with how many different females have you had sexual intercourse?

1	One	4.	Four
2	Two	5.	Five
3.	Three	6.	Six

81. In the last six months, with which of the following categories of partners have you had sexual intercourse? *(Please circle (1) for Yes and (2) for No)*

1	2	I had intercourse with a prostitute
1	2	I had intercourse with a female whom I had just met, not a prostitute.
1	2	I had intercourse with a girlfriend.
1	2.	I had intercourse with a female I had known for some time.
1	2	I had intercourse with a female (please specify) _____
1	2	I had intercourse with another male.

82. In general, to which of the following categories do your coital partners belong?
1 Prostitute
2 Females whom I just meet but not a prostitute
3 Girlfriends
4 Females whom I have known for some time, but are not girlfriends
5 Other types of female (please specify)_____
6. A male companion
7. Male prostitutes

83. To which of the following categories do your coital partners mostly belong? *(Please check more than one category if necessary).*
1 A prostitute
2 Females whom I only meet but not a prostitute
3 A girlfriends, who is not a prostitute.
4 Females whom I have known for some time, but are not girlfriends
5 I could not say who my sexual partners mostly are
6 Schoolmates/schoolgirls

84. In all of your sexual intercourse experiences, how often have you used condoms?
1 Always 2. Sometimes 3. Never

85. Have you had more than one sexual partner at one time?
1. Yes 2. No.

86. Is having more than one sexual partner at one time acceptable in your society?
1. Yes 2. No 3. Do not know.

87. Are there many people in your society that have more than one partner?
1 Yes 2. No

88. Why do they choose to have more than one partner?
_____

89. In which of the relationship is pre-marital sex acceptable?
1. Boyfriend and girlfriend relationship
2. Dating partner
3. Future wife
4. Fiancée
5. Others (specify)_____

90. Where are gays (homosexuals) mostly found?
1. Rural areas
2. Urban areas
3. Both areas

91. Are gay (homosexual) people acceptable in your society?
    1. Yes 2. No

92. Do gay people normal have more than one sexual partner?
    1. Yes
    2. No

93. Is prostitution common in your society?
    1. Yes
    2. No
    3. Do not know

94. How common is it for men in your community to visit prostitutes?
    1. Common
    2. Uncommon
    3. Never
    4. Do not know

95. Do you drink alcohol?
    1. Yes 2. No

96. If yes how often?
    1. Almost every weekend
    2. Almost every day
    3. Only on special occasions.
    4. Once in a while

Thank you very much for your participation.

May God bless you.

Hope that you find the questions educational in some ways.

APPENDIX 2

INFORMATION SHEET AND CONSENT FORM

INFORMATION SHEET

I am a Fijian woman conducting a research on the Reproductive and sexual behaviours of men in Fiji. The research I am conducting is for my study thesis. I am currently a Doctor in Philosophy (PHD) student, majoring in Demography, at the Australian National University, in Canberra, Australia. Below is a short explanatory note on the research.

This research is conducted to try and identify the social and cultural factors that influence the reproductive and sexual behaviours of males aged 15 to 24 years in Fiji. The aim of the study is to identify the factors influencing the reproductive and sexual behaviours of adolescent and young males in Fiji. In identifying the factors that influence the behaviour of males, the study can be used to plan related programs and to identify the needs relating to reproductive and sexual health services.

The findings from this research will help to improve and better the standard of reproductive health services available to men. It will help to improve the general understanding of how is the reproductive and sexual behaviours of men determined and why different social groups may have different reproductive and sexual behaviour.

I would like to inform you that all of your responses will be treated confidentially and I do not ask you to give your name, for the focus group discussions or the in-depth interviews. Your participation and honesty is appreciated in anticipation of the success of this study.

Below are my contact addresses in Fiji and in Australia. Please feel free to contact me if you have any queries. I will be in Fiji for a period of six months. I will be happy to answer any question you might have in regards to the research. If you also have any information that you think will be useful for the research please do contact me on the address below. If you feel the need to personally discuss certain issues relating to topic with me, do feel free to give me a call and I will try to help you out.

My contact address in Fiji is

31 Beach Road
Suva Point
Suva
Phone 313917
e-mail: mili_kaitani@hotmail.com

My contact address in Australia is

2 Key Street
Campbell
ACT 2612
AUSTRALIA
Phone (02) 62496264
e-mail: kaitani@coombs.anu.edu.au

Or

Demography Program
Research School of Social Science
The Australian National University
ACTON 0200
CANBERRA ACT
AUSTRALIA Phone
(02) 61253289

CONSENT FORM

The focus group discussion/in-depth interview you are about to participate in is on the reproductive and sexual health behaviors of men in Fiji. This is a voluntary discussion, so feel free to leave the discussion group/ interview if you do not want to participate.

The information collected in this research is highly confidential and no names will be identified in the data. You are requested to use fictitious names during the discussion/interview. The interviewers will provide name labels to you.
Please do read the information sheets given to you before agreeing or disagreeing to participate in the research.

Below is a consent form to be filled in be you, if you agree to participate in the research.

I _____(code number/), agree to participate in this research on the reproductive and sexual health behaviours of men in Fiji. I agree participate in the Focus group discussion/In-depth interview.

Signature or Initial. (This is voluntary)

_____