

**RISKY SEXUAL BEHAVIOUR AMONG YOUTHS: A CASE OF
MUFAKOSE, HARARE**

BY

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DEDICATION

To the Glory of the Almighty God, and to my parents who have continued to be a source of inspiration in my life.

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Mufakose Anglican Church, thank you very much guys for your prayers, indeed you stood with me in one accord, rambai makadaro vakomana vechita. Infinite thanks to the Centre for Population Studies staff and students, and also to my workmates at the Department of Statistics and Operations Research at NUST who motivated me to finish my studies. To Garikai, you are a star; thank you young man.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual Reproductive Health
CSW	Commercial Sex Workers
DALYS	Disability Adjusted Life Years
EA	Enumeration Area
FGD	Focus Group Discussion
HH	Household
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
NAC	National AIDS Council
PRB	Population Reference Bureau
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organisation
ZDHS	Zimbabwe Demography and Health Survey
ZNFPC	Zimbabwe National Family Planning Council
ZIMSTAT	Zimbabwe National Statistics Agency
HBM	Health Belief Model
TPB	Theory of Planned Behaviour
MICS	Multiple Indicator Cluster Survey
SRH	Sexual Reproductive Health

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

Sexual behaviour among youths has been a focus of health programs worldwide since the International Conference on Population and Development (ICPD) in 1994. Youth sexuality and sexual behaviour remain a challenge to most developing countries including Zimbabwe. In many countries, youths have been largely recognised as a healthy part of the population (UNFPA 2012). This has resulted in neglect of their reproductive health needs by the available services (UNFPA, 2012). Information and services are not easily accessible to youths to help them understand their sexuality and protect them from STIs and unintended pregnancies. Young people in Zimbabwe, especially young women, currently have limited access to information and services depending on where they live or whether they are married or not. This situation is of great concern because lack of knowledge on reproductive health matters which include pregnancy and STI's means that young people may-be engaging in sexual behaviours that put them at risk of reproductive health problems.

Young people comprise a greater percentage of the Global and Sub-Saharan Africa population (UN, 2013). Nearly 90% of young people reside in developing countries (UN, 2013). Youths from Sub-Saharan Africa are at a greater risk of encountering reproductive health challenges when compared to youths from other parts of the World as a result low economic and social conditions in the region (Ringheim and Gribble 2010). Unsafe sexual behaviours among the 15-24 year olds drive the HIV epidemic and also result in a high number of sexually transmitted infections and unwanted pregnancies (Zhou, 2010). Increases in school dropouts due to pregnancies result in long term effects which include a loss of potential human resources for the country (UNAIDS, 2005). Studying sexual behaviours such as early sexual debut, condom use and multiple sexual partners, is of paramount importance as the consequences of such behaviours have health related implications.

1.2 Background of the Study

Studies have indicated the prevalence of risky sexual behaviours among youths aged 15-24 years, such as early sexual debut, having multiple sexual partners, and non-use of condoms and contraception (Eaton et al., 2003; Gouws, 2010; Sambisa et al., 2008). Young men and women especially those who stay in urban areas have multiple sexual partners and usually

engage in unprotected sex (Khan and Vinod, 2008). These sexual behaviours have been the prime drivers of the HIV epidemic in sub-Saharan Africa (UNFPA, 2011; UNAIDS& WHO, 2009). The HIV and AIDS pandemic, is disproportionately affecting young people and this has made this task more urgent. The Joint United Nations Programme on HIV and AIDS estimates that more than fifty percent of new HIV infections each year to be in youths below the age of 25 years (UNAIDS, 2013). Sub-Saharan Africa is home to over 70% of young people living with HIV and AIDS and to 90% of the AIDS orphans in the world (12.1 million children) (UNAIDS 2013).

Young people remain disproportionately affected by HIV, accounting for 41% of all new infections among 15-49 year-olds (UNAIDS 2010). As at 2010, only 34% of young people held comprehensive and correct knowledge about HIV and AIDS (UNICEF, 2012). In Eastern and Southern Africa, some 2.7 million people aged 15-24 years live with HIV, more than half of all HIV-positive young people globally (UNICEF, 2012). Young people aged 15-24 comprise 22.5% and 20% to the population of Zimbabwe and Sub-Saharan Africa respectively (UN, 2007; ZIMSTATS, 2012). In Zimbabwe, the average age at first sexual intercourse is 19 years for both men and women (ZIMSTAT and ICF International, 2012) but many begin sexual experimentation far earlier (Boohene et al., 1994). Unprotected sex exposes youths to risk of unintended pregnancies which will result in dropping out of school, early marriages, baby dumping and seeking abortions(Boohene et al., 1994). In Zimbabwe the HIV prevalence rate among 15 to 24 year olds is 5.5%, again much higher in women (7.8%) than in men (3.6%) (ZIMSTAT and ICF International, 2012).According to UNAIDS (2011), young people are particularly vulnerable to HIV and in 2010, 15–24 year olds accounted for 42% of new HIV infections in people aged 15 and older(UNAIDS 2011). Peer pressure and stereotypical sexual norms influence youths especially males to prove their manhood and social standing by engaging multiple sexual partners (Boohene et al., 1994). On the other hand young females are raised to be submissive to men and avoid discussing sex which compromises their ability to insist on condom use (Bassett and Sherman, 1994). Young people are vulnerable to HIV because of risky sexual behaviour, substance use and their lack of access to HIV information and prevention services. According to UNAIDS Zimbabwe's HIV prevalence rate is one of highest in the world at 14.7% (UNAIDS 2013).

1.3 Statement of the Problem

Young people 15-24 years old in Zimbabwe are the group most vulnerable to HIV and other STIs due to factors such as early sexual experimentation, limited access to reproductive health services (UNICEF, 2012; Stally, 2003). Females are at higher risk of HIV infection due to gender norms. Risky sexual behaviour is commonly defined as behaviour that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. Studies show that sexual activity begins at an early age throughout Zimbabwe, a particular concern in a country with a large and growing young population (Zaba et al., 2004; Africare, 2000; UNICEF, 2001). Gender roles and social norms together with economic and legal factors negatively affect sexual risky behaviours in Zimbabwe and other countries globally. (Bassett and Sherman, 1994). In Sub Saharan Africa recent statistics show a high prevalence of reproductive health problems such as STIs and HIV and AIDS, infertility, ectopic pregnancy unintended pregnancies, and cervical cancer (Ringheim and Gribble, 2010). Early sexual debut, multiple sexual partners, having sex under the influence of alcohol or drugs, and unprotected sexual intercourse are some of the risky behaviours that put young people at greater risk (Centres for Disease Control and Prevention, 2010).

UNFPA in partnership with the Ministry of Health and Child Welfare and Zimbabwe National Family Planning Council, has implemented interventions to opening up opportunities for young people in sexual reproductive health issues. The Zimbabwe National Family Planning Council programme called Promotion of Youth Responsibility Project encouraged young people to adopt behaviours that reduce the risk of unwanted pregnancies and STIs, including HIV. However, the issue of sexual and reproductive health (SRH) among youths is still a topic that causes discomfort. Policy inconsistencies, provider attitudes and attitudes of parents towards sexual reproductive health issues among youths have hampered the success of the programmes. There are still challenges arising from sexual behaviours among youths which include teenage pregnancies, STI's, HIV and AIDS and abortion despite the intervention programmes in place and high knowledge of HIV and AIDS among youths. This study, then, is aimed at exploring youth's risky sexual behaviours. It seeks to understand the various aspects of youth's sexual behaviours that put them at risk in this era of HIV and AIDS.

1.4 Justification of the Study

Young people comprise a greater proportion of Sub-Saharan Africa and the global population (UN 2013). Nearly 50 percent of the world's population is made up of youths below the age of 25 (PRB, 2013). The health of young people is essential for the social and economic development of any country therefore meaningful investments should be made in their health to ensure future human capital and poverty alleviation (The World Bank Group, 2011). Therefore it is important to understand the behaviours that expose young people to risk of early sexual debut and the ability to predict and understand motivational influences on behaviour will provide information that is valuable in the development of SRH programs, pregnancy and STI prevention programs.

Addressing the reproductive health challenges of youths is very important for the development of any country and provides an opportunity for strengthening future human capital, observing sexual reproductive rights and alleviating the cycle of poverty within societies (UNFPA, 2012). Young people are exposed to many risks and dangers during adolescence but there is potential for promotion of healthy behaviour through providing comprehensive education. (Kleinert, 2007; WHO, 2007). Measures should be put in place to educate young people on health and preventive behaviour during this stage of life (Call et al. 2002). Behaviour learnt or initiated during adolescence may last forever and can have positive or negative impacts on the future of the youths (Call et al. 2002). Youths are future parents and therefore preventive behaviour learnt during adolescence may be passed on to future generations.

1.5 Objectives of the Study

The overall objective of the study is to explore sexual behaviour and related factors, of young people aged 15-24 years living in Mufakose, Harare. Specifically the objectives of the study are to:

1. Identify sexual risk behaviours amongst young people
2. Describe the risky sexual behaviours of youths.
3. Explore the factors facilitating the risky sexual behaviours youths.

1.6 Scope of the Study

The study will be carried out in Mufakose high density suburb in Harare which is an urban set up. A representative sample will be drawn among the populations of youths aged between 15-24 years old. The study is focused on identifying and exploring socio-economic factors that put young people at risk of unwanted pregnancies and contracting HIV and AIDS.

1.7 Organisation of the Study

The study is organised into five chapters:

- Chapter one is an introduction to the study;
- Chapter two unveils and synthesises literature written pertaining to reproductive health and sexual behaviours among youths globally, regionally and in Zimbabwe. This chapter will also include the theoretical frameworks used in the research;
- Chapter three focuses on the methodology of the study;
- Chapter four presents the study findings; and
- Chapter five sums up the study by giving discussions of the results and conclusions of the study as well as providing recommendations on how to solve sexual behaviour issues among youths.

2 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature review for the study. This section will give a global, regional and national overview of risky sexual behaviour among young people. The chapter will also focus on the various empirical studies conducted on sexual behaviour of youths globally, regionally and nationally. Finally the study's theoretical and conceptual framework will be discussed in detail in this chapter.

2.2 Risk Sexual Behaviour among Youths

2.2.1 The Global Overview

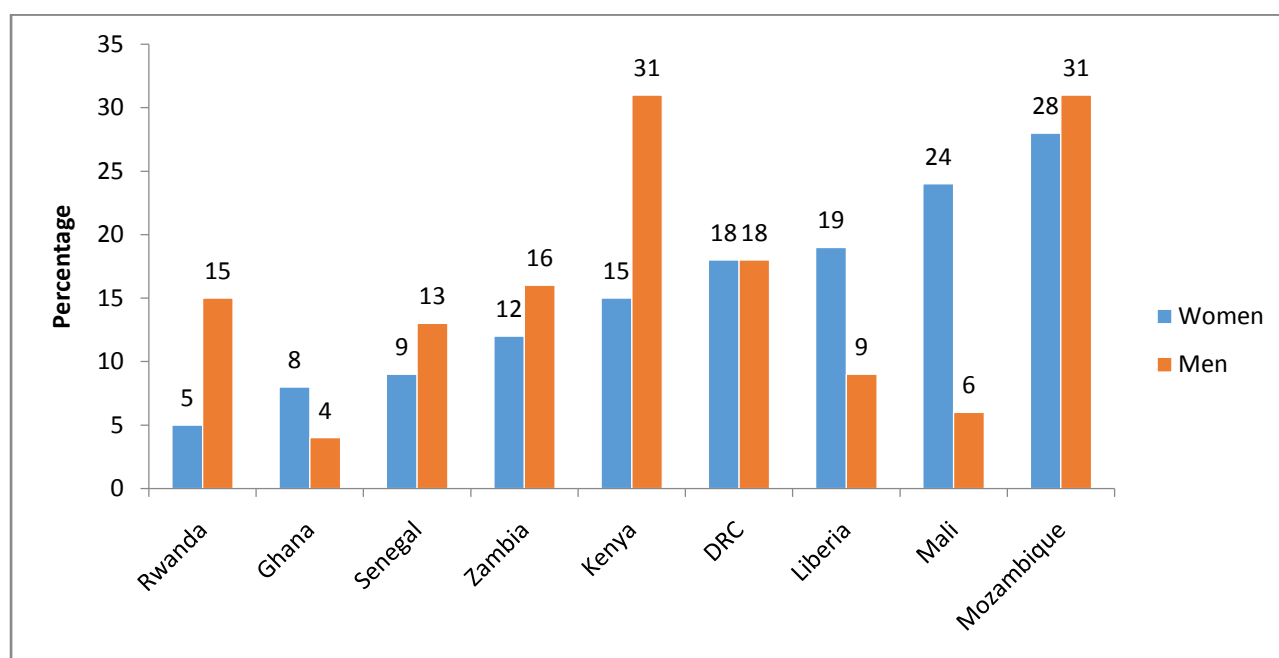
Risk sexual behaviours are defined as sexual activities that may expose young people to the risk of infection with HIV and other sexually transmitted infections (STIs). A wide range of factors can lead to risk sexual behaviour among young people and they include socio-economic and demographic for example age, sex, place of residence and income. Some indicators of risky sexual behaviours include early sexual debut, unprotected sexual intercourse, teenage pregnancy, multiple sexual partners, sexual intercourse for reward, forced sexual intercourse and using alcohol or drugs before sexual intercourse. The World Health Organisation defines youths as young people aged 15-24 years (WHO, 2002). Young people experience rapid growth and development in their minds, bodies and social relationships (Patton and Viner, 2007; WHO, 2007). This development is characterised by exposure, experimentation and vulnerability to mental and psychosocial problems (Patton and Viner, 2007; WHO, 2007). There is a renewed interest in the public health of youths because of the negative outcomes of their risky sexual behaviour which include unplanned pregnancies and infection with STIs including HIV (Adams and Montemayor, 1993).

Almost fifty percent of the world population (i.e. three billion people) is made up of young people aged 25 years and below (UNFPA, 2011). The numbers of children and young people in the less developed regions are at an all time high (1.7 billion children and 1.1 billion young people) (United Nations, 2013). According to the United Nations population estimates, adolescents aged 10-19 years and young people age 10-24 constitute eighteen percent and twenty six percent of global population figures respectively (UN, 2013). The estimates show

that young people make up 18 percent in developed countries and 32 percent of the total population in Sub-Saharan Africa (United Nations, 2013). Youths between the ages of 15-24 Young adults aged 15-24 constitute eighteen percent and twenty percent of the global and Sub-Saharan Africa populations respectively (United Nations, 2011).

Youths have been traditionally viewed as a healthy cohort, however recent evidence has pointed to a significant number of deaths occurring in this population segment. The major causes of deaths among young people were maternal causes (15%) and HIV/AIDS and tuberculosis (11%) (Blum, 2009; Patton et al. 2009). Unsafe sex is an important risk factor in low income countries contributing 10.2%, of Disability-Adjusted Life Year (DALYs) in developing regions or lost years of healthy life (DALYs) (Ezzati et al., 2002). Data from the World Health Organisation indicate that among females aged 15-29 years, reproductive health problems constitute 63 percent of Disability Adjusted Life Years and 37 percent is as a result of AIDS (Robert, 2007). According to UNAIDS (2008), globally there is a decline in youths who engage into sexual intercourse before the age of fifteen however recent evidence shows that age at sexual initiation has gone down (UNAIDS, 2008; United Nations, 2013). Globally unintended pregnancies are common among youths and adolescents (Blum, 2009). In Sub-Saharan Africa countries the share of young females who were mothers ranged from twenty percent to forty percent (Reynolds et al. 2006). Evidence from Sub-Saharan Africa shows that 58 percent of teenage births were not planned (UNFPA 2005). DHS data have shown that median age at first sex is very low in Sub-Saharan Africa, in Mali 24% of women had their first sexual intercourse before that age of 15 and mostly in the context of child marriage.(Figure 2.4)(Ringheim and Gribble, 2010).

Figure 2:1 Percentage of Youths who had sex before age 15, DHS 2003-2008



Source: Ringheim and Gribble, 2010

2.2.2 Risk Sexual Behaviours among Youths in Zimbabwe

In Zimbabwe young people constitute 62% of the entire population (ZIMSTAT, 2012). The average age at first sexual encounter is 18.9 years for women while it is 20.6 years for men in Zimbabwe hence it is clear that young women are not having their first sexual encounter with men within their age group (ZIMSTAT and ICF International, 2012). According to ZDHS 2010/11 the median age at first marriage in Zimbabwe has been declining from 19 years for women currently aged 45-49 years to 16 years for those aged 15-19 years, 15% of young women age 15-19 who had sexual intercourse in the year preceding the survey, had sex with a man 10 or more years older (ZIMSTAT and ICF International, 2012). Similarly, 1% of young men age 15-19 who reported that they had a sexual partner in the past 12 months reported having a partner 10 or more years older (ZIMSTAT and ICF International, 2012). The 2014 Multiple Indicator Cluster Survey (MICS), shows that 1 in 3 girls are married or in union before the age of 18 and 5% are married before the age of 15 (ZIMSTAT, 2014). Young people in Zimbabwe are vulnerable to reproductive health challenges because of their risky sexual behaviour, biological vulnerability, socio-cultural norms and values, as well as insufficient knowledge and misunderstanding about reproductive health services. Nationally the proportion of young people who are sexually active vary, but however figures for early sexual debut are high, ranging from 29% and 52% (ZNFPC, 1997; Moyo, 2009; Dhliwayo,

2009). According to ZDHS 2010/11 contraceptive prevalence rate in Zimbabwe stands at 59%. Teenage pregnancies increased from 21% in 2005/06 to 24% in 2010/11 while adolescents' pregnancies are 70 per 1000 girls in urban areas as compared to 144 in rural areas (ZIMSTAT and ICF International, 2012). The same survey reported that 9 out of 10 sexually active girls aged 15-19 are in some form of a marriage and that 2 out of 3 girls who first had sex before the age of 15, were forced against their will (ZIMSTAT and ICF International, 2012). The

National AIDS Council (NAC) Report of 2007/08 showed that only 11% of men age between 18 and 24 years had used a condom during first sex. Fifty two percent of men between 18 and 24 years who were not married had sex using a condom during their last sexual encounter

2.2.3 Indicators of Risky Sexual Behaviour

a) Multiple Sexual Partners

Multiple relationships are common and they expose young people to reproductive health challenges, however rates vary throughout many parts of the world and among societies and sexes (O'Sullivan et al., 2006). The number of young people with multiple sexual partners indicates the potential risks of reproductive health problems such as unplanned pregnancies and STI/HIV infection (Darroch et al., 2001). Globally young males tend to have more than one sexual partner when compared to young females; however in some developed countries multiple sexual partners are similar between males and (Wellings et al 2006). The evidence of multiple sex partners among young people worldwide is increasing. The Zimbabwe Young Adult Survey shows that among sexually experienced women aged 15-24, 71% reported having four or more life partners, 25% reported two to three and 4% reported one life partner. Concurrent sexual partners, low condom use and low prevalence of male circumcision have been identified as a key driver of HIV transmission in countries with generalized HIV epidemics (PSI, 2014).

b) Age at first intercourse

Age at first intercourse is a marker of risk sexual behaviour and sexually transmitted infections (Greenberg, 1992, Singh et al., 2000). The prevalence of early sexual debut is often assumed to be particularly high in Sub-Saharan Africa; however age at first sex is fairly consistent worldwide (Wellings et al., 2006). In many countries sexual debut occurs in late adolescence between ages 15-19, for young females in Sub-Saharan Africa, sexual debut

occurs at ages 17–20 (Wellings et al., 2006). First sexual experiences are part of the transition to adulthood, and they are influenced by the environment, context and culture in which young people develop (Rosenthal et al., 2001). The average age at first sexual encounter is 18, 9 years for women while it is 20, 6 for men in Zimbabwe (ZIMSTAT and ICF International, 2012). In a study conducted in Manicaland, age at first sexual intercourse was positively associated with men's and women's lifetime number of partners, number of recent partners and number of current sexual relationships, but also with consistent condom use (Hallett et al, 2007). Younger girls are perceived to be HIV free and are the preferred sexual partners by older men putting them at greater risk (WHO, 2012).

c) Intergenerational sex

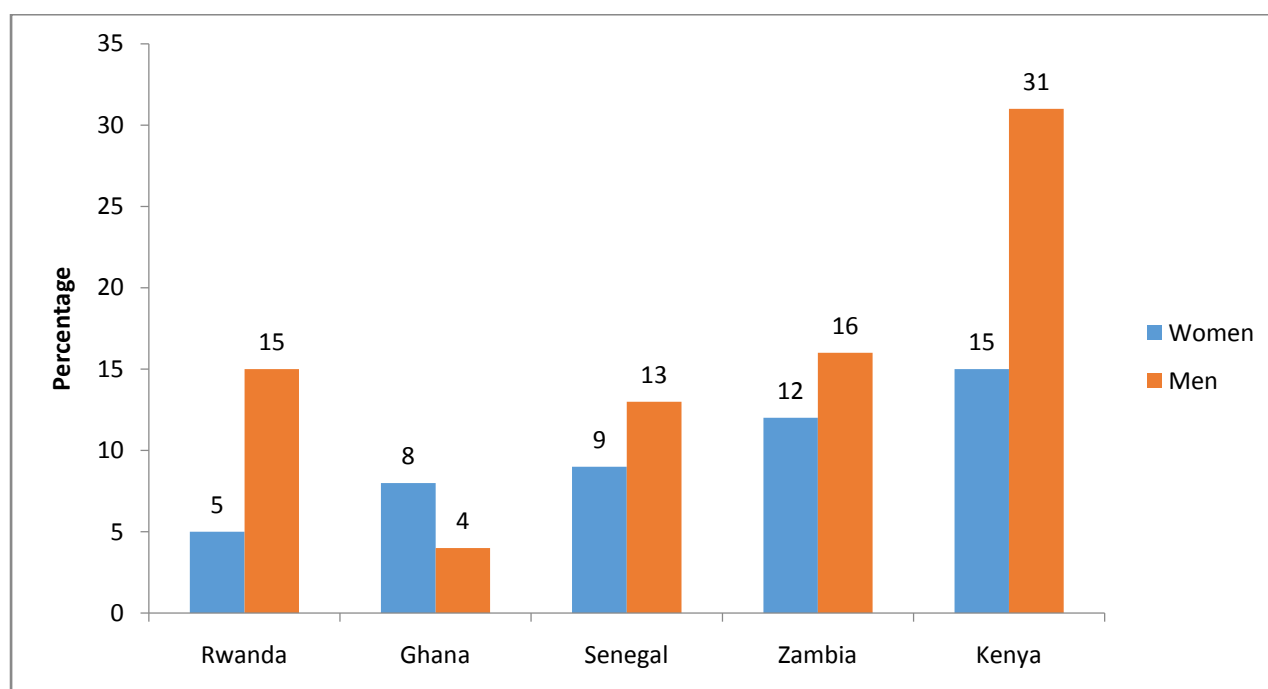
In Zimbabwe, intergenerational sexual relationships are the most common risk sexual behaviour and they include coerced, forced and transactional sex. In a survey of 1313 men in beer halls in Harare 2.5% met a definition of "sugar daddy", men with a non-marital partner at least 10 years younger and less than 20 years old, and exchanged cash or goods for sex (Wyrodetal., 2011. Fapohunda and Rutenburg (2004) in their research on intergenerational sex found that about 40% of older male respondents reported ever dating a girl 10 years younger than they were while a paltry 3% of men aged between 15 to 29 years ever dated a woman 10 or more years older than they were. In Zimbabwe the median age at first sexual intercourse is 18.9 years for women and 20.6 years for men; hence it is clear that young women are not having their first sexual encounter with men within their age group (ZIMSTAT and ICF International, 2012). Sexual coercion plays a role in sexual initiation and subsequent intercourse as evidenced by studies conducted in Ghana, Uganda and Zimbabwe (Koenig et al. 2004; Glover EK et al., 2003; Phiri and Erulkar, 2000). In a study in Ghana, 25% of females aged 12-24 reported that their first intercourse had been forced while in Zimbabwe 12 percent in a study in urban areas and 33 percent in rural areas while in Uganda 14 percent in Rakai rural district, women between the ages of 15-19 reported sexual coercion (Koenig et al. 2004; Glover EK et al., 2003; Phiri and Erulkar, 2000). Young females are exposed to greater risk of sexual coercion because they usually have older sexual partners which are commonly known as "sugar daddies" (Blum and Nelson-Mmari, 2004). Transactional sex which involves the exchange of money or gifts for sexual intercourse is common among unmarried young females in Sub-Saharan Africa (Moore et al., 2007; Nobelius et al., 2011). Evidence from DHS data in twelve countries in Sub-Saharan Africa

reveals that most women who had transactional sex were teenagers aged 15-19 years(Chatterji et al ., 2005)

d) Contraception Use among Youths

Contraceptive use among youths is reportedly low especially in Sub Saharan Africa. Several studies have shown that most pregnancies to adolescent girls in sub-Saharan Africa are unintended or mistimed and the use of family planning methods among this group remains low (Cleland et al., 2006). Young people in developed countries used contraceptives more than those in developing countries for example more than 90% of adolescents in the United Kingdom used contraceptives when compared to 31 % in Serbia and Montenegro (Avery and Lazdane 2008). About 33 percent of young people in least developed countries used modern methods of contraceptives as compared to 58 percent in developed countries (Guttmacher Institute and IPPF, 2010). Among sexually active youth, contraceptive use reduces the number of unplanned pregnancies. However as shown in Fig 2.4, young women in Sub Saharan Africa, especially those that are married are not likely to use modern methods of contraceptives. Factors associated with low contraceptive use among married adolescents include inadequate knowledge about contraception limited ability to make independent decisions about using contraceptives or when to have children and lack of experience in obtaining family planning services (Singh et al., 2009). According to the United Nations Population Fund (UNFPA) contraceptive use in Zimbabwe in 2013 was at 59 %, one of the highest in sub-Saharan Africa. Still, this is lower than the 68 % mark that the government pledged to achieve by 2020 at the 2012 London Summit on Family Planning (UNFPA, 2014). There are 222 million women around the world with an unmet need for contraception (Singh and Darroch 2012). Guttmacher Institute (2014) reported that in some regions, young women ages 15-19 are twice as likely to have an unmet need for contraception as women over twenty.

Figure 2:2 Current use of modern methods of contraception among married and unmarried women age 15-19, DHS 2003-2008



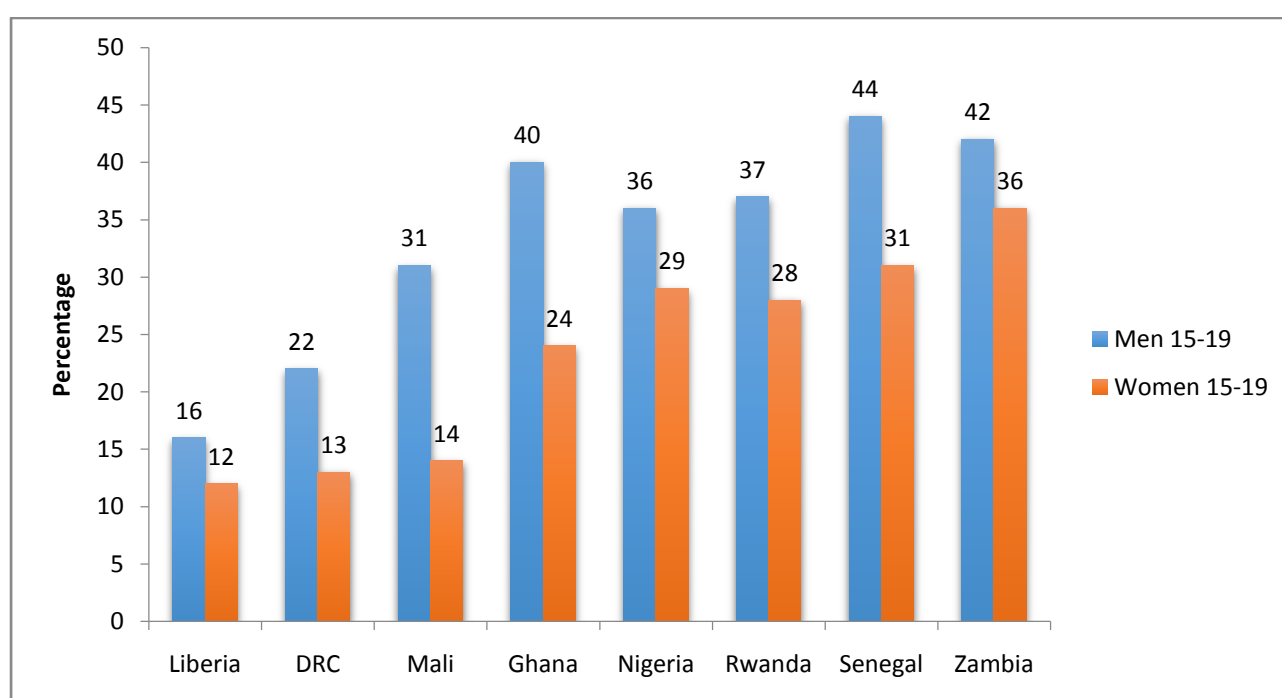
Source : Ringheim and Gribble, 2010

e) Condom use among young people

Condom use among youths is another indicator of risk sexual behaviour. Condom use after high risk sexual encounter is low in Sub-Saharan Africa as compared to other regions of the world. The proportion of young people reporting using condoms on last sexual encounter is higher for males than females; however there seems to be an increase in condom use among both sexes (Marindo et al., 2003; PRB 2001; Wellings et al., 2006; Ringheim and Gribble, 2010). Condom use among sexually experienced single females increased as shown from DHS data from 18 countries from Sub-Saharan Africa; however they mainly used them to prevent unplanned pregnancies (Cleland and Ali, 2006). According to the United Nations the use of condom during last high risk sex has increased by 10 percent between 2000 and 2007 in 11 countries in Sub-Saharan Africa (United Nations, 2010). Other studies have also noted that youths who know their HIV status do not consistently used condoms (Birungi et al, 2009; Obare and Birungi, 2010). The use of condoms among youths is heavily influenced by societal practices, values and norms (Van Rossem and Meekers, 2011). The use of condoms among youths occurred mainly during marriage and youths who once had a condom

demonstration have a better understanding of condom use (Cherutich et al., 2008); Bankole et al., 2007). In a survey conducted by the National Aids Council on adolescents in Zimbabwe, they gave a range of reasons for not using condoms. The most frequently highlighted reason was the unavailability of funds and girls were particularly concerned about malfunctioning of condoms during sexual act (NAC, 2005).

Figure 2:3 Condom use at last high risk sex act, DHS 2003-2008



Source: Ringheim and Gribble, 2010

2.2.4 Socio- Economic and Demographic factors for Risky sexual behaviours among youths

Previous studies on risky sexual behaviour of young people have proposed three levels of influences: personal determinants, the proximal determinants (physical and organisational environment) and the background determinants (culture and structural factors)(Eaton et al., 2003). The personal determinants that are associated with risky sexual behaviour include evaluation of vulnerability to a health risk; perceive severity of the health outcome, the benefits as opposed to the risky associated with risky behaviour and perceptions about social norms. The wide range of factors include socio-cultural, demographic and economic.

In sub Saharan Africa gender roles are traditionally based on unequal power relations between men and women and these traditional gender role-based attitudes gives more power to men than women, and expose women to risky sexual situations (Winghood et al., 2000; Shearer et al., 2005). Gender differences have been observed on risk sexual behaviours among youths in a sub-Saharan African setting (Voeten et al., 2004; Agardh, 2011). Young men who are internalized with such social norms may feel the pressure to behave in a stereotypical masculine manner that may include having multiple and casual sexual partners, and women may leave the important sexual decisions to men (Agardh, 2011). In Zimbabwe young women and girls are most vulnerable to high-risk sexual behaviours. Women may be compromised in their ability to ward off unwanted sexual attention or negotiate safe sex because of their economic dependence on men. They are also reluctant to use contraceptives, including condoms. Increasing levels of poverty lead some women into casual or commercial sex work, while male norms allow for multiple and concurrent sexual partnerships, including casual and commercial sex (NAC, 2006).

Religion can influence sexual behaviour through intermediate factors such as the age at first sex, marital status, and access to information and services. It can also influence attitudes to HIV, contraception, condoms and perception of risk. Young people who were more religious were more likely not to use contraceptives at sexual debut; however there were changes in the impact of religion across time (Brewster et al.1998). On the other hand other studies did not find an association between religion and non use of contraceptives (Nonnemaker et al., 2003; Jones et al., 2005)

Drug abuse and alcohol consumption is widely known to be a potential risk factor that may lead to risky sexual behaviours and the threat of sexual coercion (Stafstrom and Agardh, 2012; Balinus et al., 2010; Rudatsikira et al., 2009; Sherman et al., 2009). Sexual coercion may not allow the victim to negotiate safer sex, thus leading to risky sexual behaviours. They are also associated with non-use of contraception in relation to both first and last sexual encounter, and with a sexual encounter involving a non- steady partner (Larsson et al., 2007 Lavikainen, 2009).In a survey of men attending beer- halls in Harare, HIV prevalence was 30%, and having sex while intoxicated was strongly associated with unprotected sex with casual partners, paying for sex, and recent HIV sero-conversion (Fritz et al., 2002). Bandason and Rusakaniko (2010) in a survey among secondary school students in Harare found out that risky behaviours like substance abuse, premarital sex and physical fights are significantly associated with smoking. Two studies conducted in South Africa showed that 75% of

respondents identified local drinking places as public venues where people went specifically to meet new sexual partners and with the intention to engage in sex (Morojele et al., 2006; Weir et al., 2003).

Research suggests that family structure can strongly influence the sexual behaviour of young people. Parents' marital status, employment status, their disapproval of and discussion with youths about the standards of behaviour and the social and moral consequence of youth's sexual activity as well as parental monitoring all appear to impact youths' decisions to engage in risk sexual activities (Ramos et al., 2006). In Rwanda and Kenya studies have shown, the impact of father's presence on delaying sexual debut, father's presence reduced substantially the risk of early initiation of sexual intercourse and risky behaviours such as frequency of sexual intercourse and unwanted pregnancy (Babalola, 2004; Ngom et al., 2003).

Okonkwo et al., 2005 concluded that social environment plays an important role in the sexual behaviour of youths (Okonkwo et al., 2005). This environment include friends, peers, sexual partners friends, family members family, school and other institutions catering for the needs of young people(Okonkwo et al., 2005). Other studies found out that the association between peers and the risky sexual behaviour of youths is very strong (DiClemente, 1991; Ary et al., 1999; Staton et al., 2002). The beliefs of youths about the behaviour of their friends is associated with health behaviour and youths who think that their friends are using condoms are more likely to use them also when compared to those who do not think that way.(DiClemente, 1991; Staton et al., 2002). In a study among girls aged 15-19 in Murewa, about 15% of the girls have had sex, with girls-out-of-school more likely to be sexually experienced than schoolgirls (Wekwete and Madzingira, 2005). Other studies carried out in Zimbabwe have indicated under reporting of sexual activities among young people, therefore the problem of early sexual activity could be worse (Wekwete and Madzingira, 2005; Wekwete, 2002; Meekers and Wekwete, 1998).

Age at first sex of young people is associated with risky sexual behaviour such as the non use of contraceptives; however there are gender differences (Abma et al 2004). Previous studies have shown that older girls or women are more likely to use contraceptives during first sexual intercourse sex (Abma et al., 2004; Abma&Sonenstein, 2001; Franzetta et al., 2006). Recent studies found out that older male youths were more likely to use condoms during sex (Abma et al., 2004; Franzetta et al., 2006). The characteristics of the male partner have an impact on a young female's contraceptive use. Studies have shown that if a male partner is older that the

female partner they are less likely to use contraceptives during their first sex (Abma et al., 1998; Manlove et al., 2003; Manlove et al., 2005). This is because older men are less likely to use condoms, and usually sex among such partners may be unwanted or forced which result in young women failing to negotiate safer sex particularly the use of condoms (Ku et al., 1993); Abma et al., 1998; Luke, 2003). Murray and London (2004) indicated that the estimated odds of women engaging in transactional sex are higher among women in the younger age groups than for women 25 years and older in Zambia and Zimbabwe. They also found that 60% of single young women engage in transactional sex as compared to only 12% for married older women.

Marital status of young people has an impact on risk sexual behaviour through attitudes towards contraception. Married young females are less likely to use condoms as compared to unmarried young women (Ringheim and Gribble, 2010). Previous studies found out that contraceptive use is low among casual relationships when compared to serious steady relationships (Lescano et al 2006; Manning et al 2000; Manlove et al 2003). In Zimbabwe the widowed, divorced and separated men are usually involved in paid sex (ZIMSTAT and ICF International, 2012).

Poverty and economic status of young people affect sexual behaviour through knowledge and attitudes. Young people who derive low satisfaction from their lives are more likely to engage in risky sexual activities. Hallman (2004) argues that the poor are more likely to engage in higher-risk sexual activities like prostitution as a result of economic hardships. Booysen et al. (2002) analyzed the relationship between poverty, risky sexual behaviour, and vulnerability to HIV/AIDS, using DHS data from South Africa. Their findings showed that women from poorer households were less knowledgeable about HIV/AIDS than wealthier women. Collins and Rau (2000) have observed that poverty is likely to be associated with lack of education, and lack of education implies that messages regarding safe sexual practices and prevention measures are often inaccessible. In a study with commercial sex workers (CSW's) by Machingura (2010), CSW revealed that they are unable to negotiated condom use when a client pay more than the normal charges and requested unprotected sex.

2.3 HIV and AIDS Knowledge and Risk Perception

Young people's awareness and knowledge of how HIV spreads and a roper assessment of their own risk is a key determinant to adoption of safer sexual practices (UNAIDS,

2001) Several studies on the relationship between HIV risk perceptions and risk sexual behaviours in Sub-Saharan Africa examined variables such as non use of condoms and multiple sexual partners (Shobo, 2007; Sarker, 2005). Conflicting results have been found from these studies with some studies finding association between HIV risk perception and risky sexual behaviours (Barden-O'Fallon, 2004; Shobo, 2007; Sarker, 2005; Maharaj, 2006) and others finding none (Adetunji and Meekers, 2001). A survey using DHS data from three Sub-Saharan Africa countries revealed that knowledge of someone with HIV had a negative effect on risky sexual behaviour (Macintyre et al., 2001). The same study further on states that knowledge about somebody who suffered from AIDS or who died from AIDS will result in increased awareness of the impact of HIV and AIDS and might result in safe sexual behaviour (Macintyre et al., 2001). Youths especially females possess inadequate knowledge on the three preventive measures against HIV and AIDS (e.i abstinence, being faithful and condom use) (Khan and Vinod, 2008; Ringheim and Gribble, 2010). DHS reports from Sub-Saharan Africa shows that youth perceive that they are at low or no risk of being infected with HIV, especially young men (Khan and Vinod, 2008). Young females believe that they are at low risk since they abstain and have one sexual partner, whereas males said they are at low risk because they use condoms (Population Reference Bureau, 2001). Results from surveys conducted in least developed countries shows that only 24 percent of young females and 36 percent of young males have correct answers for five questions on HIV transmission and prevention asked. (UNAIDS, 2011)

2.4 Contraception Knowledge and Attitudes

Knowledge and attitudes towards contraception is a major determinant of risk sexual behaviour among youths. Studies have shown that a significant proportion of the young people have knowledge of contraceptive methods, but in terms of use especially in less developed countries, it is very low. The situation is more pronounced among adolescents and young unmarried segments of the population than the adult people (WHO, 2004). Before using a contraceptive, youths must first have knowledge of different methods. DHS's conducted in Mali, Burkina Faso and Senegal explored the variation in sexual knowledge and practice among youths aged 15-24 in these countries. In Senegal and Burkina Faso, more than 85 percent of young women surveyed knew at least one form of modern contraception while in Mali 76% reported the same results (Khan and Vinod, 2008).

2.5 Condom Self Efficacy

Condom self efficacy has an effect on intention and use of condom during intercourse among youths. Self-efficacy is defined as a person's belief in his or her ability to succeed in a particular situation (Bandura, 1997). According Bandura (1997) a weak perceived self-efficacy to exercise personal control can increase the likelihood of risky sexual behaviour. Previous studies have found that personal control and high self-efficacy in sexual negotiation were found to be significantly associated with safer sex behaviour among youths (Pearson, 2006). Furthermore, a favourable attitude toward contraceptives has been found to increase adolescents' intention to use them, but the perceived self-efficacy determined whether those intentions were put into use or not (Basen-Engquist, 1992). Intention to use a condom' is another predictor that can affect condom use (Schaalma, 2009; Mashegoane, 2004). In a study by Wekwete and Madzingira (2005), 45.3% of girls showed high levels of self efficacy in refusing sex. In addition girls who had never had sex were more likely to have self efficacy in refusing sex compared to the sexually experienced. Thus, girls who are not sexually experienced have some knowledge about the risks of having sex and the repercussions of unprotected sex compared i.e. contracting HIV as compared to older and experienced girls.

2.6 Theoretical Framework

This study used the theories of Health Belief Model (HBM) and The Theory of Planned Behaviour (TPB) to guide the development of the research questions and data collection instruments. This section will discuss the two theories that were used in this study to acquire a deeper insight into the risky sexual behaviour among youths. This study used behavioural theories to identify and understand factors associated with youth's sexual risk behaviours. These theories were used to come up with the study's conceptual framework.

2.6.1 Health Belief Model

The Health Belief Model (HBM) is one of the earliest theories of health behaviour. The Health Belief Model is an intrapersonal (within the individual, knowledge and beliefs) theory used in health promotion to design intervention and prevention programs (Rosenstock and Irwin, 1974). It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease, and continues to be one of the most popular and widely used theories in intervention science (Glanz et al., 2010; Janz et al., 1984). Dennill et al. (1999)

describe the HBM as a conceptual framework that can be used to explain a client's behaviour in health promotion and disease prevention and describes a person's health behaviour as an expression of health beliefs.

The focus of the HBM is to assess health behaviour of individuals through examination of perceptions someone may have towards disease and negative outcomes of certain actions. The health belief model is very useful in designing interventions that can be used to increase STI/HIV risk awareness and reduce barriers to sexual healthy behaviour among youths. The health belief model proposes that a person's health-related behaviour depends on the person's perception of five critical areas:

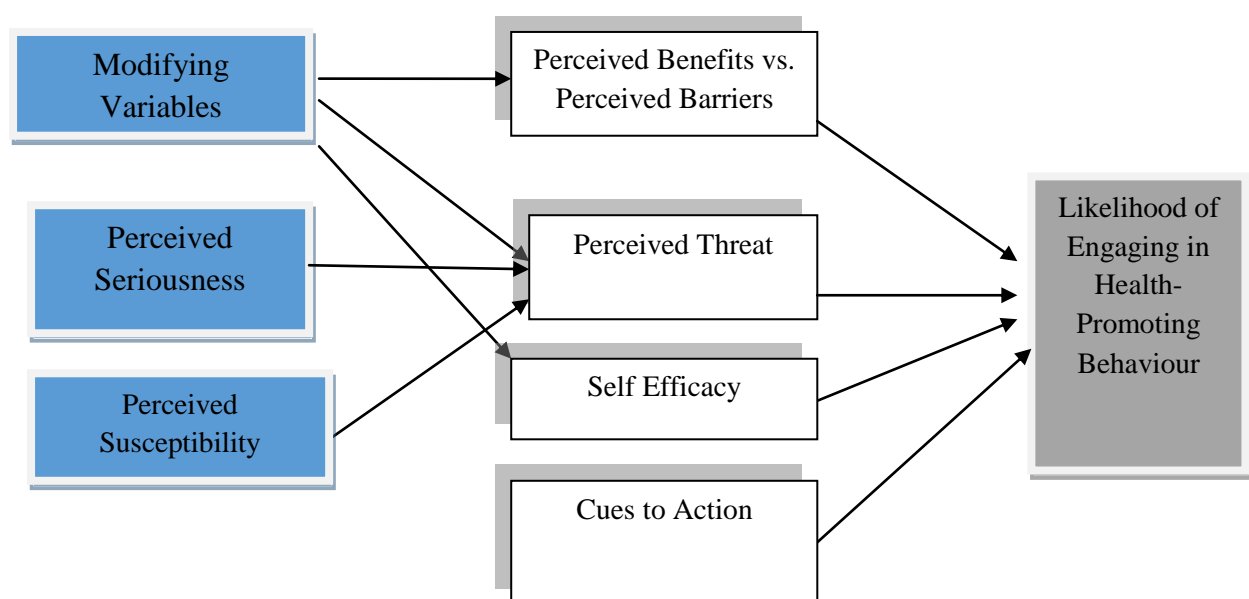
1. The severity of a potential illness,(e.g. “ how severe is HIV and AIDS)
2. The person's susceptibility to that illness, (e.g. “Am I at risk of getting an STI?”)
3. The benefits of taking a preventive action, (e.g.“ If I do not engage in sex will I avoid an unintended pregnancy”)
4. The barriers to taking that action (e.g. “ I am not comfortable with using contraceptives”)
5. Cues to action (e.g. “losing a friend or family member to HIV and AIDS”)

The model contains modifying variables in the form of individual, demographic, psychosocial and structural variables. The Health Belief Model postulates that the modifying variables through affecting perceived seriousness, susceptibility, benefits and barriers affect health related behaviours. In the background of the model there are demographic factors which comprise of age, sex, education etc. The model also includes psychosocial variables which include social standing, character, peer and reference group pressure. Finally the model comprise of structural factors which include knowledge about a given disease and prior contact with the disease etc.

However, The Health Belief Model has been criticised on its focus on individual beliefs and attitudes leaving out other factors that influence health behaviours (Janz et al., 1984). For example, other health related behaviours(e.g. smoking and seatbelt buckling). Some people practise health- related behaviours for other reasons not connected to health, for example exercising for aesthetic reasons (Janz et al., 1984). In addition to that The Health Belief Model does not put into consideration the impact of emotions on health-related behaviour (Glanz et al., 2008). Some evidence also supports the fact that fear contributes in predicting health behaviour (Glanz et al., 2008).Another weakness of The Health Belief Model is that

the theoretical constructs are broadly defined and does not specify how they interact with one another (Carpenter and Christopher, 2010). Another component, self efficacy was added to the four components of The Health Belief Model in 1988 (Glanz et al., 2008). Self efficacy means an individual's perception of his or her ability to successfully perform behaviour. It was added to The Health Belief Model to aid in explaining why there are individual differences in health behaviours (Rosenstock et al., 2008).

Figure 2:4: A diagrammatical representation of the Health Belief Model



Source Janz et al 1984

2.6.2 Theory of Planned Behaviour

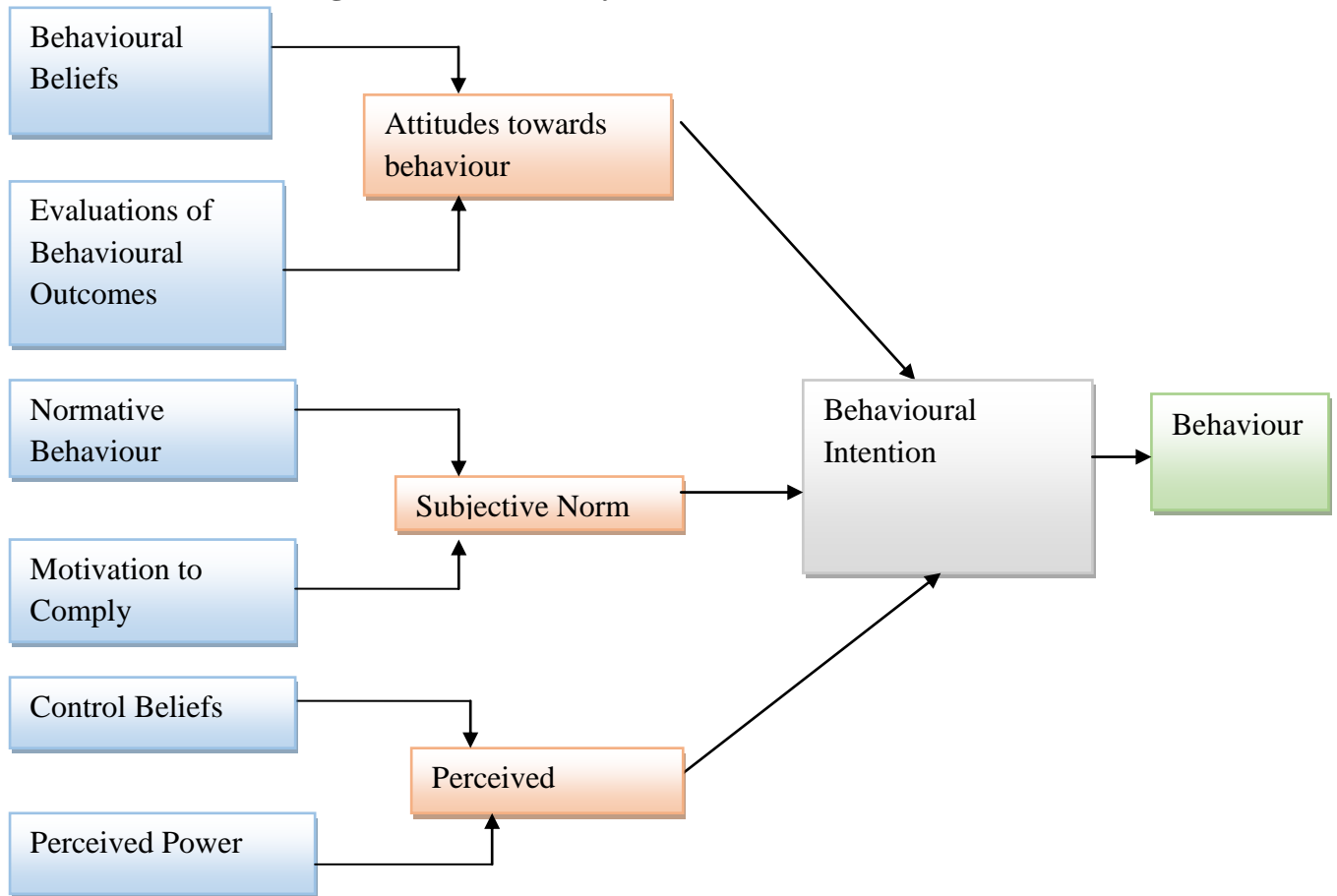
The Theory of Planned Behaviour is a theory about the link between beliefs and behaviour. It was first developed from the Theory of Reasoned Action created by Fishbein and Ajzen in 1975 to understand behaviour centred on the attitude construct (Ajzen, 1991). The theory improves on the predictive power of the Theory of Reasoned Action by including perceived behavioural control (Ajzen, 1991). The Theory of Planned Behaviour is conceptually similar to the Health Belief Model but it adds the concept of perceived behavioural control, which originates from self-efficacy theory, proposed by Bandura (Bandura, 1997). The HBM does

not cover the concept of attitudes and social influence and the TPB will explain that concept. This theory helps explain individual's intentions to engage in health behaviour (Ajzen and Fishbein, 1980). This model proposes that attitudes, subjective norms and perceived behavioural control, together with demographic and environmental factors, predict individual's behavioural intentions (Montaños and Kasprzyk, 2002).

The TPB assumes an individual to be a rational actor who weighs his or her decision toward performing the behaviour based on the attitudes, subjective norms and perceived behavioural control he or she might have regarding the behaviour. Behaviour is based on three types of behaviours. Belief about the expected or likely outcome (behavioural belief), beliefs about what others expect (normative beliefs) and beliefs about factors that exist that will either advance or block the performance of the behaviour resulting in the degree of perceived behavioural control (control beliefs). All these outcomes factors - attitude towards the behaviour, subjective norm, and perceived behavioural control - combine to determine the behavioural intention. Attitudes are influenced by individual's beliefs and to some extent by the norms and values (social influence). A young person who believes that desirable or good outcomes will result from performing the behaviour will have a positive attitude towards the behaviour. For example, a young person who has a strong belief that condom use reduces sexual pleasure will consider that to be a very undesirable outcome and will have negative attitudes towards condoms and thus less likely to use them. The attitude towards the behaviour is represented by the person's positive or negative feelings about doing the behaviour. The subjective norm is the individual's perception of whether others think the behaviour should be performed. Behaviour control is the individual's judgment around the ease or difficulty of performing the behaviour.

The concept of perceived control in TPB is similar to Bandura's concept of self-efficacy. Self efficacy is the belief or judgment that one can successfully perform behaviour under certain conditions. For example the confidence that one can use a condom, even in difficult situations when a partner does not want to use a condom

Figure 2:5: The Theory of Planned Behaviour

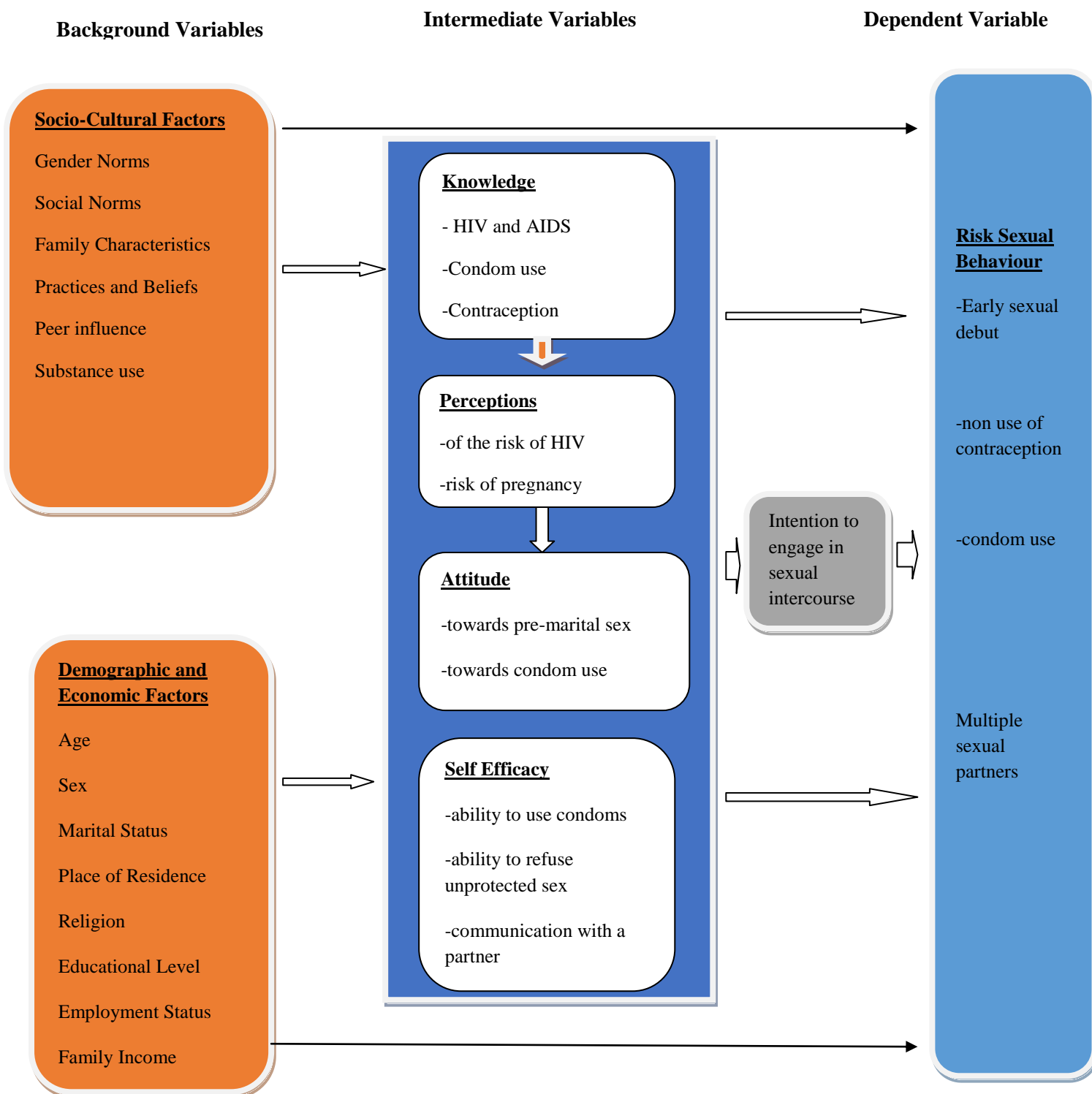


Source: Montañós and Kasprzyk, 2002

2.7 Conceptual Framework

The study's conceptual framework was developed using the HBM and TPB theories. The theory of Planned Behaviour assumes that young people's intentions to perform risky sexual behaviour is indirectly influenced through the individual's attitudes, subjective norms, and perceived behavioural control. The Health Belief Model (HBM) postulates that one's behaviour in relation to health is related to their perceptions of the severity of the illness, their susceptibility to it and the costs and benefits incurred in performing a particular behaviour (Bowling, 1997).

Figure 2:6:A conceptual framework for the study of risky sexual behaviours of youths



The study's conceptual framework is primarily based on the theory of planned behaviour by Ajzen (1991). It illustrates how the intentions to perform risky sexual behaviour of the youths under study are embedded in contextual aspects. The intentions are embedded in the contextual aspects through the determinants attitudes, subjective norms, and perceived behavioural control, according to the Theory of Planned Behaviour. The dependent variable in this study is risky sexual behaviour. The indicators of risky sexual behaviour are early sexual debut, number of sexual partners, use of condoms, multiple sexual partners and use of contraception. The independent variables of the study consist of:

Knowledge: This refers to young people's knowledge and beliefs regarding HIV and AIDS, condoms and contraception. Knowledge plays an important part in determining how young people perceive their risk and the subsequent engagement in the risk sexual behaviour.

Perception: This is the extent to which youths perceive their risk of infection with HIV/ STI and also getting pregnant.

Attitudes: This is the attitude of youths towards risk sexual behaviour. Attitudes of young people are influenced by the perceived consequences of risky sexual behaviour weighted by the value an individual places on the positive and negative consequences and also their knowledge regarding sexual matters.

Self-efficacy or Perceived Behavioural Control: This shows how youths perceive the ease or difficulty of performing a particular behaviour. Three variables were used to measure self-efficacy: self-efficacy in refusing sex, self-efficacy in communication with a partner, and self-efficacy in using a condom effectively.

All the above independent variables lead to an intention of engaging in a risk sexual behaviour which will result in the actual behaviour being done i.e. risk sexual behaviour. The model includes background variables which affect the intention of youths' engagement in risk sexual behaviours through the above intermediate variables. The background variables include the socio-cultural, economic and demographic factors. Factors included are respondent's age, sex, religion, employment status, education, family characteristics and peer influence.

2.8 Summary of Literature Review

The study has reviewed the literature on indicators of risk sexual behaviour and the factors facilitating risk sexual behaviours among youths. The literature has focused on empirical studies identifying the indicators of risk sexual behaviour which include multiple sexual partners, early sexual debut, non use of contraception. Factors associated with risk sexual behaviours were also established and included economic, socio-cultural, and demographic factors. These factors affect our dependent variable through the intermediate variables. The literature review also focused on the theories of planned behaviour and health belief model.

3 CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter gives a detailed description of the research methodology used in this study. The subsections of the research methodology discussed in this chapter include the study design, study area and population, sampling procedure, data collection (research methods and instruments), data analysis and research ethics.

3.2 Study Area

This study was conducted in Mufakose a high density suburb in the capital city of Zimbabwe, Harare. Mufakose is made up of wards 34, 35 and 36. It is located in the low income areas situated to the south western side of the city about 14 km out of the Central Business District. The suburb shares its boundaries with other high density suburbs which include Budiro, Kuwadzana, Crowborough North and Glenara as well as the high income suburb of Marimba. According the 2012 Zimbabwe National Census Harare Province has a population of 2 123 132, with a sex ratio in the province nearly 93 (ZIMSTAT, 2012). Mufakose has a total population of 55 462 and young people aged 15-24 years constitute 22% of the entire population (ZIMSTAT, 2012).

The area is selected because:

1. It is predominantly urban and its characteristics are influenced by western civilization and globalization. It is a high density suburb with all forms of poverty and remnants of traditional cultural practices mixed with flourishing cultural importation especially among the youths who have less cultural investment and superficial ties with the accepted traditional practices.
2. Mufakose accommodates people with different cultural backgrounds, norms, and values with a considerable diversity of socio-economic statuses.

3.3 Target Population

The study population was drawn from all young people age 15-24 who reside in Mufakose both in school and out of school. All young people residing in the residential area during the period of the survey were the target population for this study.

3.4 Research Design

3.4.1 Introduction

The study triangulated quantitative and qualitative methods to collect data among young males and females aged 15-24. A descriptive cross sectional survey was conducted to identify and describe the risk sexual behaviours among youths in Mufakose. Using a focus group discussion guide, focus group discussions were carried out to explore the various factors facilitating the risk sexual behaviours among youths aged 15-24. As indicated in the conceptual framework, an attempt was made to look at the influence of social, cultural and demographic factors on risk sexual behaviour and the relationship between knowledge attitudes and self-efficacy on risk on sexual behaviour.

3.4.2 Data Collection Method and Tools

3.4.2.1 Survey

A descriptive cross sectional survey was conducted with youths aged 15-24 years in Mufakose. A cross-sectional survey is a convenient method for obtaining information about knowledge, attitudes, and self-reported behaviour related to HIV spread (Coyle et al., 1991). A survey was used in-order to identify the risk sexual behaviours among youths and also to describe these risk sexual behaviours. A structured interviewer administered questionnaire was used to collect data from the respondents. Questions on the data collection instruments addressed variables related risky sexual behaviour, self efficacy, perceptions of risk and socio-economic factors influencing risky sexual behaviour. The questionnaire was designed in English because most young people in Zimbabwe understand English; however a Shona translation was readily available for respondents who are not proficient in English. A pre-test was conducted first on the questionnaire and revisions were made to make the necessary adjustments. A team of two research assistants were trained in preparation for the data collection and these assistants helped the researcher to conduct interviews with respondents. A representative sample of 135 young people was drawn among the population of young people aged 15-24 in Mufakose. Population figures and boundaries for wards and enumeration areas were obtained from the Zimbabwe National Statistics Agency. The data is based on the 2012 National Population Census. In determining the sample size the following mathematical procedure was used:

$$n = \frac{z^2 \times p \times q}{e^2}$$

Where:

n is the required sample size

p is the proportion of youths aged 15-24 in Mufakose to the population of Mufakose

$$q = 1 - p$$

e is maximum allowable error set at 0.05

z is the standard normal deviate set at 1.96 corresponding to 95% confidence interval

Total Population of Mufakose = 55462

Population aged 15-24 years in Mufakose = 12267

$$p = \frac{55462}{12267} = 0.2211$$

$$q = 1 - 0.22 = 0.88$$

$$n = \frac{1.96 \times 0.22 \times (1 - 0.22)}{0.05^2} = 134.7231989$$

Accordingly, the required sample size was 135 youths. Therefore a total of 135 interviews were carried out with youths aged 15-24 years.

3.4.2.2 Sampling strategy

Probability sampling methods were used to select the survey participants. Sampling methods used include simple random and systematic sampling. A multistage sampling technique was used and the sampling procedure is explained in stages below:

First stage: The first stage involved the listing and selection of all wards in Mufakose. This allowed all wards to be selected so as to capture the variability in Mufakose

Second Stage: All enumeration areas (EA) in each ward were listed and simple random sampling was conducted to select two enumeration areas in each ward.

Third Stage: All households in the selected EA were listed and systematic random sampling

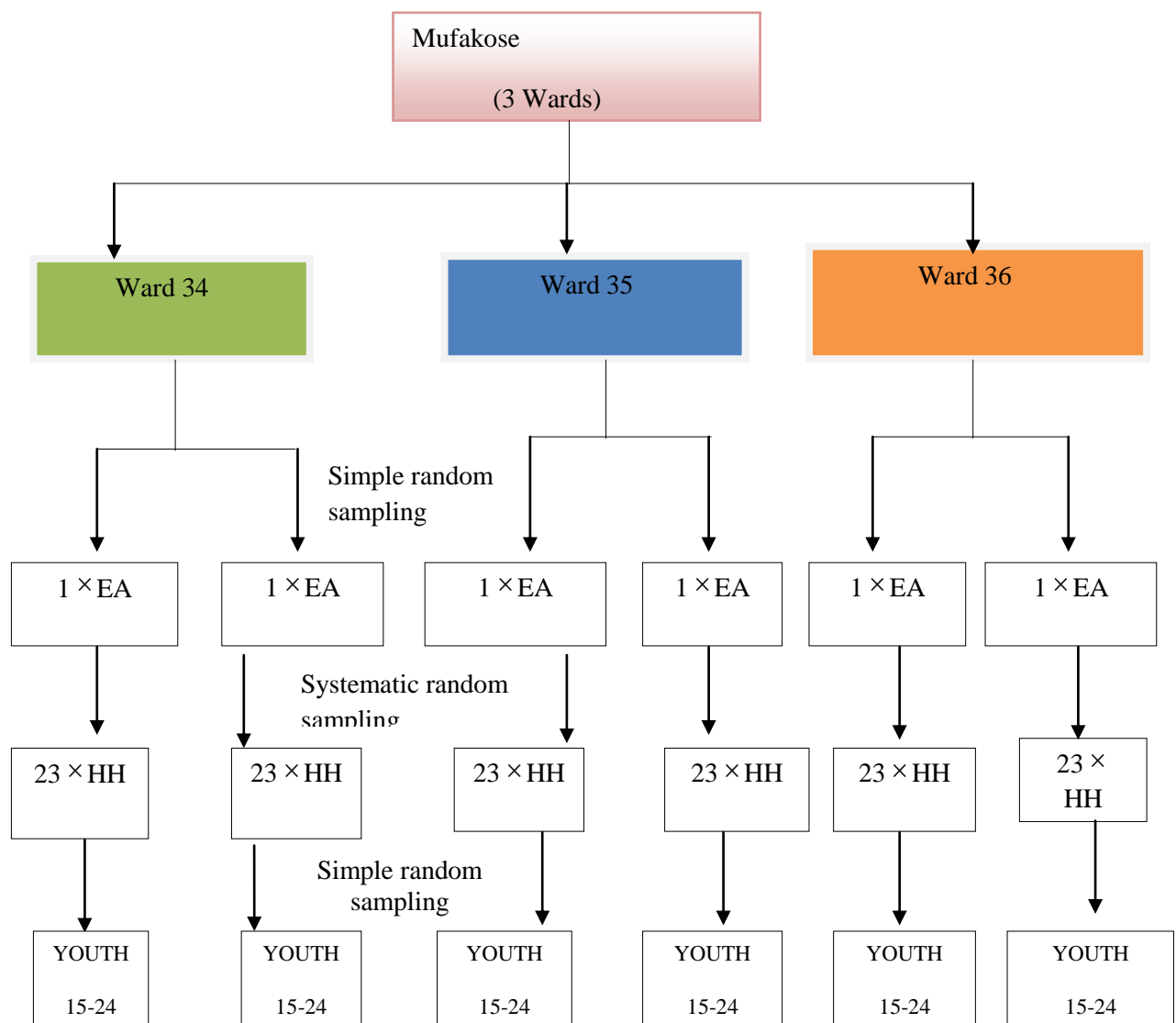
was used to select households (HH). A total of 23 households were selected in each EA.

Fourth Stage: In each selected household, all young people aged 15-24 and fulfilling the inclusion criteria were eligible for the study. Only one participant was eligible for interview. If there were more than one eligible participant in a household, simple random sampling was used to select one participant. If there was no eligible person in the household the next household was selected.

Inclusion / Exclusion Criteria

- A usual resident of Mufakose (A person who has lived in Mufakose for more than six months).
- Informed consent to take part in the study.
- Males and Females aged between 15 and 24 years.

Figure 3:1 Schematic Presentation of the Procedure Used to Select Study Participants.



3.4.2.3 Focus Group Discussion

Focus group discussions with young people in this study explored the following aspects of sexual risk behaviour: socio-cultural context, knowledge, attitude, views, perceptions and practices regarding risky sexual behaviours. FGD were held separately for males and females aged 15-24 to cater for free expressions of views during discussion of sensitive issues (Morgan, 2005). Each group had ten participants and the discussions with each group took at least 60 minutes. Focus Group Discussions were conducted using a FGD guide which was carefully structured in-order to enhance disclosure among participants. FGD's were conducted with two researchers, a moderator and a note taker. The moderator was responsible for guiding the discussion and began by explaining the purpose of the study and participants were assured of confidentiality in all they said during the discussion. Verbal consent was sought before the discussion. The role of the note taker involved taking down notes, observing and noting down on-verbal responses and making sure that tape recording was going on smoothly. Participants were purposively selected from survey participants using age and sex as selection factors. Only respondents who reported ever had sexual intercourse in the survey were selected for the focus group discussion because this group was most suited in responding to the research objective. All research instruments were originally in English but were translated to Shona the majority language to cater for respondents who do not understand English.

3.5 Data Management and Analysis

After the completion of data collection in the field, data management was done in Statistical Package for Social Science (SPSS) version 21. Data management involved editing, coding, data entry, cleaning. Data cleaning was done by scrutinizing frequencies and cross tabulation to check accuracy, outline, consistencies and missing values. Accordingly, incorrect entries were identified and re-entered. The study used univariate bivariate and multivariate analysis. Univariate analysis helps us to describe the frequency distribution of the respondents and their background characteristics. In Bivariate analysis cross tabulations of factors with the dependent variable was carried out and the chi square test was employed to test the association with the dependent variable. Furthermore, multivariate analysis was used to identify the determinants of risky sexual behaviour. Logistic regression is a multivariate analysis technique that is applied when the dependent variable is dichotomous taking values 1 and 0 when the event of interest occurs and did not occur respectively. In this study a

respondent takes a value of 1 if s/he engaged in a risky sexual behaviour and 0 otherwise. Each explanatory variable had a reference category (RC) which acted as the baseline variable to the particular factor. In logistic regression, the coefficient B represented the increase or decrease in the log odds of occurrences of an event (risky sexual behaviour) associated with a unit change in the independent variable controlling for possible confounding effect of all other variables. The term $Exp(B)$ expresses the multiplicative estimates in the odds of an event for a unit change in the independent variable keeping the effects of all other variables constant.

Assumptions have been tested such as multi-co linearity and goodness of fit test to effectively apply logistic regression. The Hosmer and Lemeshow is a model goodness of fit test which is based on accepting or rejecting the null hypothesis which states that “the model does not apply adequately”.

3.6 Ethical Consideration

This study was done in conformity with the ethical guidelines approved by the Centre for Population Studies, University of Zimbabwe. A formal letter from the Centre for Population Studies was used, to have access to the sampled households. Prior to the interview each respondent was given a detailed explanation of the objectives of the study and its significance. After explaining the objectives of the study verbal and written consent was obtained from all respondents prior to their participation in this study. Furthermore, investigators informed the participants that their participation in the study is voluntary and that they are not obliged to answer to any questions with which they are uncomfortable. They were also free to withdraw their participation from the study at any time they want. Respondents were assured that confidentiality would be maintained and that the completed questionnaire will not bear the respondent's name.

4 CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter gives a presentation of the study findings. The aim of the study was to explore risky sexual behaviours and related factors among youths in Mufakose, Harare. Descriptive statistics such as frequencies, percentages, pie charts and bar graphs are used for data presentation. The chapter begins with a discussion of the socio-economic and demographic characteristics of the respondents in the survey. Furthermore, the association of risky sexual behaviours of young women and men with selected factors will be presented using bivariate analysis methods with chi-square distribution as well as binary logistic regression methods to test for the statistical significance.

4.2 Descriptive Statistics

This section presents descriptive statistics such as frequencies, percentages and means. Pie charts and graphs were used in this section to give a detailed description of the characteristics of the study population. They allow for clear presentation of results that can be easily understood by everyone.

4.2.1 Demographic and Social Characteristics of the Respondents

The study consisted of a total of 135 respondents, among them youths in and out of school, aged between 15 and 24 years. Respondents were fairly distributed among the two sexes as shown in Figure 4.1.

Figure 4:1 Percentage Distribution of Respondents by Sex

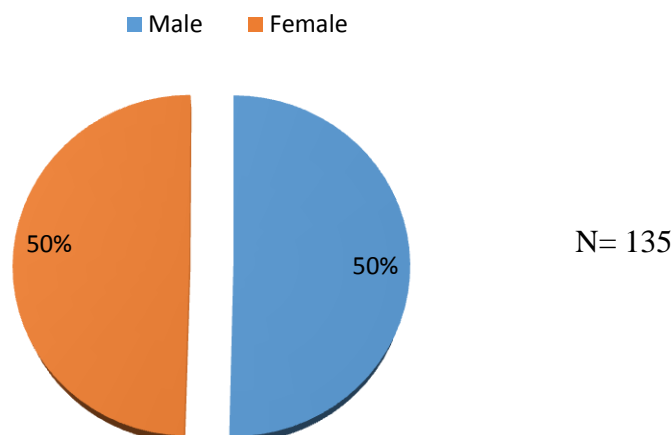


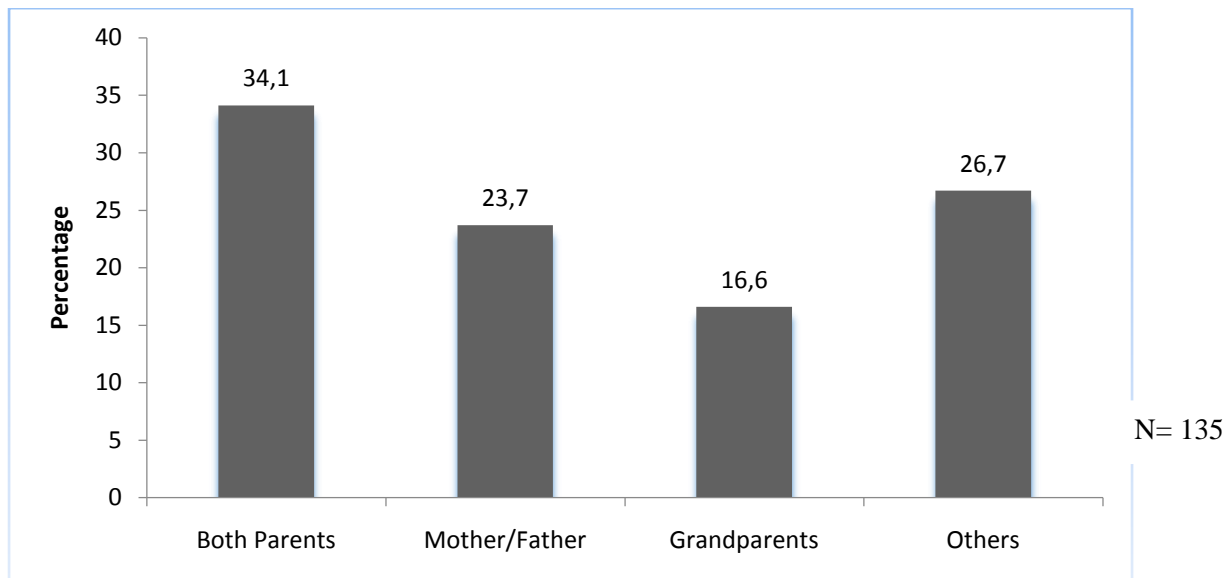
Table 4.1 presents the socio-demographic characteristics of the respondents. The majority of the respondents were aged 20-24 years, constituting 59.2% of the entire sample. Adolescent girls aged 15-19 constitute 44.9% of the female population. The mean age among respondents was 20.0 years. Among the 135 respondents, 79.3% were never married while 11.1% were married and 9.6% were divorced. The majority of the respondents indicated secondary level as their highest level of education completed (70.4%), whilst 17.8% attained primary education and 11.8% had completed tertiary education during the time of the survey. A quarter of the females (25.4%) had primary education as compared to 10.3% of males. Most males had secondary education (79.4%) whilst 61.2% of women had secondary education. Unemployment was very high among the youths with 82.2% of them not employed. The majority of the respondents were Christians with the most respondents being Pentecostals (43%), while the remainder consisted of protestant (11.8%), Roman Catholic (18.5%), apostolic sects (15.6%), Muslim (2.2%) and those with no religious affiliation (8.9%). A higher proportion of young men (14.7%) reported no religion compared to their female counterparts (3%).

Table 4:1 Socio-Demographic Characteristics of the Respondents by Sex

Sample Characteristic	Male	Female	Total
Age			
15-19	36.8	44.9	40.8
20-24	63.2	55.1	59.2
Marital Status			
Never Married	88.2	70.1	79.3
Married	4.4	17.9	11.1
Divorced	7.4	11.9	9.6
Level of Education			
Primary	10.3	25.4	17.8
Secondary	79.4	61.2	70.4
Tertiary	10.3	13.5	11.8
Employment Status			
Employed	19.1	16.4	17.8
Not Employed	80.9	83.6	82.2
Religion			
Pentecostal	35.3	50.7	43.0
Protestant	14.7	9.0	11.8
Roman Catholic	20.6	16.4	18.5
Apostolic Sects	13.2	17.9	15.6
Muslim	1.5	3.0	2.2
No religion	14.7	3.0	8.9
Total (Number)	68	67	135
Total (%)	100.0	100.0	100.0

On living arrangements, as shown in Figure 4.2, 34.1% of the youths stayed with both parents, while 23.7% lived with mother or father, 16.6% with grandparents, and the remainder lived with their aunt/uncle, brother/sister/self or husband or wife (26.7%).

Figure 4:2 Percentage distribution of Living Arrangements among Respondents.



In terms of orphan-hood, 25.9% of the youths lost their mothers and 31.1% lost their fathers. The mean number of people who share the same room at night with respondent was two. The majority of the youths, (74.1%) go to clubs or parties where young people dance and mingle with others. Young men reported frequenting these places more than young women 64.7% and 31.9% respectively. More than half of the respondents (51.9%) have never drunk alcohol, smoke or take any drugs.

4.2.2 Sexual Behaviours and Practice

A significant proportion of youths were sexually experienced (See Table 4.2). The results revealed that about 70% of the youths had had sexual intercourse. Sexual experience was almost the same across sexes, with 70.6% and 68.7% among males and females, respectively.

Table 4:2 Percentage Distribution of Sexual Intercourse by Sex of Respondent

	Male	Female	Total
Had Sex	70.6	68.7	69.6
Never had Sex	29.4	31.3	30.4
Total (Number)	48	46	94
Total (%)	100.0	100.0	100.0

The mean age at first sexual intercourse among the youth was 17.5 years (17.5 years for males and 16.7 years for females). More than half the participants (57.4%) reported to have experienced sexual intercourse before the age of 18, which shows early initiation of sex. During focus group discussions, both males and females participants highly acknowledged that most youths initiated sex before the age of eighteen years. Youths in Mufakose start having sex from as early as 12 years.

Table 4.3 describes the sexual behaviours and practices of the respondents. The majority of the sexually active youths had sex before the age of 20 years (86.2%). In terms of number of life time partners nearly half of the sexually active youth (43.6%) had more than three sexual partners in their lifetime. Almost a third of the respondents (27.7%) had one life sexual partner. A small proportion of the sexual experienced youth (16%) abstained from having sex during the last 12 months. Nearly half of the sexually experienced youths (45.7%) had one sexual partner in the last 12 months while 38.3% had two or more sexual partners. Twenty two percent of the youths paid or were paid to have sex at some point in their lives. Nearly a third of females (30.4%) were paid to have sex while 14.6% of the males paid to have sex. More than a third of the respondents (36.2%) had sex under the influence of alcohol. (About a fifth of the sexually experienced youths (17.0%) reported being forced to have sex at some point in their lifetime. More females reported being forced to have sex (28.3%) than males (6.3%).

Table 4:3 Percentage Distributions of Selected Sexual Variables by gender

Variable	Male	Female	Total (%)
Age at First Sexual Intercourse			
Less than 16	14.6	8.8	11.7
16-19	71.1	71.7	74.5
20-24	8.3	19.5	13.8
Lifetime number of partners			
One partner	25.0	30.4	27.7
2 or 3 Partners	31.2	26.0	28.7
More than three	43.8	43.6	43.6
Sexual Activity in the last 12 Months			
No Sexual Partner	16.7	15.2	16.0
One partner	50.0	41.3	45.7
Two or more partners	66.7	43.5	38.3
Ever Paid for Sex			
Paid	14.6	30.4	22.3
Never Paid	85.6	69.6	77.7
Ever sex under influence of alcohol/drugs			
Ever had	33.3	39.1	36.2
Never had	66.7	60.9	63.8
Forced Sex			
Forced	6.3	28.3	17.0
Never Forced	93.8	71.7	83.0
Total (Number)	48	46	94
Total (%)	100	100.0	100.0

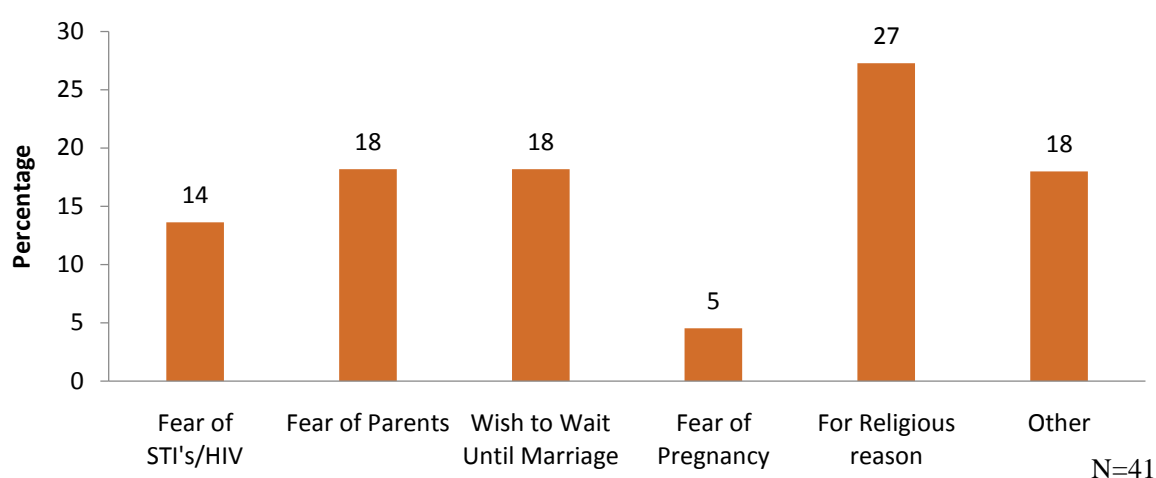
During focus group discussions with young women, they highlighted that they were not forced to have sex per-se but were tricked or coerced into having sex, especially by their boyfriends.

The majority of the respondents (80.9%) had first sexual intercourse with either a boyfriend or girlfriend. Others however, had first sex with a commercial sex worker (5.3%), one night stand (3.2%), and forced sex by stranger or relative (3.2%) and with other people (1.0%).

Sexual intercourse was mostly unplanned among the youths as 71.3% of the respondents reported that their first sex was unexpected. The same finding was affirmed during group discussions with both males and females. They said that most of their sexual acts, especially the first one, will not be planned. They further stated that it usually happens when they are alone, for example after watching a movie. In a group discussion with females, they claimed that males plan well ahead as most girls are tricked into having sex.

Several reasons were highlighted for engaging into sex and these include the need to experiment, peer pressure and poverty. Youths engage in sex for different reasons, these are to test what it feels like, for enjoyment and they are forced by their peers. For females the reason for sexual intercourse is to get money to support themselves or their family economically. Youths, who were not sexually experienced, reported that the main reason for not having sex was religious beliefs, fear of pregnancy, among other reasons as shown in Figure 4.3.

Figure 4:3. Percentage distributions of Reasons for not engaging into sex



4.2.3 Knowledge, Attitudes and Perceptions towards STI's, HIV and AIDS

According to the Theory of Planned Behaviour, the intentions of the youths to engage in risky sexual behaviour are embedded in contextual aspects. Knowledge of HIV and AIDS issues and related sexual behaviour among youths aged 15-24 has particular interest because the period between sexual initiation and marriage is for many young people a time of sexual experimentation that may involve high- risk behaviour (CSA and ORC Macro, 2006). In the conceptual framework, knowledge was expected to play an important part in determining how young people perceive their risk and the subsequent engagement in the risky sexual behaviour. The study assessed the knowledge of youths on HIV and AIDS, other STI's, condoms and contraception.

HIV and AIDS knowledge was universal among the youths. This was highlighted during focus group discussions as they reported that because young people receive HIV and AIDS lessons at school. Knowledge levels were also high on issues related to HIV and AIDS; 27.4% of the respondents think it is possible to cure HIV and they claim that it can be cured through prayers at church. More than a third 36.3% of the respondents believes that a person infected with HIV always looks unhealthy in some way. However, 55.6% reported that it is not always the case. Most of the respondents 68.1% have correct knowledge about HIV testing whilst 11.9% do not know about HIV testing.

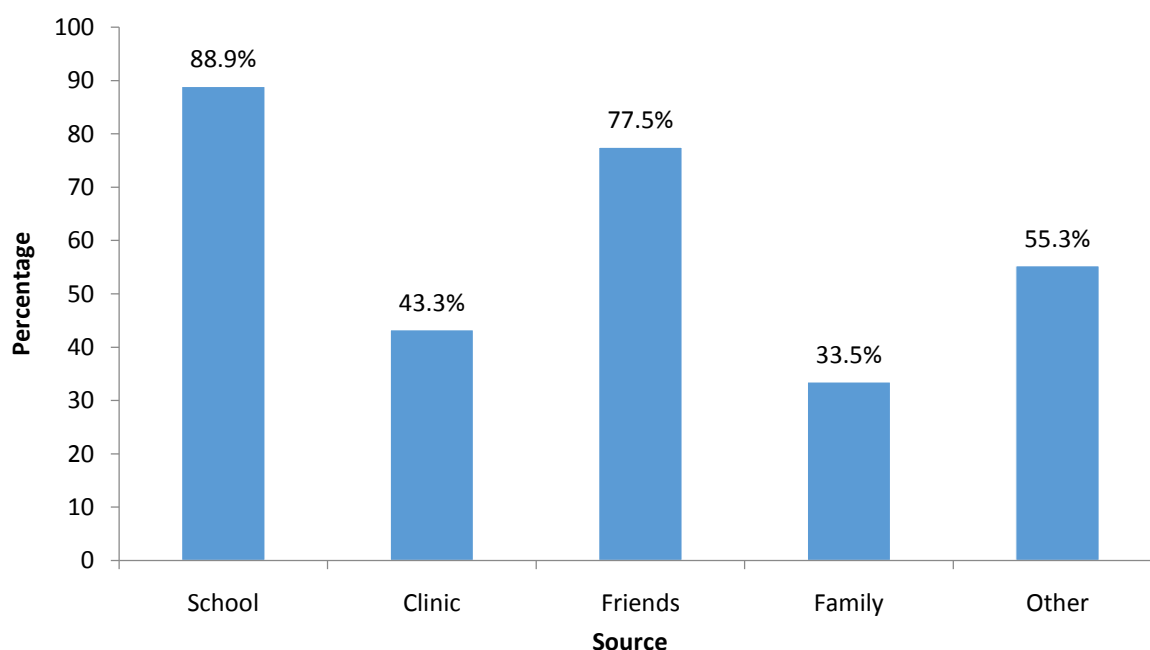
Figure 4.4 presents the sources of information on HIV. The major source of information on HIV and AIDS was school (88.9%). Others sources include friends (77.5%), clinic(43.3%), family (33.5%) and other sources (55.3%). During the focus group discussions, other sources of knowledge and information cited include close friends, school subjects, parents, church gatherings, magazines, movies, radio programmes and the clinic. The following remarks also came from the FGD in regards to their knowledge of HIV and AIDS:

“We hear a lot of things being said by our brothers and sisters and from them we learn a lot of things”.

A female from a FGD said:

“I stay with my mother and she sends me to buy her contraceptive pills regularly and that’s how I end up knowing what they are and where I can find them. I also share that information with my friend”.

Figure 4:4 Sources of Information on HIV



Knowledge about sexually transmitted infections (STIs) was high among youths in Mufakose as reported by 86.7% of the respondents who acknowledged knowing what an STI means. Females had better knowledge of STIs (96%) compared to men (78%). Knowledge of HIV and AIDS was high among the youths as compared to knowledge of STIs and this also emerged during the focus group discussions. During the FGD among young males, they highlighted their better knowledge of HIV and AIDS than STIs to the attention given to HIV and AIDS issues in school, radio, television and print media. Other sources of information that emerged during discussion are older brothers whom they share rooms with.

4.2.4 Knowledge and Ever Use of Contraceptive Methods

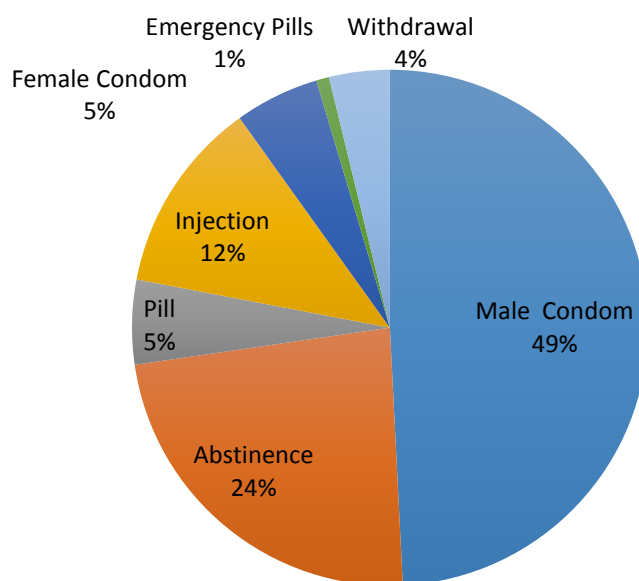
Table 4.5 presents the knowledge of contraception and contraceptive methods among the youths. Knowledge of contraception was almost universal as 97.8% of the respondents reported that they knew or had ever heard about contraceptive methods. Knowledge about specific methods showed that the male condom was the most known method among the youths (98.5%), followed by the Pill (89.4%). Other methods known include abstinence (84.1%), female condom (83.4), withdrawal (71.9%), injection (71.2%) emergency pill (47.7%) and sterilisation (40.2%).

Table 4:4 Percentage Distribution of Youth's Knowledge of Contraception by Sex

	Male	Female	Total
Knowledge about Contraception			
Yes	98.5	97.0	97.8
No	1.5	3.0	2.2
Knowledge of Contraception by Method			
Pill	42.4	47.0	89.4
Injection	36.4	34.8	71.2
Male Condom	50.8	47.7	98.5
Female Condom	41.7	41.7	83.4
Emergency Pill	19.7	28.0	47.7
Withdrawal	34.8	37.1	71.9
Abstinence	39.4	44.7	84.1
Sterilisation	25.8	14.4	40.2

More than half of the respondents (53.3%) reported that they had used contraceptive methods during their first sexual encounter. The male condom was the most used method of contraceptive (75.9%). The majority of the respondents (49.2%) think that the male condom is the most suitable contraceptive method among young people. Other suitable method mentioned include: abstinence (23.5%), pill (5.3%), injection (12.1%), female condom (5.3%), emergency pills (0.8%) and withdrawal (3.8%)(See Figure 4.5).

Figure 4:5 Percentage Distribution of Most Suitable Contraceptives Methods among Youths



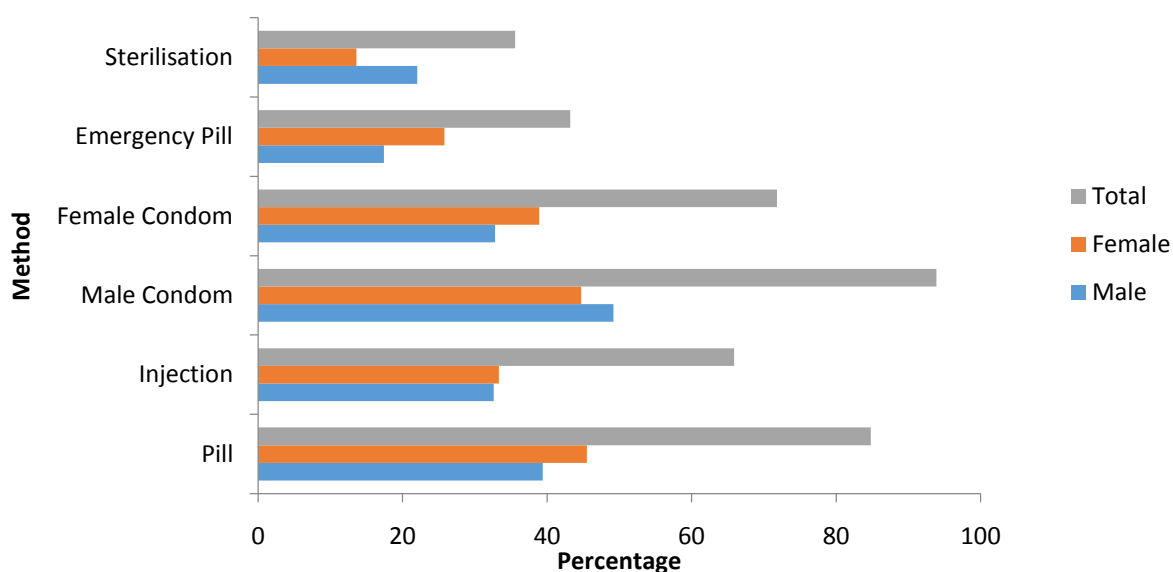
On sources of information about contraception, schools were cited as the major source of information on contraceptives (52.3%), followed by friends (44.7%). Other sources of information include health centres (31.8%), religious places (6.8%), family (20.3%), shop/pharmacy (10.6%) and others source (6.1%).

During focus group discussions, young people reported that they got their knowledge on contraceptives from within the community. Females got some of their information from their boyfriends who usually initiate sex. The following remark was said by a participant among a focus group discussion with male:

“Sometimes we hear this information from older brothers when we are sleeping at home. You often hear them discuss about condoms and how to use them with their friends. Information is also acquired in other places known as ‘mikoto’(secluded places) in local slang language”

Other sources of information that were mentioned during FGDs include television, radio, magazines, friends and police officers at school.

Figure 4:6. Percentage Distribution of Knowledge of Contraceptives methods by Sex



Knowledge levels on each contraceptive method were assessed among the youths. Figure 4.6 shows the knowledge of the different contraceptive methods among men and women. Male condom (93.9%) was the most known method among male and females, followed by the pill (84.4%) and the injection (65.9%). Sterilisation was the least commonly known method among youths (35.6%). However, among males the emergency pill (17.4%) was the least common while among females sterilisation (13.6%) was the least commonly known method of contraception. Knowledge about contraceptives methods seem to be associated with who is in control among the respective methods differs with sex. Knowledge of the pill is higher among females than males at 45.5% and 39.4% respectively. A quarter of the females 25% had knowledge about the emergency pill as compared to 17.4% among males. In addition to that knowledge of the female condom is 38.9% among females and 32.8% among males. On the other hand knowledge of the male condom (49.2%) is higher amongst males than females (44.7%).

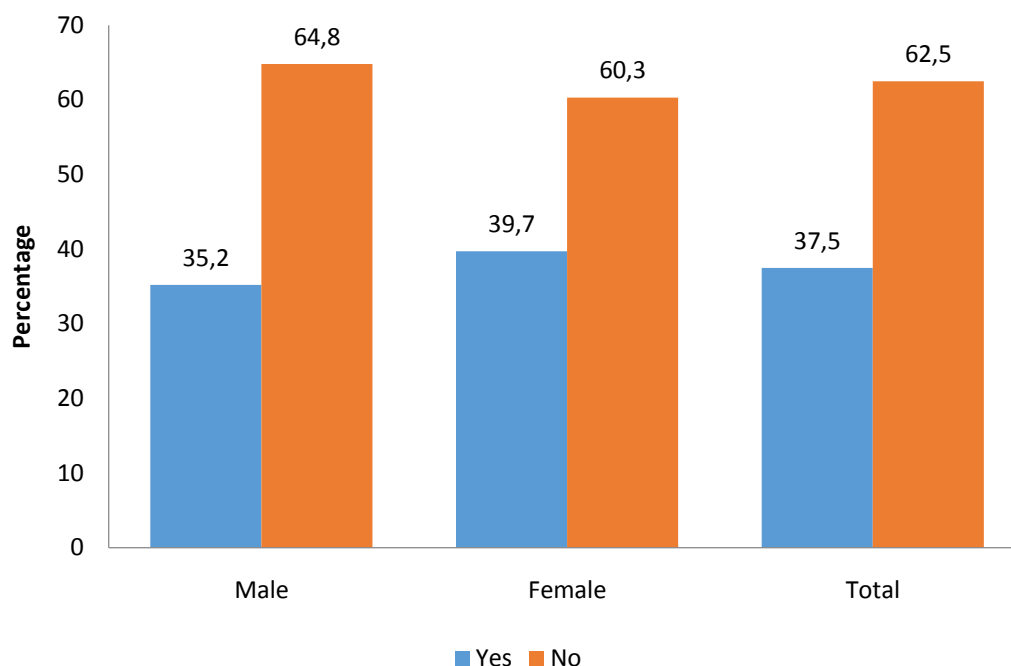
4.2.5 Condom Knowledge and Attitudes

According to UNAIDS (2014), condoms reduce the risk of acquiring HIV by at least ninety percent. Condom use is therefore considered a good measure of safe or unsafe sexual behaviour as this shows how much risk one has in contracting HIV. According to the Theory of Planned Behaviour, attitude towards the behaviour, subjective norms, and perceived

behavioural control, combine to determine the behavioural intention. Attitudes are influenced by individual's beliefs and to some extent by the norms and values (social influence). Knowledge and attitudes towards condom use were explored in this study because they can affect risky sexual behaviour via the perceived behavioural control.

Results show that male condoms were well known by every respondent in this study. Figure 4.7 shows the percentage distribution of youths who used condoms during their last sexual act. More than a third of the youths (37.5%) reported ever using a condom during their last sexual act. More females reported using the male condom during their last sexual encounter than males 39.7% and 35.2% respectively.

Figure 4:7 Condom Use at Last Sexual Encounter

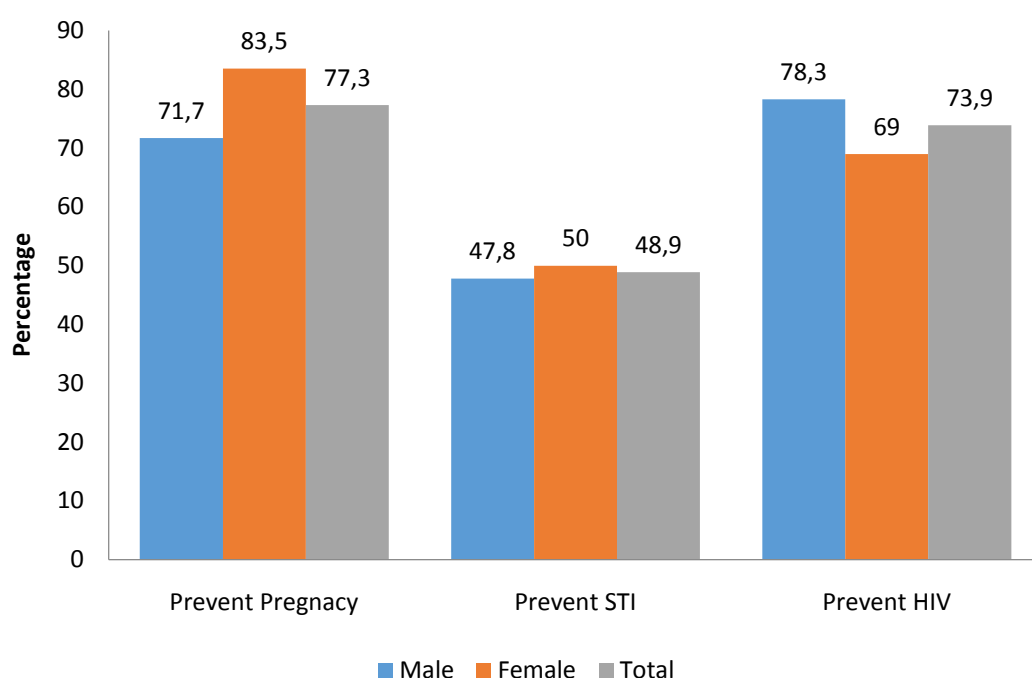


N=84

Figure 4.8 shows the percentage distribution of the reasons for using the male condom. Reasons cited for using condoms among the youths were to prevent: pregnancy(77.3%), STI's (48.9%) and HIV (73.9%). In terms of knowledge, the youths showed comprehensive knowledge about condoms. The majority of them agreed that condoms are an effective

method of preventing pregnancy, STI's and HIV and AIDS (78.5%). The majority (81.5%) also disagreed with the fact that condoms can be used more than once.

Figure 4:8 Reasons for using Male Condoms



N=57

However, most of the respondents were not comfortable with condom use by the sexually active youths. Almost half of the youths (48.9%) feel that it is too embarrassing for them to be seen buying condoms while 46.7% believe that if girls suggest using condoms, then it means she does not trust her partner. Youths showed a negative attitude towards condom use as more than half (51.9%) believe that condoms reduce sexual pleasure.

This was also highlighted during FGDs among young men by the following remark:

“Young men do not use condoms during sex because it takes time to negotiate for sex and therefore trying to wear a condom might result in the girl refusing to have sex. At the end I will end up having sex without the condom, ‘ndinofa ndanakirwa’ (I would rather die after enjoying myself)”

Young women also share the same views with their male counterparts on condoms. They have a negative attitude towards condoms because they feel that condoms are used mainly with prostitutes, therefore if they allow their boyfriends to use condoms on them they will be treated as prostitutes. Their major reason for refusal to use condoms is that they do not want to be used by the boys.

Nearly two thirds of the respondents (63.7%) disagreed or were not sure if condoms were suitable for steady relationships. During focus group discussions with both male and females, they pointed out that most young people perceive themselves as having steady and loving relations in which the use of condoms during sex is not acceptable. They said after dating for a long time they develop trust and will be more comfortable with each other to an extent of having sex without any form of protection.

4.3 Self-Efficacy

Self-efficacy or perceived behavioural control is an important predictor of behaviour as explained by the Theory of Planned Behaviour. If self-efficacy is very high, behaviour is more likely to happen. The study looked at self-efficacy in refusing sex, abstaining after experiencing sex, negotiating condom use and communicating with a sexual partner

4.3.1 Self- efficacy in refusing sex

Table 4.5 shows the self-efficacy among young people. Almost a third of the respondents (31.1%) had low self-efficacy in refusing sex, while 33.3% had high self-efficacy and 35.6% were moderate in-terms of refusing sex. Self-efficacy was very high among youths who were not sexually experienced (77.2%) as compared to sexually experienced youths (24.6%). Self-efficacy was different among sex with males reporting low self-efficacy in refusing sex (22.3%) when compared to women (54.9%). This also came out during focus group discussions with young men. Refusing sex was highlighted as a difficult action to take. The following comments were made by participants in the FGDs:

“If my girlfriend asks me to have sex, I will start removing my clothes and kissing her before she even finishes the word sex...”

“If my girlfriend suggests that we have sex, I will start calling my friends to ask for a base(place to have sex) at their place so that we can have sex. If you refuse to have

sex, you will be labelled a fool and the girl will walk around Mufakose telling everyone 'kuti wakasticker' (that you were afraid)''

During the same discussion, young men also mentioned that it is not possible to refuse sex because girls expect them to have sex with them. As friends, they would be in a competition to see who is going to have more sexual partners at the end of the year. Therefore, if an opportunity to have sex presents itself, they will not be able to refuse otherwise they will lose the context to their friends. One of the participants among a FGD with young females remarked:

"Sometimes, as a girl, you do not want to have sex, therefore you refuse at first but because of circumstances you end up agreeing to have sex at the end of the day"

Another factor that was brought forward which makes it difficult girls to refuse sex was poverty. A female participant explained how girls end up having sex in the following remark:

"As a young woman, you will be looking for money for clothes, going to hair salon food, and the guy just needs sex. Therefore, the logical thing to do will be to meet in between and have sex for money"

Another discussant weighed in and added that:

'At first you refuse sex because you are afraid of getting pregnant or you fear being portrayed as loose, but the guy will tell you to leave his house if you do not want sex. It then becomes difficult for a girl to stand up and go because they would be away from home and also shy to leave after going into the boy's bedroom knowing very well that chances would be high that they might have sex'

Sixteen percent of the youths had low self-esteem in sticking to one partner for three months, 42.2% had moderate levels while 41.5% had high levels. Nearly a third of the youths (30.4%) had low self-efficacy in abstaining for a period of three months while 40.7% and 28.9% had moderate and high levels of self-efficacy, respectively. Young men were more likely to have high self-esteem in sticking to one partner (65.7%) than young women (43.9%)(not in table)

Table 4:5 Self efficacy and the Intention to Practice Safe Sex

Variable	Self Efficacy		
	Low	Moderate	High
I can abstain from sex even if I have had sex in the past,	31.1	35.6	33.3
I am sure I will stick to one partner in the next 3 months,	16.3	42.2	41.5
I plan to abstain in the next 3 months.	30.4	40.7	28.9
I am certain that I know how to use a condom correctly.	35.5	31.9	32.6
I will try my level best to use condoms if I have sex.	17.0	48.9	34.1
I can talk to the person with whom I have sex about using condoms.	9.6	56.3	34.1
I feel confident telling someone I am dating that I am HIV positive.	53.4	28.1	18.5
I am confident that I can have safer sex.	17.0	47.4	35.6

4.3.2 Self-efficacy in Condom Use

Table 4.5 also shows self-efficacy in condom use among the youths. The youths have high self-efficacy in using condoms. Nearly half of the youths (48.9%) had moderate self-efficacy, 34.1% high self-efficacy and 17.0% had low self-efficacy in using condoms if they have sex. More than a third (35.5%) had low self-efficacy in using a condom correctly while 31.9% and 32.6% had moderate and high self-efficacy, respectively. Self-efficacy in condom use was high among males 83.2% had high self-efficacy, 10.4% moderate and 6.4% had low self-efficacy. More than half of young women (50.7%) had low self-efficacy in condom use, 23.9% and 25.4% had moderate and high self-efficacy in condom use, respectively.

Youths believe that they can negotiate for condom use with their partners prior to sex. Thirty-four percent of the youths had high self-efficacy in negotiating condom use before sex, 56.3% had moderate efficacy while the remainder (9.6%) had low self-efficacy. More than half of the youths (53.4%) do not have the self-efficacy to tell their partners their HIV status, 18.5% had high self-efficacy while 28.1% reported moderate self-efficacy in disclosing their HIV status to partners. Youths had high self-efficacy in practising safe sex (35.6%) and 47.4% had moderate self-efficacy while 17.0% had low self-efficacy.

4.4 Perceptions of Risks

Perceptions about risk are a major determinant of risky sexual behaviour. The Health Belief Model suggests that health-related behaviour is affected by a person's perceived

susceptibility to a particular illness. The study looked at how youths perceive their risk of contracting HIV and getting pregnant. It was expected that if an individual perceives him/herself to be at a greater risk of contracting HIV, an STI or getting pregnant, he/she will take steps to avoid risky sexual behaviour. Perceptions are closely related to self-efficacy as explained by the Theory of Planned Behaviour.

4.4.1 Perceptions of Risk to HIV

The majority of the youths (69.0%) perceived themselves not at risk of HIV. However, among the sexually experienced youths, 33% perceived themselves not at risk. Among the sexually experienced youths, 44.7% of them were concerned about contracting HIV. Three-quarters of these youths did something to avoid pregnancy. Condoms were used by the majority of the sexually active youths to prevent pregnancy (95.8%) while 12.5% reported taking herbal medicines. None of the youths went for an HIV test prior to engaging in sexual intercourse.

4.4.2 Perceptions of Risk of Pregnancy

Perceptions of risk of pregnancy among sexually experienced young females showed that 63.8% perceived themselves not to be at risk of getting pregnant. Eight-five percent of the sexually experienced youths were able to do something to reduce the risk of getting pregnant. The majority of them used condoms (84.8%), contraceptive pills (21.7%) and other contraceptive methods (13%). A quarter of the respondents had been pregnant or had made someone pregnant. Among those who got pregnant, 32.4% of them had an unwanted pregnancy.

4.5 Factors associated with Risky Sexual Behaviour: Bivariate Analysis

Bivariate analyses were used to determine the statistical significance of various demographic and socio-economic factors on sexual risk behaviour among youths. Cross tabulations of the two variables with chi-squared test were used to show the status of the relationship of each factor to sexual risk behaviour. The chi-square was also employed in the bivariate analysis to identify the statistical significance of the association between the two variables, by using a predetermined standard level of significance (0.05%).

4.5.1 Individual Characteristics and Sexual Risk Behaviour of Youths

The bivariate analysis for the youths' socio-economic and demographic characteristics revealed that age, religious attendance and schooling status of the respondents have significant relationship with respondents practising risky sexual behaviours. But, variables such as sex, religion, level of education and employment status do not have significant relationship with the dependent variable (See Table 4.6).

Of the youths interviewed, 37.8% reported engaging in risky sexual behaviour. Table 4.8 shows the proportion of young people who engaged in risky sexual behaviour by each background characteristics. Risky sexual behaviour was significantly associated with age. Risky sexual behaviour increases with increasing age among young people. Youths aged 20-24 were more likely to engage in risky sexual behaviour (39%) than those aged 15-19(12%)($p<0.05$). Young people attending school are significantly less likely to engage in risky sexual behaviour (28.2%) when compared to youths out of school(48.4%)($p<0.05$).

This was highlighted during a FGD with young men:

“After we finish school and you are not employed you spend most of your time at home and you do not have anything to do. At the end, you are forced to look for a girlfriend and have sex for fun. This is not the case if you are going to school because you will have homework and other school-related things to be worried about”

On the other hand, educational level was not significantly associated with risky sexual behaviour. Even though religion does not have a statistically significant association with sexual risk behaviour of youths; religious attendance has been found to have a significant association. Religious attendance was found to have an association with the sexual behaviour of youths ($p<0.05$). Youths who attended religious services once a month were more likely to engage in risky sexual behaviour (62.5%) than those attending services more than once a week (23.4%) or once a week (40.3%) ($p<0.05$). Employed youths were more likely to engage in risky sexual behaviour (45.8%) compared to the unemployed(36%). Employment status is not significantly associated with risky sexual behaviour among the youths (Table 4.8)

Table 4:6 Bivariate Analysis of Demographic Characteristics and Sexual Risk Behaviour

Background Characteristic	Sexual Risk Behaviour			Chi Squared	p-value
	No Risky Behaviour	Risky Behaviour	Number		
Sex					
Male	63.2	36.8	68	0.60	0.807
Female	61.2	38.8	67		
Age				21.90	0.01
15-19	78.1	21.9	55		
20-24	51.1	48.9	80		
Schooling Status				5.883	0.015
In School	71.8	28.2	71		
Not in School	51.6	48.4	64		
Level of Education				3.12	0.21
Primary	70.8	29.2	24		
Secondary	63.2	36.8	95		
Tertiary	43.8	56.3	16		
Religion				7.80	0.10
Pentecostal	60.3	39.7	58		
Protestant	68.8	31.1	16		
Catholic	68.0	32.0	25		
Apostolic Sects	76.2	23.3	21		
No Religion	33.3	66.7	15		
Religiosity				9.514	0.02
More than once a week	76.6	23.4	47		
Once a week	59.7	40.3	67		
Once a month	37.5	62.5	8		
Never	38.5	61.5	13		
Employment Status				0.806	0.369
Employed	54.2	45.8	24		
Not employed	64.0	36.0	111		
Total	62.2	37.8	135		

4.5.2 Socio-Economic and Living Arrangement Factors

Table 4.7 shows the association between socio-cultural factors and risky sexual behaviour using bivariate analysis. Overall, risky sexual behaviour is significantly associated with attending parties, drinking or smoking, sleeping arrangement and household. However, family structure is not associated with risky sexual behaviour.

Risky sexual behaviour is significantly associated with going to parties or clubs. Youths who attended parties or clubs were more likely to be involved in risky sexual behaviour (43.3%) than those who did not attend (22.9%) ($p < 0.05$). This also emerged during FGDs.

“Our environment here in Mufakose leads us to some of these things, there are parties all over the neighbourhood popularly known as ‘pasapasa’, you meet girls in the middle of the night and we end up engaging in sex”

“There are brothels and ‘shebeens’ around full of commercial sex workers and because of these frequent power cuts, we go to those places for entertainment and maybe something more”

Taking drugs and alcohol was statistically significantly associated with risky sexual behaviour among youths. Youths who neither drink nor smoke were less likely to engage in risky sexual behaviours (20.0%) when compared to youths who drink and smoke (56.9%) ($p < 0.001$). During focus group discussions, both male and females agreed that alcohol and drugs have an effect on the sexual behaviour of young people in Mufakose. This is a remark from a male participant in one of the FGDs

“Young people, especially boys, take drugs such as bronco, histallix and mbanje, they act as confidence boosters and we end up doing whatever we feel. This is mainly due to peer pressure most of the time”

Sleeping arrangement was statistically significantly associated with risky sexual behaviour. Youths who do not share their room with another person or who stay alone were more likely to engage in risky sexual behaviours (50.0%) when compared to youths who share a room with one person (31.1%), two other people (47.5%) and more than three other people (25.0%) ($p < 0.05$).

Focus group discussions also confirmed that young people who stay alone or who have a room of their own are at a greater risk of being involved in risky sexual behaviour. A male participant from a FGD supported this statement by the following remark.

“I stay alone and I have all the freedom to do as I please. Even if I want my girlfriend to sleep over at my place, I do not need to seek any permission from someone”.

Another male participant from the focus group discussion said the following:

“In some instances, youths visit each other at their places they end up in their boyfriends or girlfriend’s room. In these rooms, it is very difficult to avoid sex. This is different in the case where they are sharing rooms with others, they must first of all

secure a place to meet, which is commonly known among them as to 'import chimoko kubase' (taking my girlfriend home)''.

Participants from the group discussions also said that sharing rooms with older brothers expose them to risky sexual behaviour as they are made to see or hear about sexual issues.

"We share rooms with older brothers and they watch porn or discuss sex related issues with friends over the phone. This enlightens us and we become so curious to Experiment the things we hear and see"

The socio-economic factors, identified in the group discussions as determinants of youths 'risky sexual behaviour included: poverty; "sugar daddies or mommies" who tend to be older and more sexually experienced than the youths; dressing by girls which was seductive to men; and peer pressure from friends. Some young people engage in sexual activity due to influence by friends. In most cases, they do not use any methods to protect themselves against HIV. These views emerged from the group discussions:

A female from a group discussion said the following remark:

"If you are still a virgin, you are labelled a fool. They will call you 'wakasara' (you are backward)"

Participants among FGD with young men also said the following statements:

"As boys, we compete to have sex with as many girls as we can and sometimes with one girl as a way of fixing her "

"Boys need sugar mommies to buy them nice cell phones, clothes or give me a car to use. On the other hand, girls want money to buy clothes, do their hair etc."

Household income had an impact on sexual risky behaviour as shown in Table 4.7. The poorer the household was, the higher the chances of young people engaging in risky sexual behaviour. Income was statistically significantly associated with risky sexual behaviour. Youths who come from poor households with an income less than \$500 were more likely to experience risky sexual behaviour (40.7%) compared to youths from households with an income between \$501-\$999(35.7%) and an income above \$1000 (28.6%)($p < 0.05$)

Table 4:7 Socio-Cultural and Living arrangements by Sexual Risk Behaviour

Variable	Sexual Risk Behaviour			Chi Square	p-value
	No Risky Behaviour	Risky Behaviour	Number		
Ever go to clubs/parties				4.475	0.034
Yes	57.0	43.0	100		
No	77.1	22.9	35		
Ever Drink or Smoke				19.548	0.000
Yes	43.1	56.9	65		
No	80.0	20.0	70		
Family structure				7.693	0.053
Both Parents					
Mother/Father	73.9	26.1	46		
Grandparents	62.5	37.5	32		
Other	66.7	33.3	21		
	44.4	55.6	36		
Sleeping Arrangement				12.842	0.046
Alone	50.0	50.0	22		
1	68.9	31.1	45		
2	52.5	47.5	40		
More than 3	75.0	25.0	28		
Household Income				7.120	0.037
Below 500	59.3	40.7	86		
\$501-\$999	64.3	35.7	28		
Above \$1000	71.4	28.6	21		

4.5.3 Parental Characteristics

Table 4.8 shows the association between parental characteristics and risky sexual behaviour. The association between youth's sexual risk behaviour and parental characteristics such as marital status, household headship and educational status of parents has been assessed in this study. Parents' education, marital status and if respondent's father is alive or not were found to be statistically significantly associated with youth's risky sexual behaviour. However, whether mother is alive or not was not statistically associated with risky sexual behaviour among youths.

Youths who had a mother without any formal education were more likely to engage in risky sexual behaviour (45.5%) when compared to youths with a mother with secondary education (29.4%) and tertiary education (33.3%)($p < 0.001$). Similarly, youths who had a father with tertiary education were less likely to be involved in risky sexual behaviour (31.3%) when compared to youths who had a father with secondary education (34.3%)($p < 0.01$).

Risky sexual behaviour was statistically associated by whether father is alive or dead. Respondents who reported that their father was still alive were less likely to engage in risky sexual behaviour (51.1%) when compared to youths whose father was dead (31.1%) ($p < 0.05$). In addition, the bivariate analysis depicted that marital status of parents and youth's risky sexual behaviour has a statistically significant association. Youths who had one parent alive were more likely to be involved in risky sexual behaviour (53.6%) compared to youths from divorced or separated (27.6%) and currently married parents (33.9%) ($p < 0.01$).

Table 4:8 Parental Characteristics and Sexual Risk Behaviour

Variable	Sexual Risk Behaviour			Chi Squared	p-value
	No Risky Behaviour	Risky Behaviour	Number		
Mother Still Alive				0.928	0.335
Alive	64.6	35.4	99		
Not Alive	55.6	44.4	36		
Mother's Education level(N=105)				23.308	0.000
No Education	54.5	45.5	11		
Primary	47.1	52.9	17		
Secondary	70.6	29.4	68		
Tertiary	66.7	33.3	9		
Father Still Alive				5.105	0.024
Alive	68.9	31.1	90		
Not Alive	48.9	51.1	45		
Fathers Education Level(N=98)				10.637	0.002
No Education	100.0	0	3		
Primary	100.0	0	6		
Secondary	65.7	34.3	67		
Tertiary	68.2	31.8	22		
Marital Status of Parents(N=116)				14.67	0.001
Currently Married	66.1	33.9	59		
Separated/ Divorced	72.9	27.6	29		
Widowed	46.4	53.6	28		

4.6 Determinants of Risky Sexual Behaviour: Multivariate Analysis Results

In the previous sections, an attempt was made to see whether or not there is an association or relationship between risky sexual behaviour and various demographic and socio-economic characteristics of youths and selected family or parents' background variables using bivariate analysis and chi-square test of independence at 5% level of significance. In the bivariate analysis, factors associated with risky sexual behaviour were identified.

In this section, the study analysed the background variables that are associated with risky sexual behaviour. A binary logistic regression model was fitted and adjusted odds ratio computed. Table 4.9 presents the results of the multivariate analysis. Religiosity, schooling status, family structure, attending parties or clubbing and taking drugs or alcohol are significantly associated with the risky sexual behaviour. However the association between risky sexual behaviour and sex, age, employment status, educational level and income was not statistically significant.

Findings show youths who were not attending school or college were more likely to engage in a risky sexual behaviour (OR=1.56; CI= (1.03-4.57)). Religiosity was significantly associated with risky sexual behaviour; results show that as the frequency of attending religious services decreases, the odds of engaging in risky sexual behaviour increases. Youths who attend religious services once a week were 3.04 times more likely to engage in risky sexual behaviour than youths who attend religious services more than once a week ((OR=3.04; 95% CI = (1.12-3.06)). Attending religious services once a month increases the risk of engaging in a risky sexual behaviour by 7.28 chances when compared to youths who attend religious services more than once a week ((OR=7.28; 95% CI = (2.26-20.28)). Young people who do not attend any religious service are 21 times more likely to engage in risky sexual behaviour than youths who attend religious services more than once a week((OR=21.05; 95% CI = (10.56-72.11)).

Family structure was statistically associated with risky sexual behaviour among the youths. Youths who stay with either mother or father were 1.18 times more likely to engage in risky sexual behaviour when compared to youths who stay with both parents((OR=1.18; 95% CI = (1.33-3.79)). Similarly, youths who stay alone or with other relatives were 2.68 times more likely to engage in risky sexual behaviour when compared to youths who stay with both parents ((OR=2.68; 95% CI = (1.68-5.94)). Young people who stay with their grandparents were 1.76 times more likely to engage in a risky sexual behaviour when compared to youths who stay with both parents ((OR=1.76; 95% CI = (1.18-4.28)).

Youths who attend parties or go to clubs were more likely to engage in a risky sexual behaviour. Young people who attend parties or go to clubs were 1.52 times more likely to engage in risky sexual behaviour than youths who do not go to these places ((OR=1.52; 95%

CI = (2.36-6.32)). Similarly, smoking or taking alcohol was significantly associated with risky sexual behaviour ($p < 0.05$) Youths who do not drink or smoke were 0.78 times less likely to engage in a risky sexual behaviour when compare to youths who drink or smoke ((OR=0.22; 95% CI = (0.07-0.74)).

Table 4:9 Results of Multivariate Analysis of the Factors Facilitating Risk Sexual Behaviour

Variable	P value	Exp(B)	95 % CI for Exp(B)	
			Lower	Upper
Sex (Male RC) Female	0.297	1.784	0.601	5.292
Age (15-19RC) 20-24	0.188	1.161	0.930	1.450
Schooling Status (In School RC) Out of School	0.041	1.558	1.032	4.567
Religiosity (More than Once RC) Once a Week Once a Month Never Attended	0.004 0.042 0.018	3.047 7.283 21.049	1.116 2.262 10.559	3.057 20.282 72.113
Employment Status (Employed RC) Unemployed	0.942	1.047	0.304	3.606
Family Structure (Both Parents RC) Mother/Father Grandparents Alone/Other Relatives	0.038 0.013 0.036	1.117 1.760 2.674	1.330 1.176 1.678	3.785 4.283 5.942
Parties/Clubs (Do not Attend RC) Attend	0.046	1.517	2.364	6.316
Alcohol/Drugs (Smoke/DrinkRC) Do not smoke/drink	0.014	0.229	0.071	0.738
Educational (Level Primary RC) Secondary Tertiary	0.994 0.483	1.005 2.073	0.265 0.329	3.816 13.063
Income (Below \$501RC) \$501-\$999 Above \$1000	0.835 0.334	0.881 0.503	0.268 0.119	2.900 2.123

5 CHAPTER FIVE: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a summary of the findings and a discussion of the results. It further goes on to conclude and make recommendations for future interventions with regard to sexual health of young people, based on the discussion.

5.2 Summary of Findings

This study was conducted among youths aged 15-24 years in Mufakose, Harare. The overall objective of the study was to explore risky sexual behaviours and related factors of young people aged 15-24 years living in Mufakose. The theories reviewed in this study helped to identify the variables that were investigated. The theories that were used to identify variables to be investigated in this study include the Health Belief Model and The Theory of Planned Behaviour. The risky sexual behaviours identified among the youths are early sexual debut, multiple sexual partners, non-use of condoms and other contraceptive methods. The study found out that 86.2% of youths had sex before the age of 20 and 38.3% had more than two sexual partners in the past twelve months. Among the sexually experienced youths, 37.5% did not use condoms during their last sexual encounter while 46.7% did not use other contraceptive methods. Knowledge on contraceptive methods, awareness on HIV and AIDS and condoms knowledge was high among the youths. Self-efficacy in refusing sex was low among the youths especially the sexually experienced youths. The majority of the youths perceived themselves not at risk of HIV. Factors significantly associated with risky sexual behaviour include schooling status, religiosity, family structure, attending parties or clubs and consuming alcohol or taking drugs. Furthermore, the findings did not reveal a statistically significant association between sexual risk behaviour and educational level, income, sex and age.

5.3 Discussion

The study showed that most youths (70%) were sexually experienced with out-of-school youths more likely to be sexually experienced than school-going youths. Females (68.7%) reported ever having sex when compared to 70.6% of males. However, under-reporting of sexual activity by the females is suspected because of cultural norms which expect girls to remain virgins until they marry. This finding is consistent with other studies carried out in

Zimbabwe among females who underreported sex (Wekwete, 2002; Phiri and Erulkar, 2000; Meekers and Wekwete, 1998; Wekwete, 2010). Young people are exposed to risky sexual behaviours as shown by the proportion of young people who had early sexual debut, multiple sexual partners, did not use condoms and other contraceptive methods during their last sexual act. The median age at first sexual intercourse among youths in Mufakose was 17.5 years. This result corresponds to the overall median age reported in studies done in Zimbabwe and elsewhere, ranging from 16 – 20 years (Wellings et al, 2006; Khan and Vinod, 2008, ZIMSTAT and ICF International, 2012; Gregson et al, 2002). Females engage into sex earlier than males, among youths in Mufakose the median age at first sex for females is 16.7 and 17.5 years for males. However, it is lower than the median age of 18.9 years for women aged 25-49 and 20.6 years for men age 25-54 reported from earlier studies (ZIMSTAT and ICF International, 2012; Phiri and Erulkar 2000). This shows that youths are now engaging in sexual activity at younger ages.

Sexual activity in the last twelve months was very high because only 16% of the youths did not have sex. Among youths who had sex in the last 12 months, 38.3% had more than two sexual partners with males having more sexual partners than females. This finding is consistent with studies done in Sub-Saharan Africa (Wellings et al, 2006). Multiple and concurrent sexual partners have been identified as a key driver of HIV transmission in countries with generalized epidemic (PSI, 2014). Frequently changing sexual partners expose young people to the risk of unintended pregnancy and STI infection.

Almost a quarter of the youths (22%) had transactional sex, with more females (30.4%) than males (14.6%) reporting transactional sex. This result is supported by earlier findings which showed that transactional sex is a common occurrence among unmarried young people in Sub-Saharan Africa (Moore et al, 2007; Nobelius et al, 2011). Transactional sex exposes young women to high risk of STI and HIV infection because older men are more sexually experienced thus are more likely to be infected with HIV (Chatterji et al, 2005; Biddlecom and Zulu, 2007; Machingura, 2010). Young people, especially young women, engage in transactional sex as a means of getting money to buy clothes, food and visiting the hair salon. When sex is treated as a commodity, young people are unable to negotiate condom use which exposes them to risk sexual behaviours such as non use of condoms.

Results on sexual intercourse among the youths suggest that sex was unexpected or unplanned as reported by 71.3% of the youths who said that their first sex was unplanned. Earlier studies have also found that teenage sex is unplanned, especially among young girls, 30% of sexually experienced girls in a study in rural Zimbabwe reported that their first sex was unexpected (Wekwete and Madzingira, 2008; Wekwete, 2010). This is in contrast to the HBM and The Theory of Planned Behaviour, which stipulate that youths make rational decisions before they engage in sexual activity. Young people put themselves at risk of HIV/pregnancy when they have unplanned sex because it is highly unlikely that they use condoms and other methods of contraception. During focus group discussions, females said that they have unplanned sex because they are tricked by their boyfriends into having sex. Results from this study also showed that unplanned sex was a result of forced sex, especially among young women. Nearly a fifth of the youths (17%) were forced to have sex at some point in their lives. Studies conducted earlier found higher levels of forced sex among youths where 33% youths in urban Zimbabwe, 25% in Ghana and 14% in Rwanda were forced to have sex (Phiri and Erulkar, 2000; Koenig et al. 2004; Glover et al., 2003). Forced sex exposes young people to risky sexual behaviours such as non-use of condoms and other contraceptive because the conditions just before having sex will not allow the use of condoms or other contraceptives. More females (28.3%) than males (6.3%) reported forced sex probably because their sexual partners are older than them. This result is supported by findings from other studies conducted before on forced sex among females (Moore et al., 2007; Nobelius et al., 2011; Blum and Nelson-Mmari, 2004; Chatterji et al., 2005). During focus group discussions, young women reported that males planned well ahead of them and they force or trick them into having sex. Reasons for forced sex among young people cited include social norms which expect men to be aggressive when having sex with women, especially if the girl is a virgin.

In regard to contraceptive use, despite high contraceptive knowledge among youths, nearly half of the sexually experienced youths (46.7%) did not use contraceptives during their last sexual encounter. This shows that knowledge of contraceptives does not translate to use among youths. Failure to use contraceptives puts young people at risk of unwanted pregnancies. Young people did not use contraceptives because most of their sexual experiences were not planned, they just happened. Contraceptive use on last sexual encounter (53.3%) is lower than the Zimbabwe level of 59% (ZIMSTAT and ICF International, 2012) and even less than the 68% that the government pledged to achieve by

2020(UNFPA, 2014) but higher than the 33% reported by Guttmacher Institute and IPPF (2010) among adolescents in Sub-Saharan Africa.

Misconceptions and negative attitudes towards contraceptives are closely associated with non-use of contraceptives. Findings from FGDs show that young women believe that contraceptive methods have side effects and cause in-fertility. Similar findings are reported in a study by Singh et al.(2009) who concluded that negative attitude, inadequate knowledge about contraception, limited ability to make independent decisions about using contraceptives or when to have children and lack of experience in obtaining family planning services have a negative effect on contraceptive use among youths. Young people have a negative attitude towards safe sex, such as using contraceptives, because most of them view it as boring and as a routine. The male condom (75.9%) was the most used method of contraception. On the other hand, almost half of the youths (49%) believe that the male condom is the most suitable method of contraception among young people. One of the reasons of preferring the male condom over other methods is that it is cheaper to get and easy to use.

Use of condoms at last sexual intercourse was low because 37.5% of the youths in the study did not use male condoms during their last sexual encounter. Failure to use condoms among young people exposes them to unwanted pregnancies and the risk of HIV infection. The proportion of males who used the male condom (39.5%) during their last sexual encounter is higher than that of females (35.2%). Previous research conducted also shows that males use the male condom more than females (Marindo et al., 2003; Wellings et al., 2006; Ringheim and Gribble, 2010). Males usually initiate sex and they plan on using the male condom because it is easy to use when compared to other methods. The main reason for using condoms among youths was to prevent pregnancy, which was reported by 50% of the youths who used condoms. This study also found out that condom use is affected by drugs use and alcohol consumption. During FGDs, youths explained that it is very difficult to think about using condoms when someone is drunk. Young people in these circumstances will have unprotected sex without considering the risks. Other studies have also found a correlation between alcohol and non-use of condoms (Larsson et al., 2007; Lavikainen, 2009).

Negative attitudes towards condoms were closely related with non-use of condoms among youths. Nearly half of the youths (48.9%) feel that it is too embarrassing for them to be seen buying male condoms and (46.7%) also believe that if a girl suggests using male condoms,

then it means she does not trust her partner. In addition, more than half (51.9%) believe that male condoms reduce sexual pleasure. During group discussions, young people associated male condom use with prostitution; hence young people will not use condoms because agreeing to condom use will result in being labelled a prostitute. Van Rossem and Meekers (2011) reported similar findings on the influence of social norms on condom use. Males are more likely to use male condoms than females and one of the reasons highlighted in the FGDs is that males usually initiate sex and they are in control. They also said that it is embarrassing for young women to carry either the male or female condoms because it will appear as if they are promiscuous individuals.

Despite the almost universal awareness of HIV and AIDS, a significant proportion of youths were engaging in risky sexual behaviour, i.e., having multiple sexual partners, non-use of condoms to protect themselves against HIV infection and pregnancy, and non use of contraception. Knowledge levels were high among the youths although there are still misconceptions about HIV and AIDS among the youths. Nearly a third 27.4% of the youths think that it is possible to cure HIV and AIDS. The majority of them believe that they can be cured through prayers at church. Other youths believe that a person with HIV always look sick. Such misconceptions put the youths at risk of HIV infection. A study conducted among women in rural Zimbabwe found out that misconceptions about HIV and AIDS lead young women into risky sexual behaviour such as multiple sexual partners and non-use of condoms (Wekwete, 2010).

Self-efficacy in refusing sex was low among the youths, especially those who were sexually experienced. Two thirds of the youths had low to moderate self-efficacy in refusing sex. Many of them aimed to abstain until marriage but doubted whether they would be able to prevent themselves from engaging in sexual intercourse. Young women had low self-efficacy in refusing sex when compared to men. This is explained by the patriarchal cultural system where young women are raised to be submissive to men. Findings from the FGDs showed that young people feared relationships, hugging, and kissing because they believed it could lead people into having sex, showing that youths seemed more concerned about their self-efficacy in abstaining and refusing sex. Other studies have found out that young people have low self-efficacy in refusing sex or abstinence (Babalola et al. 2002; Louw, 2012). Self-efficacy on ability to use male condoms was very high to moderate (90.3%) among the youths. Young females had low self-efficacy in using the male condom (78.7%) when

compared to males(94.3%). This may be attributed to females associating condoms with prostitution and therefore takes a negative perception with regards to condoms. Youths find it difficult to disclose their HIV status to their partners as more than half (53%) had low self-efficacy in telling their partner that they are HIV positive. This means that when young people do not disclose their HIV status to their partners, they might be infecting each other along the way as they also battle to control themselves from having sexual intercourse.

Factors that facilitate risky sexual behaviour were explored, some of the findings supporting previous studies and others refuting. The study findings showed an association between various socio-economic factors and risky sexual behaviours, including early sexual debut, multiple sexual partners, non use of condoms and other contraceptive methods. Schooling status was associated with risky sexual behaviour. The study found out that being out of school is associated with risky sexual behaviour. These findings are in correspondence with previous studies where not attending school has been found to increase the likelihood of engaging in sexual risk behaviour (Okonkwo et al., 2005; Wekwete and Madzingira, 2008; Staton et al., 2002). Most young people who are not in school are most likely not to be working and do not have anything to occupy them most of the time and these are more likely to be at risk of sexual behaviour and Okonkwo et al (2005) further stated that it may be closely connected to social environment.

In addition, the likelihood of engaging in risky sexual behaviour was also associated with the level of religiosity. Young people who do not attend any religious services were at a greater risk of engaging in risky sexual behaviour when compared to youths who frequently attended religious services. Risky sexual behaviour increased with decreasing religiosity. Risky sexual behaviour was common among youths who attended religious services once a month (62.5%) than those attending once a week (40.3%) or more than once a week (23.4%). Religious reasons were also cited as the main reason for not engaging in sex among the sexually inexperienced youths. These findings are in correspondence with other previous findings where religious youths were less likely to engage in risky sexual behaviour (Brewster et al. (1998; Edwards et al, 2011). Religiosity plays a key role in shaping young people's sexual behaviour through attitudes towards pre-marital sex, HIV, contraception including condoms and perception of risk.

The study identified an association between family structure and risky sexual behaviour. Living arrangement was closely associated with risky sexual behaviour among the youths. Those staying alone or with other relatives (55.6%) were more likely to engage in risky sexual behaviour than those staying with both parents (26.1%). This may be explained by the fact that young people who stay alone have the liberty and freedom to do as they please most of the times. Other studies also noted father's absence and marital status of parents was strongly associated with risky sexual behaviours which include early sexual debut, findings from Rwanda and Kenya shows that father's presence had an impact in delaying sexual debut and also father's presence reduced substantially the risk of early initiation of sexual intercourse and risky behaviours such as frequency of sexual intercourse and unwanted pregnancy (Babalola, 2004; Ngom et al., 2003). During FGDs youths said that they are afraid of going out of the house during the night when their fathers are present.

Young people who attend parties or go to clubs were more likely to engage in risky sexual behaviour, which includes multiple sexual partners and non-use of condoms. Nearly half of the youths (43%) who attend parties or go to clubs engaged in risky sexual behaviour. Previous studies have also identified the association between attending parties and risky sexual behaviour and it may be closely connected to where a person meets the sexual partner (O'Connell et al, 2009). Other studies conducted in Sub-Saharan Africa linked drinking places, local brew sellers, restaurants with high risk sexual behaviour such as non use of condoms and multiple sexual partners (Hoffmann et al, 2004). Due to the low possibility of ever meeting the person again, meeting places like these are likely to affect normal restraints regarding sexual intercourse. In addition, the likelihood of engaging in risky sex with a casual partner may also be influenced by alcohol and drugs which are readily available in these places. Other studies have found a correlation between alcohol abuse and multiple sexual partners (Baliunas et al, 2010; Fisher et al, 2008). Drug use and alcohol consumption is widely known to be a potential risk factor that may lead to risky sexual behaviours and the threat of sexual coercion (Stafstrom and Agardh, 2012; Balinus et al., 2010; Rudatsikira et al., 2009; Sherman et al., 2009). These previous studies support the findings of this study which revealed that more than half of youths (56.9%) who take alcohol or drugs engaged in sexual risk behaviour when compared to 20% among those who do not consume alcohol or take drugs. Results from the study indicate that alcohol and drugs were associated with non-use of condoms and other contraceptive methods because they lead to unplanned sex or sexual

coercion. This is also consistent with findings from other studies conducted earlier among teenagers in Sweden and Finland (Larsson et al., 2007; Lavikainen, 2009).

Household income was associated with risky sexual behaviour among young people. Youths from households with low income, below \$500, were more likely to engage in risky sexual behaviour (40%) than those with higher incomes of \$501-999 and \$1000 and above (35.7% and 28.6%, respectively). Poverty and economic hardships are associated with risky sexual behaviour because young people who are not satisfied with their lives are more likely to engage in risky sexual activities. As shown in this study young people, especially young girls, had sex in exchange for material things which include money, cell phone, clothes and food. Poverty is also strongly linked to transactional sex and non-use of condoms due to the unequal power relations between the two parties. These findings are supported by earlier studies on sexual behaviour (Silas, 2013; Booyesen et al. 2002; Hallman, 2004).

There was a significant association between age and risky sexual behaviour in this study. Risky sexual behaviour increased with increasing age among young people. Nearly half of the youths aged 20-24 engaged in a risky sexual behaviour (48.9%) compared to 21.9% of youths aged 15-19. Similar findings have also been reported by studies conducted in Zimbabwe and elsewhere (Ku et al., 1993; Abma et al., 1998; Luke, 2003; Murray and London, 2004).

5.4 Conclusion

Risky sexual behaviour among young people is a problem in Zimbabwe which needs urgent attention. The study has managed to identify the risky sexual behaviours common among youths in Mufakose and also explored the critical pathways facilitating this problem. The risky sexual behaviours identified among youths in Mufakose include early sexual debut, multiple sexual partners, non use of condoms and other contraceptive methods. Risky sexual behaviour among the youths is facilitated by various demographic and socio-economic factors.

The study noted that schooling status was one of the factors leading youths into risky sexual behaviour. This relationship is a cause for concern not only because young people are leaving school early but also because unemployment is very high and young people out of school are more likely to be unemployed. Idleness among young people leads them into indulging into

risky behaviours such as drug use and risky sex. Youths who attend school are occupied with their school work most of the time and peer influence is less likely to affect them. They also take their teachers as role models and strive to copy their lifestyle. Therefore, measures should be put in place to keep young people in school so that they can have activities to occupy them.

Young people who attend parties or go to clubs were at a greater risk of engaging in risky sexual behaviour than youths who do not go to these places. This maybe due to the fact that in these places they usually meet casual partners and have unprotected sex. The environment in clubs or parties is conducive for sexual networking, drug use and alcohol consumption which all lead young people into risky sexual behaviours. Young people should be discouraged from going to clubs and other high risky drinking places where people meet and drink alcohol and engage into sex. Consuming alcohol and drug use was associated with risky sexual behaviour. Young people who had sex under the influence of drugs and alcohol do not use condoms correctly. Drug use and alcohol consumption among young people is a result of the high unemployment rate which has resulted in young people spending much of their time in street corners. Therefore there is a need to keep young people busy and subsequently keep them out of the streets.

The study also found that religious youths were less likely to engage in risky sexual behaviour. Frequency of going to church had an impact on the risky sexual behaviour of young people. This is largely due to the fact that religious institutions teach young people about abstinence and being faithful to one partner. There is need to encourage young people to attend religious services always so that they can be able to learn from older people. It was noted that family structure has an impact on risky sexual behaviour among young people. Youths who stay alone were more exposed to risky sexual behaviour when compared to young people who stayed with both parents. The presence of a father in the family deters young people from engaging into activities that lead to risky sexual behaviours. There is need for society to take measures that encourage the survival of the traditional family structures. Older people within the community need to play a parental role to young people even though they are not their biological parents.

Despite the widespread awareness on HIV and AIDS, youths continue to engage in risky sexual behaviours, putting them at high risk of HIV infection. The findings of this study show that the assumptions that once awareness of HIV and AIDS has been created, people will

adopt safer sexual relationships, does not hold among youths in Mufakose, Harare. Despite engaging in risky sexual behaviour, most youths perceived themselves not at risk, which was even higher among the sexually experienced. Given that sex among youths is not planned, more are even putting themselves at higher risk of HIV infection and pregnancy. There is need for more comprehensive awareness among the youths especially to address the various misconceptions they hold on HIV and AIDS.

Young people have a negative attitude towards contraceptives and this put them at greater risk because they are less likely going to use contraceptives. While this is not always true there is need to change these negative attitudes among the young people. Self efficacy was low among the youths. Young people were concerned that they would not be able to control themselves not to have sexual intercourse. For instance, they feared relationships, hugging, and kissing because they believed it could lead people into having sex. Young people should be equipped with the skills that enhance their self efficacy so that they can be able to refuse sex and negotiate safer sex.

5.5 Recommendations

There is need for intensive awareness campaigns that will educate young people on the consequences of risky sexual behaviour. The strategies to be introduced should reach out to young people out of school who occupy a significant proportion of the youth population. There is need for intensive school-based programmes for SRH education among young people who are in school. On the other hand, to cater for young people out of the school, there must be community-based SRH education programmes that offer comprehensive sexual reproductive health education.

The majority of young people out of school are unemployed and spend most of their time idle in street corners. Youths of school going age should be kept in school while those who have finished should be provided with jobs or income generating projects to keep them busy so that they avoid frequenting clubs too often and abuse alcohol and drugs. The law enforcement agents should intensify clamping down on people who sell drugs, run brothels and organise sex parties in the community so as to curb the exposure of young people, especially those less than 18 years to such places that put them at greater risk.

The study recommends the establishment of life skills centre in the community. In these centres young people should be trained on various skills that can help them to fight unemployment. These centres will keep young people busy and occupied and they can serve also as places where young people can get sex education and get access to condoms and contraceptives.

Family structure is associated with risky sexual behaviour among youths. Under the traditional Zimbabwean culture, it is the role of aunts and uncles to educate youths on sexuality but this has been eroded by modern practices including urbanization, leaving parents to fulfil this role. However, some parents and guardians lack knowledge to impart to their children because they were never taught themselves when they were young while others still regard it as taboo to discuss SRH issues with youths. These findings point to the need for advocacy for youth sexual and reproductive health rights and the need for increased awareness by parents, community leaders and policy makers on SRH risks youths are exposed to. Religiosity has a protective effect in shaping young people's sexual behaviour. Therefore religious institutions such as churches should scale up their efforts in teaching responsible behaviour among youths. Parents and guardians should encourage their children to attend religious services regularly.

5.6 Future Research

The results of this study would be interesting if they are conducted on a larger scale, for example on a national level. Furthermore, it would be interesting to study the same topic on youths with different characteristics, such as in and out-of-school, youths in rural settings and youths in slum conditions. The results of this study have shown that sexual risk behaviour is more common among youths out of school. It would be interesting if other studies are conducted among youths out of school only. Further, research could show whether this is true and whether there is a need for sexuality education in Universities.

Young people in this study reported using the internet and western media for sex education. These media include western high school movies, magazines and pornography. It was discussed how certain cultural values in these movies, such as kissing in public, influenced young people to copy what they see. Since internet connections are becoming faster and more widespread, thereby bringing western cultures closer to the Zimbabwean culture, it would be

interesting to study whether and how international media could affect sexual risk behaviours and attitudes among youths living in both rural and urban areas of Zimbabwe.

|

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7 APPENDIX

University of Zimbabwe, Faculty of Social Studies Centre for Population Studies

A Study on Risky Sexual Behaviour among Youths: A Case of Mufakose Questionnaire Prepared for Youths aged of 15- 24 Harare, Zimbabwe, 2014

Dear Respondent

Greetings! My name isI am a part of a team from the University of Zimbabwe, Centre for Population Studies in the Faculty of Social Studies. We are interviewing young people of your age in order to find out about their sexual behaviour, related knowledge, attitude, risky sexual behaviour and practices. You have been randomly selected as a respondent in my research. I will greatly appreciate your responding to this questionnaire and in so doing you will be helping to create a better community and indeed a better Zimbabwe.

Consent

I am going to ask you some personal questions, which some people might find them difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may quit this interview at any time you want to. Your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. We would greatly appreciate your help in responding to this survey. The survey will take about 30-40 minutes.

Would you be willing to participate in this study?"

If yes, proceed.

If no, thank the person and leave the household.

Questionnaire number

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Section 1: Socio-economic and Demographic Characteristics of Respondent

Question	Response	Skip to		
1.1 Sex of Respondent	Male 1 Female 2			
1.2 How old were you at your last birthday?	<table border="1"><tr><td></td><td></td></tr></table>			
1.3 What is your Marital status	Never Married 01 Married 02 Divorced 03 Widowed 04			
1.4 Are you currently attending school, college or university?	Yes 01 No 02			
1.5 What is the highest level of education you completed?	Primary 01 Secondary 02 Technical/College 03 University 09 Postgraduate 10			
1.6 What is your religion?	Pentecostal 01 Protestant 02 Catholic 03 Apostolic sects 04 Muslim 05 Other(specify)_____ 06			
1.7 How often do you go to church/mosque or other religious institutions?	More than once per week 01 Once per week 02 Once per month 03 Other(specify)_____ 04			

1.8 Are you currently working?	Yes No	01 02	
1.9 Now I have some questions about your family Is your mother still alive?	Yes No Don't Know	01 02 03	→ 1.11
1.10 What is your mother's highest level of education attained?	No formal education Primary education Secondary education Tertiary education	01 02 03 04	
1.11 Is your father still alive?	Yes No Don't Know	01 02 03	→ 1.13
1.12 What is your father's highest level of education attained?	No formal education Primary education Secondary education Tertiary education	01 02 03 04	
1.13. Whom do you stay with?	Both Parents Mother /Father Grandparents Other(specify)_____	01 02 03 04	
1.14. What is your parent's marital status if they are alive?	Currently married Separated Divorced Widowed Not alive	01 02 03 04 05	
1.15. What is your estimated monthly family income?	\$500 and below \$501-\$999 \$1000-\$1500 Above \$1500	01 02 03 04	
1.16. How many people sleep in the same room with you at night when you are at home (beside yourself)?		<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>	
1.17. In relation to other families in your neighbourhood, what would you say about your family?	We are very poor. We are average. We are better than others.	01 02 03	

	Do not know.88	
1.18. And now I have some questions about your social activities. Do you ever go to clubs or parties where young people dance?	Yes 01 No 02	→ 1.20
1.19. How often did you go to any of these places in the past?	Daily 01 Once in a week 02 Once in a month 03	
1.20. Do you ever drink alcohol, smoke or take any drugs?	Yes 01 No 02	→ 2.1
1.21. How often do you smoke, drink or take drugs?	Always 01 Sometimes 02	

Section 2: Sexual Behaviours and Practice

2.1 Have you ever had sexual intercourse in your life?	Yes 01 No 02	→ 2.19
2.2 How old were you at the time you first had sex.	AGE <input type="text"/> <input type="text"/>	
2.3 How would describe your relationship to that person? PROBE	Boy/girl friend 01 Stranger/relative/other person who forced me 02 One night stand 03 Commercial sex partner 04	
2.4 Were you ever concerned that you might catch AIDS or another sexually transmitted infection from your partner? IF YES Very or somewhat?	Very concerned 01 Somewhat concerned 02 Not concerned 03	→ 2.7

2.5 Were you able to do anything to reduce the risk of infection	Yes 01 No 02	→ 2.7
2.6 What did you do? <i>Probe</i>	Use condoms 01 Take medicines 02 HIV Testing 03 Other 04	
2.7 During your life, with how many people have you had sexual intercourse?	<input type="text"/>	
2.8 How many sexual partners have you had in the past 12 months?	<input type="text"/>	
2.9 Have you ever paid and/ or received money or gifts in exchange for sexual intercourse	Yes 01 No 02	
2.10 Have you ever had sexual intercourse under the influence of drugs/alcohol?	Yes 01 No 02	
2.11 MALES: Have you ever made a girl or woman pregnant? IF YES How many times? FEMALES: Have you ever been pregnant? IF YES How many times?	No. <input type="text"/> Never 01 Not Sure 02	→ 2.13
2.12 Thinking of the most recent pregnancy, did you want the pregnancy at that time or not want it?	Want 01 Not want 02	
2.13 Were you ever concerned that you might get pregnant/impregnant your partner IF YES Very or somewhat?	Very concerned 01 Somewhat concerned 02 Not concerned 03	→ 2.16
2.14 Were you able to do anything to reduce the risk of pregnancy	Yes 01 No 02	→ 2.16
2.15 What did you do? <i>Probe</i>	Use condoms 01 Used contraceptives 02	

	Take medicines 03 Other 04	
2.16 Think back to the first time you had sex. Would you say. READ OUT	Yes No	
(a) I forced my partner to have intercourse against her/his will	1 2	
(b) I persuaded my partner to have intercourse	1 2	
(c) My partner persuaded me to have intercourse	1 2	
(d) My partner forced me to have intercourse	1 2	
(e) We were both equally willing	1 2	
2.17 And would you say it was planned or unexpected?	Planned 01 Unexpected 2	
2.18 Some young people are forced to have sexual intercourse against their will by a stranger, a relative or an older person. Has this ever happened to you?	Yes 01 No 02	→ 4.3
2.19 What is the main reason for you not to have had sexual intercourse?	Fear of STDs and HIV/AIDS 01 Fear of parents 02 Wish to wait until Marriage 03 Fear of pregnancy 04 For religious reason 05 Other(specify)_____ 06	
2.20 People have different opinions regarding sexual practices . I will read out some opinions. For each one, I want you to tell me whether you always never or sometimes do it.	Never Sometimes Always	
1. I insist on condom use when I have sexual intercourse.	1 2 3	
2. I use drugs/alcohol prior to or during sexual intercourse.	1 2 3	
4. I ask potential sexual partners about their sexual histories.	1 2 3	

7. I engage in sexual intercourse on a first date.	1	2	3	
8. I abstain from sexual intercourse when I do not know my partner's sexual history.	1	2	3	
10. If I know an encounter may lead to sexual intercourse, I carry a condom with me.	1	2	3	

Section 3: Knowledge, attitude and perceptions towards STI's, HIV and AIDS

3.1 Have you heard of HIV or AIDS	Yes No	1 2	→ 3.3
3.2 I am now going to read you some statements about HIV/AIDS. Please tell me whether you think the statement is true, or false, or whether you don't know.	True	False	Don't know
1 It is possible to cure AIDS	1	2	3
2 A person with HIV always looks unhealthy in some way	1	2	3
3 People can take a simple test to find out whether they have HIV	1	2	3
3.3 Apart from HIV/AIDS, there are other sexually transmitted infections that men and women can catch by having sexual intercourse. Have you heard of any of these STI's?	Yes No	01 02	→ SECTION 4
3.4 What are the signs and symptoms of a sexually transmitted infection in a man?	Discharge from penis Pain during urination Ulcers/sores in genital area Other..... D.K. any signs	01 02 03 04 08	
3.5 And what are the signs or symptoms when	Vaginal discharge	01	

a woman is infected?	Pain during urination 02 Ulcers/sores in genital area 03 Other..... 04 D.K. any signs 08	
3.6 If a friend of yours needed treatment for a sexually transmitted infection, where could he or she obtain such treatment?	Shop 01 Pharmacy 02 Govt. hospital/clinic 03 Private doctor/nurse/clinic 04 Other 05	
3.7 Have you ever had a sexually transmitted disease? IF YES Once or more than once?	Once 01 More than once 02 Never 03	SECTION 4
3.8 (On the last occasion) did you seek treatment?	Yes 01 No 02	3.10
3.9 Where did you seek treatment?	Shop 01 Pharmacy 02 Govt. Hospital/clinic 03 Private doctor/clinic 04 Other 05	
3.10 Did your sexual partner (any of your partners) also obtain treatment?	Yes 01 No 02 Don't know 03	

Section 4: Knowledge and ever use of contraceptive methods

4.1 Do you know about any contraceptive method?	Yes 01 No 02	SECTION 5
4.2 What type of contraceptive methods do you know?		Do you know any place or person where young people

			could obtain this method?	
	Yes	No	Yes	No
Pill	1	2	1	2
Injection	1	2	1	2
Male Condom	1	2	1	2
Female Condom	1	2	1	2
Emergency Pill	1	2	1	2
Withdrawal	1	2	1	2
Abstinence/Rhythm	1	2	1	2
Sterilization	1	2	1	2
4.3 Which method do you think is most suitable for young people?	Pill 01 Injection 02 Male Condom 03 Female Condom 04 Emerg. Pills 05 Withdrawal 06 Periodic. Ab. 07 Other 08 D.K. 09			
4.4 Where do you get contraceptive method information?(Multiple response)	Health centre 01 Schools 02 Religious institute 03 Friends 04 Family guidance 05 Shop/Pharmacy 06 Other (specify)_____ 07			
4.5 On the first time you had sex did you or your sexual partner did anything to avoid a pregnancy?	Yes 01 No 02			

Section 5: Condom knowledge and attitudes

5.1 Have you ever seen or heard about a condom?	Yes No	01 02	SECTION 6 →															
5.2 Have you or a partner ever used a condom?	Yes No	01 02	→ 5.4															
5.3 If you have ever used, what is your reason for using it?		<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> </tr> <tr> <td>To prevent pregnancy</td> <td>1</td> <td>2</td> </tr> <tr> <td>To prevent STI</td> <td>1</td> <td>2</td> </tr> <tr> <td>To prevent HIV/AIDS</td> <td>1</td> <td>2</td> </tr> <tr> <td>Other (specify) _____</td> <td></td> <td>4</td> </tr> </table>		YES	NO	To prevent pregnancy	1	2	To prevent STI	1	2	To prevent HIV/AIDS	1	2	Other (specify) _____		4	
	YES	NO																
To prevent pregnancy	1	2																
To prevent STI	1	2																
To prevent HIV/AIDS	1	2																
Other (specify) _____		4																
5.4 People have different opinions about condoms. I will read out some opinions. For each one, I want you to tell me whether you agree or disagree, or whether you don't know	Agree	Don't know/not sure	Disagree															
1. Condoms are an effective method of preventing pregnancy	1	2	3															
2. Condoms can be used more than once	1	2	3															
3. A girl can suggest to her boyfriend that he use a condom	1	2	3															
4. A boy can suggest to his girlfriend that he use a condom	1	2	3															
5. Condoms are an effective way of protecting against HIV/AIDS	1	2	3															
6. Condoms are suitable for casual relationships	1	2	3															
7. Condoms are suitable for steady, loving relationships	1	2	3															
8. It would be too embarrassing for someone like me to buy or obtain condoms	1	2	3															
9. If a girl suggested using condoms to her	1	2	3															

partner, it would mean that she didn't trust him			
10. Condoms reduce sexual pleasure	1	2	3
11. Condoms are an effective way of protecting against sexually transmitted infections.	1	2	3

Section 6: Self-efficacy, Self-esteem and the Intention to Practice Safe Sex

	Strongly Disagree	Disagree	Agree	Strongly Agree
1.1. I can abstain from sex even if I have had sex in the past,	1	2	3	4
1.2. I am sure I will stick to one partner in the next 3 months,	1	2	3	4
1.3. I can talk to the person with whom I have sex about using condoms.	1	2	3	4
1.4. I plan to abstain in the next 3 months.	1	2	3	4
1.5. I plan to stick to one partner if I am to have a partner in the next 3 months.	1	2	3	4
1.6. I will try my level best to use condoms if I have sex in the next 3 months.	1	2	3	4
1.7. I am certain that I know how to use a condom correctly.	1	2	3	4

1.8.I feel confident telling someone I was dating that I am HIV positive.	1 2 3 4
1.9.I am confident that I can have safer sex and satisfy my partner.	1 2 3 4

Section 7: Sexual relationship, gender and norms

Young people have various views about relationships. I will read you out some views. For each one, please tell me whether you agree, Don't know/not sure or disagree?		
7.1 I believe it's all right for unmarried boys and girls to have dates (USE LOCAL TERM)	Agree Don't know/not sure Disagree 1 2 3	
7.2 I believe it's all right for boys and girls to kiss, hug and touch each other.	1 2 3	
7.3 I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	1 2 3	
7.4 I think that sometimes a boy has to force a girl to have sex if he loves her.	1 2 3	
7.5 A boy will not respect a girl who agrees to have sex with him.	1 2 3	
7.6 Most girls who have sex before marriage		

regret it afterwards.	1	2	3	
7.7 Most boys who have sex before marriage regret it afterwards.	1	2	3	
7.8 A boy and a girl should have sex before they become engaged to see whether they are suited to each other.	1	2	3	
7.9 I believe that girls should remain virgins until they marry.	1	2	3	
7.10 I believe that boys should remain virgins until they marry.	1	2	3	
7.11 It is sometimes justifiable for a boy to hit his girlfriend.	1	2	3	

Focus Group Discussion Guide: Youths aged 15-24

Introductory Remarks

We are a team from The University of Zimbabwe and conducting research on risky sexual behaviour among youths aged of 15-24 years in Mufakose. The objective of the research is to explore sexual behaviours and related factors among young people aged 15-24 years living in Mufakose. You have been invited to participate in this discussion because you are a young person living in Mufakose. We, therefore, request your participation in this discussion freely. All that you say will be taken in strict confidence and remain just between us.

Identification of the participants

Type of participants	
Number of participants	
Average age of participants	
Time at start of the discussion	
Time at the end of the discussion	
Ward	
Date	

1. How do young people of your age find out about relationships, sex, contraception, STI and HIV/AIDS? Do you feel that the information you have received has been adequate?
2. Is abstinence actively promoted? Do young people of your age actively abstain from having sex?
3. What proportion of young men/women of your age do you think are sexually active? At what age would you say young people start having sex? What discussions/negotiations go on before sex takes place
4. Why do you think men/women of your age have sex?

5. To what extent do you think that people of your age take risks of any sort during sex? Do men and women take the same or different risks?
6. To what extent do you think HIV/AIDS is a risk to young people of your age? Are young people more worried / concerned about pregnancy or HIV/AIDS and other STIs? Do you think young people take the risks seriously?
7. To what extent do you think that people of your age are pressured into sex? Are there any differences in the pressures experienced by young men and women?
8. What factors are there in your society that could influence young people's involvement in risk sexual behaviour? (Probe about gender, stigma, norms and traditions)
9. Imagine you have a boy/girlfriend and (s)he asks you to have sex. What would you decide? What would be reasons for you to agree or refuse to have sex? Do you think it is always possible to refuse sex?
10. What measures are used to prevent STIs, HIV/AIDS and early pregnancies in your society?
11. What does safe sex mean to young people? What do young people think about condoms and contraceptives? Some people would say that they would rather not have sex than use a condom. What do you think women / men of your age think about that?