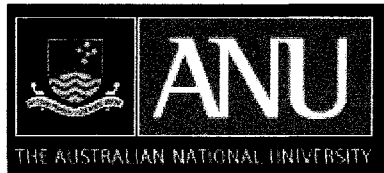


Bridging The Gap:

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

October 2003

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 is 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 otherwise 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 acknowledged 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.

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

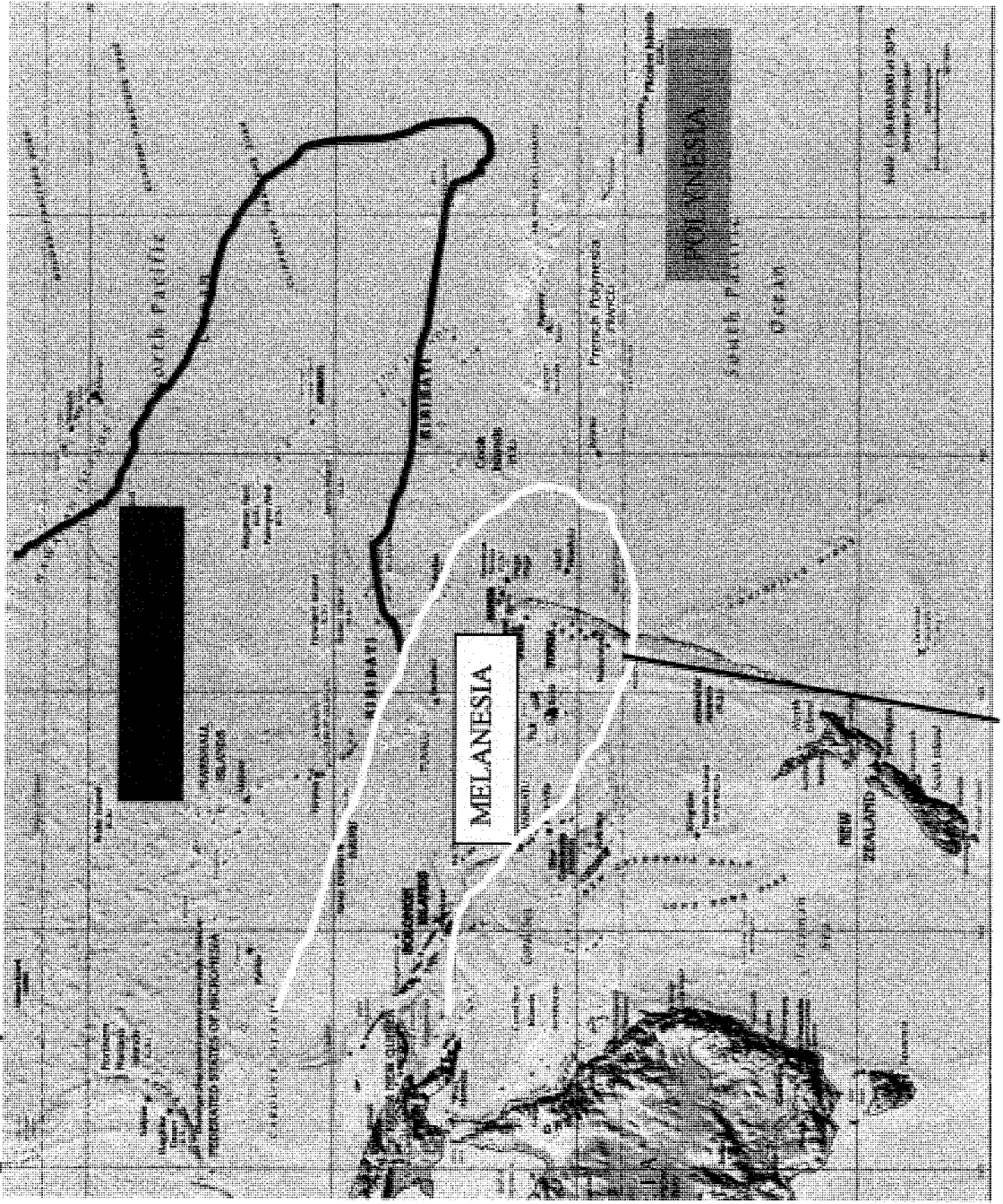
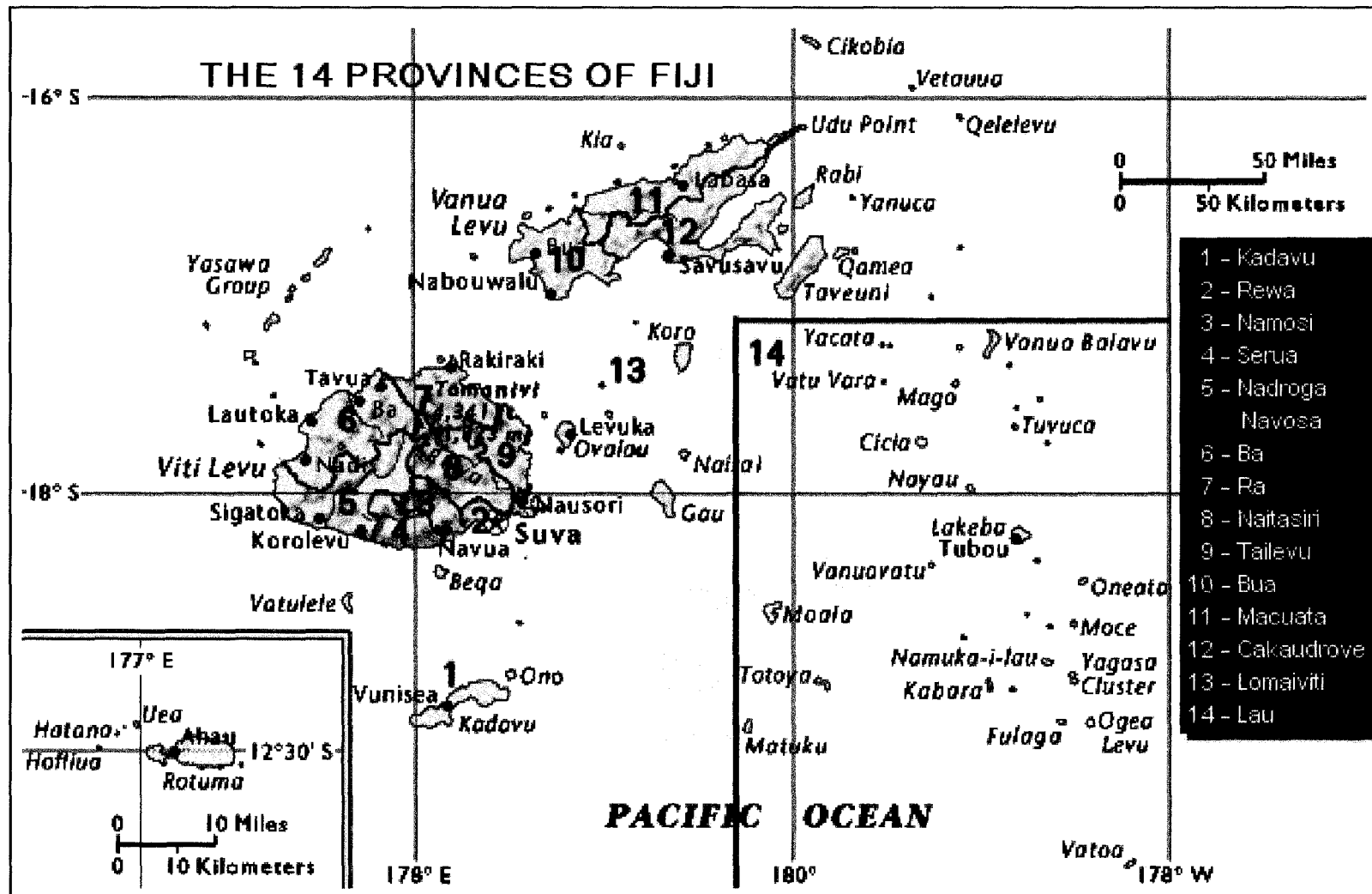


Figure 2.2 Map of Fiji and the Fijian Provinces



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-quarter 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
<i>Money economy</i>	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 access 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 *yagona*, 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		Total
	Fijian	Indian	
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. From 1966 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 MCH 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

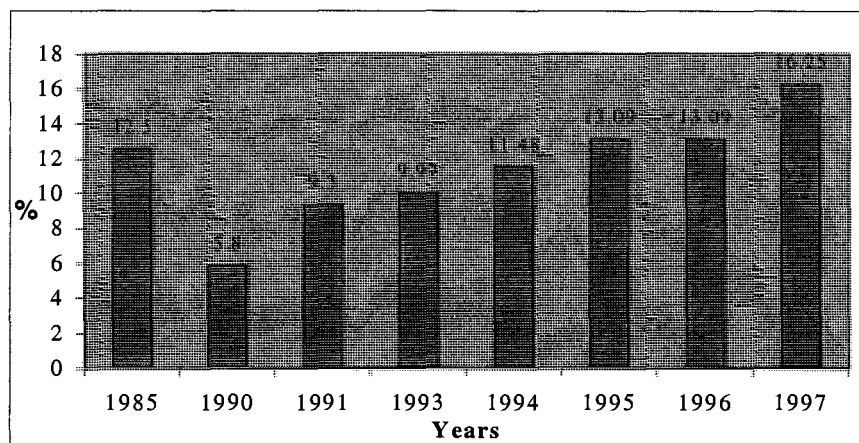
addresses family planning needs in Fiji. The services provided through the family planning service today have expanded from offering free contraceptives and counselling for women to including counselling for both partners and giving free contraceptives to men. However the community perception that the 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 knew 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.

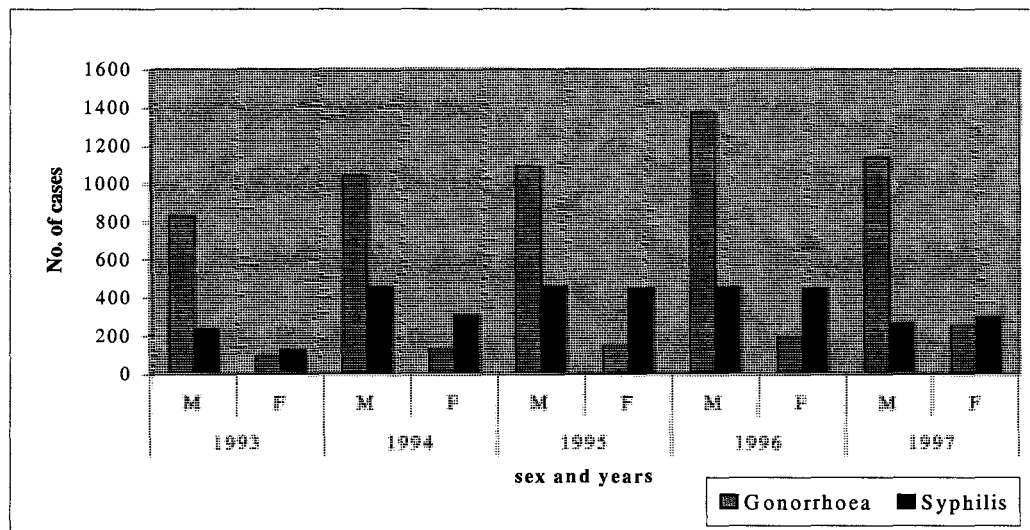
Table 2.4: Incidence of Infection with Gonorrhoea and Syphilis in Fiji, 1993-1997, by Ethnicity (Percentages)

	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 Gonorrhoea 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 (Waqā 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 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.

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) youths¹ 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 2003². 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.

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 planning³ and transmission of sexually transmitted diseases⁴ 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 friends⁵ 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).

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 in 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 Creatas 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; Tavis 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 is 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 countries school systems sex education as a curriculum is taught to students aged 17 years and above, however most studies 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 coercion 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 led 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 in 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 contracting 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 paralleled 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 on 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 weakened. 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 statistic (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 than one third of the adolescents interviewed had sexual intercourse in the month preceding the survey (Odimegwu et al. 2002).

The socialization of youths has 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 whom 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 Scandinavia (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

<i>Region, country, and survey year</i>	<i>Type of survey</i>	<i>Female median age at first coitus</i>	<i>Males median age at first coitus</i>
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 risk-taking behaviour may be of greater significance at first sex. Forrest and Singh (1990) 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 contract 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 emphasize 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 onset 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 (Updegrave 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; Updegrave 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.

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 widens 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 contracting STI and passing them to their partners or wives.

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 meet 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 as 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 where 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 persons 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 quarter of the respondents stated 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

<i>Socio-demographic variables</i>	<i>Number</i>	<i>Percentage</i>
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)

<i>Socio-Demographic Variables</i>	<i>Age</i>	
	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/boardings	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.

<i>Category</i>	<i>Number</i>
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 too 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.