Qualitative Evidence on Adolescents' Views of Sexual and Reproductive Health in Sub-Saharan Africa

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Executive Summary

This qualitative study examines how young people in Sub-Saharan Africa view sexual and reproductive health issues, such as abstinence, condom use and sexually transmitted infections (STIs), and what they think about sources of sexual and reproductive health information and services. The data come from 55 focus group discussions (FGDs) conducted in Burkina Faso, Ghana, Malawi and Uganda in 2003. Focus groups included in- and out-of-school youth aged 14–19 who lived in rural and urban areas.

Key findings

Sexual relationships: Overall, young people did not express disproportionately negative or positive judgments about adolescents' having sex, and discussions overwhelmingly focused on relationships with boyfriends or girlfriends, older (often married) men or women and occasional sex partners. However, young women and men were portrayed differently with respect to initiating sexual relationships. Young women were described as dressing "invitingly" or going to secluded places where young people meet for sex; in all countries except Burkina Faso, FGDs indicated that some young women engage in sex for money or with men other than their boyfriends. In contrast, young men were consistently described as actively pursuing sexual relationships or "conning" young women into having sex.

Sex for money or gifts: Both male and female adolescents discussed sexual relationships with older, typically married men or women that involved material exchange. (These relationships were also implicated in the breakdown of such protective behaviors as abstinence and condom use.) A common expectation was that once a young woman received a gift, she owed something in return—a debt explicitly talked about as sex. Moreover, there was frequent mention that young men give young women money or gifts in exchange for sex or in hopes of having sex in the future. Young women expected money and material goods not only from older partners but also from age-mates, and young men expected to give something for sex. Thus, "transactional sex" is more widely reflective of adolescent relationships than just young women having sex with much older male partners.

Premarital pregnancy: FGDs indicated that young men and women involved in a premarital pregnancy are treated in radically different ways: Young men who father a child before marriage are pitied, teased or "gossiped about," whereas the consequences are more severe for unmarried, pregnant young women, who may have to drop out of school or be chased from their home. Young women in all four countries mentioned that young men often deny responsibility for premarital pregnancies.

HIV/AIDS and other STIs: Our findings suggest that young people are aware that they may be at risk of contracting STIs, including HIV, but the quality and depth of their knowledge vary and misconceptions persist. Although most participants were aware that a person can have HIV without displaying physical symptoms, they did not hold the same view about other STIs. Instead, they judged whether someone had an STI using visual signs (e.g., walking in a funny way) and did not recognize that many STIs may not cause obvious or visible symptoms.

Abstinence: Although abstinence was generally viewed in a favorable light and as an ideal goal, young people differed as to how realistic they considered this option. Abstinence was viewed as a means of preventing HIV, other STIs and pregnancy, and less often as a way to preserve oneself for marriage. Young people also discussed abstinence as a strategy for sexually experienced individuals to cope with an STI or suspected HIV infection.

Views about condoms: Most of the discussion groups

identified condom use as a way to protect against HIV and other STIs and, to a lesser degree, against pregnancy. Although other studies have highlighted misperceptions about condoms and barriers to access as primary impediments to condom use, we found that the values young people attach to sexual intercourse also present an important impediment. Young people talked about enjoying sex without condoms ("the only way is raw"). Other reasons for nonuse were trusting that one's partner did not have HIV, loving one's partner and forgetting to use a condom because of the anxiety or excitement involved in having sex.

Negotiating condom use: Participants generally recognized that young women have the right to ask their partners to use condoms; in fact, insisting on condom use was perceived to be primarily women's responsibility. However, young women's right to demand condom use depended on whether they had received money or gifts. Young women often talked about the difficulties they faced, or the lack of power they had, in getting their male partners to use condoms.

Information: Young people placed a high value on being able to obtain confidential and accurate sexual and reproductive health information. They reported that they got this information mainly from the mass media (i.e., radio, newspapers and television), health care providers, schools or teachers and dramatic performances. Parents, aunts, grandparents, older persons in the community and friends were also mentioned as sources. No single source of information was dominant either among preferred or among actual sources. Barriers to obtaining sexual and reproductive health information included not having access to a radio or newspaper, not being able to ask questions, illiteracy, unwelcoming health care providers, feeling too shy or ashamed to ask parents and not trusting the accuracy of information.

Communication: Adolescents identified friends, parents (especially mothers) and, in all countries except Burkina Faso, grandparents as the people with whom they most commonly discuss sexual matters. However, in all four countries, many adolescents also mentioned that they were unable to talk with parents (especially fathers) about sexual issues because parents would shout, punish or beat them, adolescents are too shy to talk about such things with their parents, and it is culturally taboo or disrespectful to do so.

Services: Young people said that they typically seek reproductive health services from a variety of sources. For STI problems, hospitals, public health centers and traditional healers were commonly mentioned sources of care. A wide range of sources were described for contraceptive methods. For abortions, young people turn to home remedies, hospitals and traditional healers. Key barriers to access include young people's shyness or shame, distance of providers and cost of services, and negative attitudes from health care workers.

Voluntary counseling and testing (VCT): Young people did not seem to have fully internalized the advantages of VCT, in part because of the limited treatment available for AIDS and low levels of awareness and availability of VCT services. The main advantages cited were the ability to better protect oneself and to avoid infecting others. Participants spoke more strongly about the disadvantages of a positive test result, including the intentional spreading of HIV to others for revenge, the high cost of treatment and depression.

Policy and program implications

Our key findings have several implications for programmatic and policy approaches to improving adolescent sexual and reproductive health.

HIV/AIDS and other STIs: Efforts are still needed to educate young people about STIs and the modes of transmission, about the consequences of STIs if left untreated (e.g., infertility and increased susceptibility to HIV) and that people may be infected but not show any physical symptoms.

Information: Mass media sources remain important ways to provide young people with sexual and reproductive health information, and these efforts should continue. FGDs showed that young people value a source's level of knowledge, experience and trustworthiness. In addition to mass media campaigns, efforts to address adolescents' need for information should be linked more strongly with health care providers, who have the knowledge and training to educate youth about sexual issues. Moreover, the shyness and concerns about privacy conveyed by focus group participants suggest that more investment is needed in comprehensive sex education programs—both in and out of school—that deliver information without identifying or stigmatizing youth who are sexually active. Linking schools with health clinics could also improve the quality of information and encourage young people to uti-

lize services, although privacy issues would still need to be addressed.

The greatest disagreement and debate among participants focused on parents, with whom many adolescents felt unable to discuss sex-related matters. Nevertheless, improving information outreach to adults could help increase parents' desire to support their children in obtaining accurate and comprehensive sexual and reproductive health information.

Services: Our findings highlight the need for improved training of health care workers who provide STI-related and contraceptive services. Young people expressed a need for providers with relevant skills and accepting attitudes who would be receptive to serving young, unmarried clients and protecting adolescents' privacy. FGDs also indicated a demand for abortion services among young people, and the wide range of methods described by participants to terminate pregnancy suggests that medical sources for postabortion care merit ongoing investment.

Although VCT services are still rare in Burkina Faso, they are more available in Ghana, Malawi and Uganda. However, most youth did not discuss the personal benefits of VCT, despite their understanding that VCT can help prevent HIV/AIDS. Programs should seek to increase awareness of and accessibility to VCT services in Burkina Faso; improve accessibility in rural areas of Ghana, Malawi and Uganda; and, in all countries, ensure adequate posttest counseling and support groups for youth who test positive for HIV. FGDs also indicated that youth associate the personal advantages of getting tested with the possibility of receiving treatment. Therefore, our study supports ongoing efforts to increase the availability and affordability of antiretroviral treatment.

Abstinence: Most participants understood the benefits of abstinence and acknowledged that it is an effective way to prevent STIs, including HIV/AIDS, and pregnancy. However, postponing sex until marriage was not a common motivation for abstinence; rather, FGDs indicated that this decision is typically based on a desire to avoid infection and pregnancy. As age at first marriage continues to increase in Sub-Saharan Africa, the message to "abstain until marriage" may become increasingly infeasible for young men and women. Thus, abstinence promotion must be accompanied by continued efforts to provide and encourage a range of protective methods, including condoms.

Condoms: Our findings suggest that condom promotion efforts must address the fact that many young people think sex is more enjoyable without condoms. Moreover, most participants agreed that young women have the right—and often the responsibility—to insist on condom use. However, exceptions were also mentioned (e.g., if a woman has received money or gifts from her partner), and young women described difficulties in negotiating condom use. In-depth research is needed to understand adolescents' motivations for using condoms and the extent to which condoms are used consistently and correctly. This would inform efforts to improve use among sexually active adolescents who use condoms infrequently or not at all.

Overall, our findings point to an ongoing need to coordinate HIV prevention programs with other activities that address the poor economic conditions and unequal gender norms that encourage young people to engage in risky sexual relationships. A range of examples from 55 FGDs conducted in four different social and cultural contexts support this broad type of investment—from the negative consequences of premarital pregnancy for young women (but not for young men) to the frequent mention of young women's having sex in exchange for money or gifts. Evidence provided by the young people who participated in these discussions supports continued investment in young women to increase educational attainment, improve financial opportunities and expand legal rights. The benefits will be reflected in young women's sexual and reproductive health and in the health of their male partners.

Introduction

Report objectives

Given the high prevalence rate of HIV among young people in Sub-Saharan Africa, it has become critical to understand the sexual behaviors of adolescents and the factors that protect them from or put them at risk of HIV infection. The goal of this report is to describe how young people understand and respond to common sexual and reproductive health issues, such as abstinence, condom use and sexually transmitted infections (STIs), what their sexual relationships are like and what they think about sexual and reproductive health information and service sources for young people in their communities. The analysis is based on data from 55 focus group discussions (FGDs) conducted with young people aged 14–19 in Burkina Faso, Ghana, Malawi and Uganda in 2003.

FGDs were held as part of a larger, five-year study of adolescent sexual and reproductive health issues called *Protecting the Next Generation: Understanding HIV Risk Among Youth*. The project seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, health care providers and the media, in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people. In addition to FGDs with young people, the research involves in-depth interviews with adolescents, teachers and health workers as well as national surveys of adolescents.

The four countries were selected to represent different regions of Sub-Saharan Africa and Anglophone (Ghana, Malawi and Uganda) and Francophone (Burkina Faso) countries, and to span varying levels of HIV prevalence, which currently range from an estimated 3% among adults in Ghana to 14% in Malawi.[1] School enrollment and education levels among adolescents vary across the countries; for example, only 9% of 15–19-year-old women in Burkina Faso are enrolled in school, compared with 38% of women that age in Ghana.[2] However, the context of many young people's lives in these four countries share some common characteristics: most live in rural areas (two-thirds or more of 15–19-year-olds) and many live in poverty (40% or more of the population in each country lives below the national poverty line).[3]

Key topics

FGDs addressed a wide range of topics: sexual activities, awareness about HIV and other STIs, health care–seeking behavior, risk perceptions and sources of information about reproductive health (see Appendix 1 for FGD guidelines). One area of inquiry was adolescents' sexual activities (i.e., terms used to describe sexual activities, types of sexual partners, places where young people meet potential sex partners, places where sex occurs and the important consequences of sexual activities). Another area of inquiry in our study was STIs and young people's level of awareness of different STIs.

Adolescents were asked whether young people in general seek health services for pregnancy, abortion, HIV, other STIs or contraceptives; the availability and different costs and benefits associated with various service sources named; and where young people prefer to go for services. The same sets of questions were asked specifically about voluntary counseling and testing for HIV. Probes were used specifically for sources that are outside of the formal medical care system (i.e., traditional healers, faith-based treatment and other forms of alternative medicine).

The discussions covered adolescents' perceptions and management of sexual and reproductive health risks, such as preventing pregnancy and contracting

HIV or other STIs. Specific questions were asked about what adolescents considered risky behaviors, the situations that raised young people's risk of HIV and STIs, ways of preventing HIV, other STIs and unplanned pregnancy, and adolescents' attitudes about unmarried adolescents who had become pregnant or fathered a child.

Finally, the discussions included questions about information sources for and communication about sexual matters and reproductive health problems. Adolescents were asked to describe common sources for information about pregnancy, STIs and HIV; who young people talk to about these issues (with probing about parents and other adult relatives, peers, sexual partners, media, teachers and health providers); the different costs and benefits associated with various sources and people identified; and the kind of information adolescents would like.

Substantive contributions

The findings from this study contribute substantially to knowledge about adolescent sexual and reproductive health by examining young people's views of sexual behavior and its consequences in contexts that have been differentially affected by the HIV/AIDS epidemic and across different groups of adolescents within each country (urban and rural communities; males and females; and in-school and out-of-school adolescents). Although many existing studies of adolescent sexual and reproductive health have shown results based on cross-national survey data, the evidence base for qualitative studies is much less developed. Even published studies drawing on qualitative data are quite varied, with some studies using qualitative evidence in an illustrative manner to support the survey results[4] and others systematically analyzing qualitative data.[5]

Challenges to conducting and analyzing FGDs are that the moderator styles varied across and within countries as did the comfort level of participants in discussing sexual behavior and relationships. However, the similarity of questions and probes used in the discussion groups and the systematic variation in group composition across all four countries enabled us to analyze the discussions for a number of key issues. We explicitly point out in the text any views that we found to be the result of how the FGDs were administered, because a few questions were not asked in all groups. In Malawi, young people were specifically asked about the sexual and reproductive health behaviors of Born Agains, and information was collected on initiation rites.

The FGDs were also designed to inform the content of a questionnaire for a national survey of young people in each country and to assist in the development of a guide for in-depth interviews with young people. Relevant findings from the FGDs that influenced these two separate data-collection efforts are described in Appendix 2.

This report will first briefly describe the study settings, the approaches used to select study sites and FGD participants, and the important challenges to implementing comparative, qualitative research. Findings are then presented on sexual activity, HIV/AIDS and other STIs; protective behaviors, such as abstinence, condom use and fidelity; and young people's views of information, communication and service sources for sexual and reproductive health problems. Relevant findings from other qualitative studies among Sub-Saharan African youth are included in each section. We conclude the report with the implications of the findings for policy and program approaches aimed at preventing the spread of HIV and STIs and reducing unwanted pregnancy among young people.

Study settings

The four countries in this study have each established a formal governmental body to coordinate the public response to the HIV/AIDS epidemic; these include the National AIDS Commissions in Ghana, Malawi and Uganda and the Conseil National de Lutte Contre le Sida et les IST in Burkina Faso. All countries have some type of national AIDS policy and reproductive health policy, the latter of which either focuses on adolescents or has a provision that addresses the needs of adolescents. However, the level of national attention and commitment given to implementing these policies differs across countries. In addition, the reach of programs beyond urban areas and the types of programs implemented in each country vary considerably. As a result, young people in these countries have been exposed to a variety of messages and services.

In Burkina Faso, the adolescent population is largely rural and has low levels of schooling: Slightly over three-quarters of 15–19-year-olds live in rural areas, and less than one in five have had more than seven years of schooling.[6] Nearly two-thirds of 15–24-year-olds live below the poverty line.[7] The Joint United Nations Program on HIV/AIDS (UNAIDS) estimate of adult HIV prevalence in 2003 was 4%, and results from

a nationally representative household-based HIV testing effort in the 2003 Demographic and Health Survey (DHS) showed an adult HIV prevalence rate of 2% (1% among 15–19-year-olds and among 20–24-year-olds); more young women than young men were HIV-positive.[8] In the survey-based HIV testing, 8% of eligible women and 14% of eligible men did not get tested. A number of HIV prevention messages have been developed through the use of the media: television advertisement campaigns, such as "C'est ma vie" ("It's my life"), the comic book "Marcelline et Jojo," interviews with people living with AIDS broadcast on the radio, and film screenings followed by discussions on a particular theme. HIV-specific interventions have been implemented, including caravans traveling across the country to raise awareness about HIV/AIDS and demonstrate condom use; the creation of "anti-SIDA" youth clubs in rural areas to provide information about HIV/AIDS and to sell condoms; the distribution and promotion of condoms through the Promotion du Marketing Social du Condom (PROMACO) marketing campaign and a special program for young women to do community outreach work and teach other young people about sexual and reproductive health issues, including HIV/AIDS.[9]

In Ghana, young people are more urbanized and fewer live in poverty than in Burkina Faso, but the majority (63% of 15–19-year-old females and 69% of 15–19-year-old males) still live in rural areas, and 45% of all 15–24-year-olds are estimated to live below the poverty line.[10] In contrast to the other three countries, most young Ghanaians have had at least seven years of schooling: 64% of 15–19-year-old females and 70% of 15–19-year-old males.[11] The UNAIDS estimate for adult HIV prevalence in 2003 was 3% and the 2003 DHS showed a 2% HIV prevalence level among adults (less than 1% among 15–19-year-olds and 1% among 20–24-year-olds); as in Burkina Faso, young women constituted the majority of HIV-positive young people.[12] In the survey-based HIV testing in Ghana, 11% of eligible women and 20% of eligible men did not get tested. A wide range of interventions targeting young people in Ghana have been conducted, among which are mass media activities to increase awareness and knowledge about HIV/AIDS along the lines of the ABC approach to behavior change (abstinence, being faithful and condom use); the formation of 'Virgin Clubs'; a set of media campaigns focused on the promotion of condom use in radio and television advertisements and promotion of brand names of condoms; television series that target young people on sexual and reproductive health issues; and a young women's empowerment program to prevent HIV infection and encourage school enrollment and attendance.[13]

In Uganda, the majority of adolescents live in rural areas (over 80% of 15–19-year-olds) and have less than seven years of schooling (65% of 15–19-year-old females and 61% of their male counterparts).[14] Substantial declines in the HIV prevalence level occurred in the 1990s. National surveillance data showed that estimated HIV prevalence among adults decreased from 18% in 1992 to 5% in 2001.[15] In 2003, the UNAIDS estimated prevalence level was 4%, but rates remained high for some groups. For example, among 15–24-year-old pregnant women in the capital city of Kampala, surveillance data showed an HIV prevalence rate of 10%.[16] For the past decade, Uganda has adopted the ABC approach, and a number of interventions aimed at behavior change and improved service delivery for young people have been developed. These include school-based programs, such as "Save Youth from AIDS," which integrate HIV education into the school curricula; media interventions aimed at young people, including free hotlines; phone-in radio programs and "Straight Talk" and "Young Talk" print materials; seminars conducted by The AIDS Support Organization (TASO) and the AIDS Information Centre to provide information on HIV/AIDS; and innovative peer interventions, such as the Program for Enhancing Adolescent Reproductive Life (PEARL), which seek to enhance young people's skills in communicating, negotiating sex and dealing with peer pressure.[17]

The rural setting and schooling levels that characterize most adolescents in Malawi are very similar to those for Ugandan adolescents. Free primary education was introduced in Malawi in 1994, but the evidence thus far shows that the majority of Malawian youth drop out before completing the eight years of primary school: About two-thirds of 15–19-year-olds have had less than seven years of schooling.[18] HIV/AIDS prevalence in Malawi is similar to that in Uganda a decade ago. HIV prevalence among Malawian adults in 2003 was estimated to be 14%; among 15–24-year-old pregnant women in the capital of Lilongwe, the HIV prevalence rate was 18%.[19] A variety of activities have begun in Malawi to prevent the spread of HIV among young people: anti-AIDS or "Edzi Toto" clubs for both in-school and out-of-school youth to teach them about the transmission and prevention of HIV and, for out-of-school youth, to provide income-generating opportu-

nities; life skills classes in schools; and an abstinence-based education program called "Why Wait?" in secondary schools and some primary schools.[20]

Given these different contexts, young people's access to information and services vary considerably—both across and within countries. In addition, the meanings of messages and definitions of sexual behaviors may be interpreted differently depending on the country context. The views of adolescents analyzed in this study are not likely to have been shaped by exposure to any one media message or program approach. What the views do show are the ways in which young people see sexual relationships and sexual intercourse; the risks they perceive; and their perceptions of how and where young people can get important information and health services for the sexual and reproductive health consequences they commonly face.

Methodology

A total of 55 focus group discussions (FGDs) were conducted from January through March 2003: 16 in both Burkina Faso and Ghana, 11 in Malawi and 12 in Uganda (Table 1). Young people were selected from both urban and rural areas and represented a mixture of male and female and in-school and out-of-school adolescents. In Malawi and Uganda, there were also groups of married men and married or single mothers. Discussions were conducted with homogenous groups of adolescents, segregated by sex, urban or rural residence and school status (in or out of school) (see Table 1, page 16). In Burkina Faso and Ghana, the discussions were further divided by age (14–16 and 17–19). The numbers of FGDs in each country differ because of slight variations in the social categories used (i.e., married adolescents or those who already had a child in Uganda and Malawi) and because the FGDs in Malawi and Uganda were not separated into age-groups.

Each FGD had 8–12 participants and lasted an average of 2–2.5 hours. The discussions were tape-recorded, transcribed and translated from local languages into English and, in the case of Burkina Faso, into French.

Burkina Faso: In Burkina Faso, half of the FGDs took place in rural Bazega province. The area was chosen for its relatively isolated location, familiarity of the research team with the local language (Mooré) and the fact that the researchers had worked in this area before and were thus not likely to arouse suspicion, given the sensitive nature of the FGD topics. The other FGDs took place in Ouagadougou, the capital city of Burkina Faso.

Ghana: In Ghana, urban FGDs were conducted in Accra, the capital, for out-of-school young people and in Kumasi for those who were in school. Kumasi was chosen as the site of the in-school FGDs because students in the secondary (boarding) institutions in the city are from all over the country. For the rural FGDs, out-of-school young people were recruited from Tolon/Kumbungu, which has the highest number of school dropouts in the northern region, and in-school young people were selected in West Mamprusi. The selection of urban and rural sites was done to reflect the three ecological zones in Ghana: the coast, middle and northern savannah belts.

Malawi: In Malawi, FGDs were conducted in Blantyre City, one of the oldest urban areas in Malawi, and in rural Mchinji district. Mchinji was chosen for its remoteness, high fertility rate and because a number of sexual and reproductive health programs have been implemented in the area.

Uganda: In Uganda, the FGDs took place in the urban areas of Kampala district, the capital, and Mbarara town, and in rural areas in Mbarara district. Kampala district was selected because many young people had theoretically been exposed to behavior change interventions in relation to HIV/AIDS. Mbarara district, about 300 km south of Kampala, was selected for its high prevalence of HIV/AIDS and its relative remoteness.

Research teams and participant recruitment

Each country had research teams that consisted of both males and females, most of whom were in their 20s and 30s, who served as moderators, note takers and research assistants. The majority of research team members had graduate school experience or experience in qualitative research and were fluent in at least one local language. Each country team used the same FGD training manual to practice for the actual fieldwork.

The research teams gained access to communities through letters and meetings (explaining the study) with high-level administrative officials, various community leaders and constituents. Consent was obtained

from all young people before they participated in the discussions and parental or guardian consent was also obtained for young people younger than 18 (the legal age of consent in each country). However, for students in boarding schools in Ghana, consent was obtained through the heads of school, who were treated as the guardians of students. In a few cases in Malawi, the Chief or an older person who knew the participant was asked for consent if the parent or guardian could not be found.

Although the basic design of the FGDs was similar across countries, the research teams used several approaches for recruiting participants. Initially, all teams were to use a facilities-based recruitment approach in urban areas (i.e., screening young people from predetermined venues visited by adolescents in large numbers) and a community-based approach in rural areas (i.e., working with a community leader to identify eligible adolescents). Below are the different recruitment strategies actually implemented in the four countries.

Burkina Faso: Participants in rural areas were recruited from facilities usually visited by young people, including the market, football fields, public water taps and pumps, kiosks, video clubs, youth clubs and bars. Young people in urban areas were recruited at many of the same types of facilities as those in rural areas, but also at cyber cafes, movie theaters, hair salons or barbershops and meeting places for different student groups. The FGDs were held in either a courtyard of a local nongovernmental organization, a yard owned by a theater company, or a kindergarten.

Ghana: In Accra, out-of-school young people were recruited through a facilities-based approach. Participants were screened from among street vendors, bars, lorry stations and playgrounds. After the screening, selected participants were driven to a local university's guesthouse for the FGD. To recruit out-of-school young people in rural areas (Tolon/Kumbungu), screening was done at a market square and on playgrounds, and the FGDs were held in a district assembly hall.

In Kumasi, in-school young people were recruited from boarding schools, vocational and technical schools and junior secondary schools. To ensure confidentiality, one student was selected from each school so that no two students came from the same school. The FGDs were either held in a neutral or quiet location. In West Mamprusi, in-school youth were recruited from junior and senior secondary schools. Screening among junior secondary schools was done in the teachers' common room and selected participants were driven to Walewale, the district capital, for the discussion.

Uganda: A community-based approach was used for both urban and rural areas with the help of a community "mobilizer" who accompanied the team from household to household to recruit young people. Screening took place at the local council person's residence, public meeting place or under a tree. The discussions were held in classrooms or, in the villages, in an empty room provided by the local council chairperson or a private, shady spot outdoors.

Malawi: The research team encountered resistance and distrust from community members when they began to use a facilities-based approach (reasons are discussed in the following section on challenges to collecting comparative data). As a result, the research team switched to a community-based approach. In Blantyre city, participants were recruited through the Chief, and all discussions took place at the Chief's house—discussions seemed free-flowing in this venue and the Chief was not present during the discussions. In the rural area of Mchinji district, a group village headman who oversees a number of villages served as the contact person. The group village headman requested that young people aged 14–19 from the six villages under him meet at his residence. Word of mouth also brought in some young people from beyond the six villages. The FGDs were conducted at the residence of the group village headman (who was not present during the discussions) or in tobacco grading sheds.

Challenges to collecting focus group data

One challenge to this study was that several recruitment approaches were used in the countries, despite initial efforts to adhere to the same design. The country research teams faced different obstacles in the field that led to changes in the proposed recruitment and screening strategies. For example, in Malawi, the facilities-based approach was difficult to implement because participants and their parents or relatives, especially in the urban areas, were not comfortable having young people picked up and taken to a venue because of rumors about child trafficking. To improve the level of participation, the team worked more directly with community leaders. It is not clear the degree to which different recruitment strategies may have influenced

the types of young people who participated in the FGDs apart from the demographic characteristics that were intentionally part of the design (e.g., age, gender, urban or rural residence and school status).

Another challenge was that the questions asked by the discussion moderators varied to some degree. On the one hand, adhering to the FGD guide too strictly could have compromised moderators' ability to obtain interesting and relevant points of view that had not been anticipated. Some moderators did probe further into topics and issues that were not included in the topic guide. In a few instances, questions in the FGD guidelines were omitted during the discussions.

An inevitable limitation of FGDs is that the styles of moderators vary, even when standard training materials have been used, as was the case in this study; thus the tone of each discussion is likely to reflect a combination of the moderator's style and the comfort, interest and willingness of participants to speak about a particular topic. Differences in exposure of countries and study sites to reproductive health information and services and differences in norms, beliefs and practices are more likely to explain variation in the type and amount of information discussed on a particular topic. Additionally, the difficulty of translation from the language of discussion into English or French may alter the meaning of the questions to respondents and therefore the meaning of the data.

Analysis approach

A general coding scheme using 10 codes was developed to capture the main topic areas discussed: sexual activity, sexually transmitted infections and HIV/AIDS, abstinence, condoms, risk perceptions, communication and sexual and reproductive health information and services. The 55 FGD transcripts were coded by two of the authors using *N6* qualitative software. The different sections were assigned to the authors and the text searches on each topic were read. Each author prepared summary matrices of the substantive themes on her topic area by gender of the study participants (for some topics, themes were examined by urban or rural residence). Each focus group was treated as a unit of analysis and recorded in the relevant topical matrix. Summary text was then written based on common themes arising from the matrices. For most sections of this report, at least one other author read the summary text and compared it with the matrix of themes to ensure that one researcher's subjective biases did not determine the conclusions drawn.

As with all qualitative data, the views described and discussed in this report reflect those of the young people who participated in the FGDs conducted in each country. The FGDs were designed to capture the opinions of males and females, young people in urban and rural areas, and young people in- and out-of-school in the areas where the FGDs were conducted. However, the findings reported here may not necessarily represent the views held by young people in general in Burkina Faso, Ghana, Malawi or Uganda.

Table 1. Composition of focus groups

	Female groups				Male groups				Total groups
	Urban		Rural		Urban		Rural		
	Schooling status				Schooling status				
	In	Out	In	Out	In	Out	In	Out	
Burkina Faso	2	2	1	3	2	2	2	2	16
Ghana	2	2	2	2	2	2	2	2	16
Malawi	1	2	1	2	1	1	1	2	11
Uganda	2	1	1	2	2	2	1	1	12
Total	14		14		14		13		55

Findings

Sexual activity

The focus of the discussions on sexual activity in each country was primarily on sexual intercourse rather than other kinds of sexual activities. Even though the moderator usually began with a question about "sexual activities," young people mainly spoke about sexual intercourse. However, other forms of sexual expression were mentioned occasionally in the groups (i.e., hugging and kissing, fondling and masturbation). Oral sex and anal sex were also mentioned in the Ghana focus group discussion (FGDs) in the context of what were "risky" sexual behaviors for young people (oral sex was described as risky in one male FGD and not risky in one female FGD).

Adolescents were generally forthcoming in speaking about sexual intercourse. In each country, young people mentioned different names, phrases or proverbs that described sexual intercourse; for example, "to extinguish my fire" among Burkinabé young women, "the Adam and Eve affair" among Burkinabé young men, "going to reduce our water level" among Ghanaian young men and "investigating Kandahar" among Ugandan young men.* Some said they used these euphemisms to hide their activities from parents or other adults. Because of probing by the moderators, the discussions in Malawi were especially rich regarding the use of alternative expressions for sexual intercourse by adolescents when talking about sexual activity in the presence of parents or strangers; for example, "cleaning a gun," "hitting water on beans," or "putting Colgate on a toothbrush" (Colgate refers to semen and the toothbrush to the female genitals). All groups understood what sexual intercourse meant, and discussions, if somewhat halting at the start for some groups, followed from the few introductory questions without any need to rely on colloquial terms or phrases to clarify.† The only case where discussion was generally difficult and characterized by silence or persistent probes by the moderator was among 14–16-year-old women in Burkina Faso. Talking about sex appeared to be very taboo for young women in Burkina Faso; they may speak about sex with their best friends, but they are reluctant to speak about it even with other age-mates of the same gender.

The overall tone of young people's discussions was not characterized by disproportionately negative or positive judgments about young people having sex. In several groups across the countries, sex was described as being a "bad thing," "misbehavior" or "prostitution," but such views were not expressed in most groups. Sexual intercourse was not often discussed in terms of enjoyment or pleasure, but these views emerged indirectly when young people talked about why condoms were not used (e.g., enjoying sex without a barrier—enjoying a "sweet without a wrapper"—or because condoms are forgotten in the excitement of the moment) and when young people talked about seeking sexual partners. Enjoyment was also alluded to in discussions of abstaining from sexual intercourse, as this young woman explained:

> *When you enter into a relationship with a boy, I think it is not all the time you will say no to his request for sex. Once [in] a while you should satisfy yourselves.*
> *—Ghana, FGD1, females, urban, in school*

A varied depiction of young people and sex emerged from the discussions. Sexual intercourse was described

*"Kandahar" refers to female genitals. The term came into use after the United States bombardment of Kandahar, Afghanistan. Because Kandahar was a Taliban stronghold, a lot of effort was needed to capture it and, once captured, Kandahar surrendered to United States forces. A Ugandan newspaper began to use "Kandahar" to mean female genitals and young people picked up the term.

†One motivation for the FGDs was to see whether colloquial phrases for sexual intercourse and STIs should be used in a structured survey instrument or in an in-depth interview guide, but it seems that this would not have worked well, given that the terms themselves are not meant for outsiders to use. Moreover, the FGDs indicated that young people understood what sexual intercourse meant without colloquial terms.

as being part of an intimate relationship (as in a boyfriend or girlfriend), as part of an exchange for money, as something that one is pressured or forced into, and as just something to do:

Football makes the adolescent boys very busy but if found free, not playing football, they only chat with girls to have sex with them.
—Malawi, FGD9, males, urban, out of school

Other qualitative studies have found that young people talk about a variety of reasons for initiating sexual activity that range from curiosity and peer pressure[21] to being forced, for some women.[22] Young people also perceive sexual desire as normal and natural[23] or, from a study in Ghana, as being caused by biological needs that must be met.[24]

In this study, there were distinct gender differences in the discussions of who initiates sex. Some of the more extensive and stronger sentiments about gender differences in initiating sexual relationships occurred in the Burkina Faso discussions. Young men were described as the ones who make overtures, while young women were described as primarily passive recipients:

Moderator: But if the girl sees a boy that she likes, how does she approach him?
P1: That's rare.
(Laughter)
P1: Even if the girl sees a boy that she loves, it is difficult for her to tell the boy that she saw him and wants him. We don't do that.
—Burkina Faso, FGD4, females, rural, out of school

However, in two focus groups of young women in Burkina Faso, it was mentioned that the young women would give signs (e.g., visiting with young men) to indicate that they were interested.

In the discussions in Ghana, Malawi and Uganda, young women were described as dressing "invitingly," going to secluded places where young men and women meet each other and looking for sex because they want money, or having sex with men other than their boyfriends:

…What I want to say is that some guys trust their girls. But while you are asleep, they will be having an affair with some men. So men must study girls properly before befriending them.
—Ghana, FGD6, males, urban, out of school

Consistently across groups, young men described other young men in terms of pursuing relationships or, in stronger terms, "conning" young women into having sex (the latter was most evident in the Uganda discussions and is supported by similar findings from FGDs with adults in another study).[25]

Sex partners

When FGD participants were asked with whom young people have sex, discussions overwhelmingly focused on three types of partners: (1) boyfriends or girlfriends, (2) older (sometimes married) men or women, and (3) occasional sex partners (e.g., one-night stands). In all four countries, both female and male discussion groups talked about girlfriend or boyfriend relationships where ages were similar and where there usually was some type of commitment, whether in the form of marriage intentions (described in Malawi), swearing an oath (described in Ghana), phrases used to describe the relationship (e.g., a "permanent" boyfriend or girlfriend, described in Uganda) or love (e.g., described as "love" in Burkina Faso, "true lovers" in Ghana and "real love" in Uganda). However, one caution is that the word "love" was used in different ways, sometimes to mean affection or emotional commitment and sometimes to mean simply a desire for sexual relations with the person. In the Burkina Faso discussions among young men, both of these very different meanings were expressed. Similar observations about the very different ways the word "like" is used by young people in Uganda have been raised elsewhere anecdotally.[26]

Having sexual relations with older, sometimes married, men and women was usually discussed as something done for money or gifts (discussed below). A less common reason—mentioned only in Malawi—given for having sexual relations with an older adult was gaining sexual experience. This reason was only presented as a motivation for young men to have sexual relations with an older woman. When the extramarital affair was between a young woman and an older man, the male partner's behavior was attributed to his sexual desire (i.e., he was looking for variety or was not satisfied at home). When the extramarital affair was between a young man and an older woman, her motivation was usually described as wanting money or household necessities (described in Burkina Faso, Malawi and Uganda). Finally, occasional sex partners were referred to by different terms ("one-night stands," "pick and play" or "eat and run") or specified as bargirls or prostitutes in all four countries.

Mostly in youth the relationships that are common are "eat and run." You eat and do not go back…
—Uganda, FGD12, males, urban, out of school

The range of sex partners described by young women and men in these discussions is similar to partners described by young people in other qualitative studies. In nearly all the qualitative studies we reviewed, young people talked about sex partners being peers and older partners.[27] One Ugandan study found that young men sometimes had sex with younger women because they believed that these women were relatively unlikely to have HIV and because they did not need to worry about pleasing younger women sexually.[28] This point did not arise in the discussions we analyzed. Several other studies showed that young people have multiple partnerships for a variety of reasons, from the economic benefits of having financially well-off partners who could provide gifts or economic necessities for young women[29] to feelings of manliness for young men.[30] While our study did not focus on the motivations for having multiple sex partners, the economic reasons underpinning sexual relationships among young people proved to be common across all countries.

Exchange of gifts or money for sex

Exchanging gifts or money for sex was discussed across all countries and, more importantly, arose in the discussions from the participants themselves: It was not a topic initiated by the discussion moderators in any of the countries. The intensity of this theme also varied across countries, with the topic arising more frequently in Malawi and Uganda than in Ghana and Burkina Faso. Discussion about money and gifts cut across ages and types of partners (i.e., like-aged boyfriends or girlfriends and older partners).

Having "sugar daddies" or "uncles" (older men as sexual partners among young women) and "sugar mummies" (older women as sexual partners among young men) specifically for money or gifts was mentioned in Ghana by young women and in Uganda and Malawi by both young women and young men.

P1: Maybe a young girl is taken with [a] sugar dad…seeing her like his grandchild.
P2: She wants money, otherwise that means she has been forced to do so…
P3: Some girls are doing this because of poverty, it is not intentional, and it is because you are starving so you end up falling in love with men.
—Malawi, FGD10, females, urban, out of school

P1: Then there is the relationship between young girls and an older man, what we call sugar daddies...
P2: Then there are also sugar mammies; the situation of older women befriending young boys (laughter).
—Ghana, FGD2, females, urban, in school

The laughter among the young women in Ghana following the mention of "sugar mammies" was of a mocking nature—a boy is doing something that he should not be doing—and not of embarrassment in talking about the topic.[31] Sex with older partners in exchange for money or gifts was also described in Burkina Faso, but was about young women receiving money or gifts from older men for sex and did not refer to young men having sex with older women for those reasons.

Discussions specifically about *young* men (not only older men) giving *young* women money or gifts in exchange for sex or, less directly, in hopes of having sex in the future, were common. In Burkina Faso, "enticing" or "flattering" young women with money or gifts was mentioned in both the male and female FGDs. A young man gives a small gift to develop the relationship—a tacit contract—and as the gifts keep coming, the young woman will have a harder time refusing sex. In Uganda, almost all the female and male groups talked about "girls looking for money" or "detoothing boys," and the behavior seemed to be a common part of the social landscape.

Girls, let me say they want to impress boys or attract boys, yet it will not help them because they get those boys for money, they call it "detoothing" but the end result is bad—they can get raped or they [the boys] ask them to return the money in another way which may not help them, so I advise them to get better things instead of boys. For example sports or staying at home and listen to music—there is no problem.
—Uganda, FGD11, females, urban, in school

A similar sentiment was expressed in some of the Malawian groups, but not to the same extent, and the discussion was more often tinged with the sense that it was solely out of economic desperation (e.g., sex in exchange for vegetables or salt). It was also in a Malawi FGD where young women talked about parents pressuring their daughters to have sex with men for money or basic household goods like soap.

Sometimes parents do not even care what their daughter does. Even if they know that she is engaged in sex, they are happy with her because she brings something home.
—Malawi, FGD3, females, rural, out of school

When talking about the consequences of sex, young men in some of the FGDs in Burkina Faso, Ghana and Uganda mentioned having to steal money to use on young women or that they do not "prosper" financially because money is spent on women.

Moderator: What are some of the consequences of sexual activities?
P1: One may not prosper in life as the little money that one receives may be used on girls.
P2: There may be an unplanned pregnancy. This may lead to abortion and can affect the girl in many ways.
P3: The boy may resort to stealing and cheating just to meet the needs of the girl.
—Ghana, FGD13, males, rural, out of school

Other qualitative studies have also shown that young people have sex for economic reasons,[32] and the material goods such as food, gifts, clothing, books and toiletries that older, more established men can provide to young women were specifically mentioned as encouragements for young females to have sex with older partners.[33] These transactions between young women and older male partners are not uncommon in Sub-Saharan Africa.[34] In some cases, the pressure to have sex for economic reasons came from parents as well; in two studies in Ghana and Zimbabwe, some parents encouraged their daughters to have sex for the material rewards.[35] The findings from this study, though, show how commonplace gifts and money are *among peers* in exchange for sexual relations, and not just with respect to much older sex partners.

Where to meet the opposite sex

Places and events named by adolescents for meeting the opposite sex varied by country and, with the exception of Burkina Faso, were not similar across most groups within each country. Given the very different amenities in urban and rural areas and perhaps due to different social norms about where young women and men can mix, it is not surprising that we do not see common places for meeting the opposite sex arising across all discussion groups.

In Burkina Faso, celebrations to mark holidays and parties were named in almost all the discussion groups. "Bringues" (a dance party at someone's house) and market days, especially on Sunday, were also common. Bars were named in four of the discussion groups with females and only one group with males, and weddings, churchs or mosques and schools were also named.

In Ghana, dances and festivals were named in four of the male discussion groups, but in most male and female groups a variety of places were named and none of them were common across all groups. Among these places or events were weddings, dances or "jams," parties, markets, people's homes, bars and places that had the aura of being removed from watchful eyes of others, such as school buildings at night, abandoned buildings and "dark corners."

As in Ghana, young people in Uganda named a range of places at which to meet the opposite sex, and few places or events stood out as being common across discussion groups. Clubs and discos were named in four groups. Other places or events mentioned were cinema halls, markets, on the road, weddings, churches, bars and the beach.

In Malawi, a range of places were named such as local markets, on the road, traditional dance events, beer-drinking places, dances, football matches and wedding ceremonies. Discussion on this topic was much more limited than in the other countries.

Where sex happens

Some things about young people and sexual activity seem universal: Young people usually do not have ready access to private space, and they usually need to hide their sexual activities from adults. Findings from the FGDs across all four countries about where sex happens for young people support this observation. The two overwhelmingly common places where young people have sex were in their homes (or a friend's home, depending on which home was most likely not to have an adult around) or in the bush or field, especially at night.

For young people, it's primarily at the boy's house. But there are exceptions because if you have a tutor or a father who can disturb you then you go to your friend's house to have sex.
—Burkina Faso, FGD3, males, rural, in school

P1: Some people meet in dark corners at night or in uncompleted buildings.
P2: Some meet in their homes.
P3: Some people arrange to meet in the houses

of friends, especially in homes where the parents are out most of the time.
—Ghana, FGD9, females, urban, out of school

Less common places, but still mentioned by a few groups across several countries, were rooms that could be rented for a short period of time to have sex ("chambres de passe" in Burkina Faso or rooms in "lodges" in Uganda and "rest houses" in Malawi), abandoned or unfinished buildings, school buildings or classrooms after hours and toilets or latrines. If one had money, as was more frequently the case when having sex with an older partner (sugar daddy/mummy), then privacy could be purchased in a rented room. Otherwise, young people described places like those above—a friend's home, the bush, unfinished buildings—that afforded cheap privacy.

Rape or forced sex

A less common topic arising in the discussions was rape or forced sexual intercourse. When discussed, it was usually in the context of a child being forced to have sex (being "defiled") or in the context of what some men, after drinking alcohol or smoking hemp or marijuana, will do to young women. The latter context was related to men's "uncontrollable" urges or willingness to engage in unprotected sex when under the influence of alcohol or drugs.

In some discussions, rape or forced sex was described as a response to young women refusing sex, even after attempts by young men to negotiate for sex, and particularly if young women received money or gifts (mentioned among males in Burkina Faso and Uganda and in both the male and female discussion groups in Malawi).

P1: Some smoke marijuana and just rape.
P2: If you have been financially assisted by a sugar mummy or sugar daddy, he or she makes you pay in kind…
—Uganda, FGD5, males, urban, in school

Rape or forced sex was rarely mentioned within marriage or boyfriend and girlfriend relationships. A common theme in the female discussion groups in Burkina Faso was that men drug young women in order to have sex with them. This situation was not talked about in the other countries with the exception of drinking alcohol, which is discussed later in this report. Finally, gang rape was mentioned in two discussion groups (one female and one male) in Ghana with the terms "gala" and "Black Star." "Gala" is a series of games normally associated with football in Ghana and was used in this context as young men having sex with a girl in turns. "Black Stars" is a national football team in Ghana and refers to mob or group action.

Forced sex has been mentioned in several other studies,[36] and young people's views about forced sex are mixed. In one study in Nairobi, Kenya, young people believed that "soft rape" (penetration after a girl teases a boy sexually but does not give in to sex) was acceptable.[37] Another study showed that in Nigeria pressuring a young woman to have sex if the young man has spent money on her was acceptable.[38] The findings presented here from Burkina Faso, Malawi and Uganda are similar with respect to the link between young women receiving money or gifts and having their right to say no to sexual intercourse compromised. In a South African study, young women reported experiencing partner violence, and the fear of violence prevented them from saying no to sex and compromised condom use.[39] This particular view did not come up in the discussions among young people we analyze here, but this could be because there were not extensive questions about forced sex in the discussions or because the South African study was based on semi-structured interviews with individuals, where personal experiences were asked about in detail, versus the discussions about adolescents in general that we analyze in this study.

Other sexual activities and pornography

Other issues related to sexual activity that came up less frequently were same-sex sexual activity and pornography. In Ghana, same-sex sexual activity was mainly mentioned by young women and men in the context of boarding schools and the things that can happen when the "lights are out." While two female discussion groups in Ghana talked about the existence of female-female ("supi") and male-male ("homo") relationships, the male discussion groups went further to describe specific sexual activities, such as anal intercourse and young women inserting fingers into each others' vaginas. In Malawi, male-male sex was mentioned in the context of teasing or bullying at school or what goes on in prisons. Same-sex sexual activity was not mentioned in the other discussion groups. Research on same-sex sexual activity in Sub-Saharan Africa is still quite rare. The one qualitative study of young people that mentioned same-sex sexual activity was from Ghana and reported that adolescents mentioned that same-sex sexual activity happened in young women's boarding

schools; however, young men reported no knowledge of same-sex activities.[40]

Other qualitative research, although scant, has also uncovered mixed findings on other kinds of sexual activities. Masturbation was seen as acceptable for young men as a means of sexual release when their girlfriends were menstruating and for young women as a "safe sex" method. Yet for both sexes masturbation was accompanied by feelings of shame and embarrassment.[41] Conversely, a study in Zambia found that masturbation was reported by young people as rare because it was seen to be no fun and a poor substitute for actual sexual intercourse with another person, and young women did not believe that masturbation could be sexually gratifying.[42]

Pornography or "blue" movies and books were mentioned by both males and females in Malawi and by males only in Ghana and Uganda. Pornography was discussed as an information source that young people know of and use to find out about different kinds of sexual activity and as something that encourages young people to experiment with sex (i.e., they want to practice what they saw). Pornography could be seen at specific video places, at video shows on market days, and in books and on playing cards.

There is a market day so there are video shows so these children do what? They get into video shows and watch pornographic shows and after that they would want to practice what they saw.
—Malawi, FGD5, males, rural, out of school

Perceptions of premarital pregnancy

Although the FGD guidelines for each country included a couple of specific questions about perceptions about premarital pregnancy, the questions were asked inconsistently across groups or not at all (as in the Uganda FGDs). Views about premarital pregnancy did arise in all country FGDs with respect to other topic areas (e.g., a general sense of the risk of unplanned pregnancy). The Burkina Faso FGDs had the most discussion on this topic.

The perceptions about young, unmarried pregnant women that were mentioned were overwhelmingly negative. Although some young people expressed feeling sorry for young women in this situation (most commonly expressed in Ghana), young people also said that unmarried pregnant women were often insulted or made fun of. A young, unmarried pregnant woman was generally considered to be undesirable and her prospects for marriage were bleak. In response to being asked how youth react to a young woman who gets pregnant before marriage, young men in Malawi stated:

P1: Some they see that they [pregnant, unmarried women] are out of fashion. That is why some say I can't go for that person.
Moderator: What else?
P2: Some regard her as a prostitute [not clearly heard].
Moderator: What else? Now you said they regard her "out of fashion," what are you trying to say actually?
P1: That is to say she has a child [so] that nobody can get attracted to her.
—Malawi, FGD8, males, urban, in school

The young woman's reputation may even be tarnished; in some instances, she may be associated with being a prostitute (mentioned mainly in Malawi and Burkina Faso FGDs). Young people in Ghana and Malawi mentioned that young women in this situation will most likely drop out of school as a result of the pregnancy.

It is interesting to note the views about parents and premarital pregnancy where, on the one hand, parents and family are blamed for their lack of control or guidance over their daughters, and on the other hand, parents and family were mentioned as driving unmarried pregnant daughters out of the home once they became pregnant. Being chased out of the home was mainly mentioned in Burkina Faso and was brought up equally by young men and young women.

This depiction of unmarried pregnant women is in stark contrast to perceptions of adolescent fathers. While young men who were adolescent fathers were also viewed in a negative light, themes of pity and more minor consequences like "teasing" or being "gossiped about" were described for young men, compared with the much more severe judgments and consequences described for unmarried, pregnant young women. A less common view was that unmarried adolescent fathers were "real men" and were admired. The notion that for a man to make a woman pregnant is a sign of fertility was evoked in only four groups overall in Burkina Faso and Malawi.

Most young people in Burkina Faso reiterated that young, unmarried women who were pregnant were far worse off and suffered more than the unmarried adolescent fathers. The reasons for this were that young women had no home; ultimately they had to take care of the child; they had no money; and they could not deny responsibility for the pregnancy. More generally,

a young woman being "worse off" is linked to gender roles in which women are primarily responsible for pregnancy. A young woman in Burkina Faso illustrated this point:

> *For young boys, especially in the villages, they are not accused, but it is the girl who is at fault. Even if the boy says that he does not want the girl, no one in the village will treat him as worthless. He is considered because he is always right and he worries about nothing. But the girl who is pregnant will be insulted by her parents. The problem always falls on women. Your father and your brothers blame you.*
> *—Burkina Faso, FGD4, married females, rural, out of school*

Descriptions of young men denying responsibility for a pregnancy came up in the FGDs across all four countries, but mainly in the FGDs with young women. In some instances, the denial of paternity was discussed as a factor in young women's decisions to get abortions:

> *A girl does not want to abort the pregnancy, but there are things that happen for a girl to decide to abort. If the man is not interested in the lady, she may end up aborting as she thinks that she will not have a place where to stay. Maybe she has been chased from her home by her parents and then the boy denies responsibility, hence the decision to abort.*
> *—Malawi, FGD 10, females, urban, out of school*

Sexually transmitted infections (STIs)

The STIs commonly mentioned by groups in all four countries were gonorrhea and syphilis. Other infections mentioned, but not in all four countries, were bubos or chancroid (in Malawi and Uganda), yeast or candida (in Ghana and Uganda), genital warts (in Malawi) and herpes (in Uganda). Some infections were talked about using local terms such as "tuma" (syphilis) in Burkina Faso, "likango" (genital warts) in Malawi and "enziku" (gonorrhea) in Uganda.

In general, young women were less knowledgeable about STIs than young men in each country. For example, the male discussion groups in Ghana tended to identify syphilis and gonorrhea with clear symptoms whereas the female discussion groups did not. For the youngest adolescents in the discussion groups in Burkina Faso and Ghana, where separate discussion groups were held with 14–16 year olds, even if the names of STIs were discussed, the symptoms were not very well known.

> *Moderator: What are the signs that show youth is suffering from clap?*
> *P1: We hear about clap but we don't know about signs.*
> *Moderator: If some one is suffering from gonorrhea, what are the signs that can show he is suffering from that illness?*
> *P2: We hear about gonorrhea, but we don't know anything about the signs.*
> *—Burkina Faso, FGD10, females, urban, out of school*

For the FGDs in Malawi, Uganda and among older adolescents in Ghana, symptoms for gonorrhea and syphilis appeared to be known. The discussions suggest that awareness of STIs and STI symptoms is more evident in the groups that were also more open to talking about sexual activity than others.

> *Moderator: What symptoms does a person suffering from syphilis have?*
> *P1: Some wash and fingers get cracked in between and rash all over the body.*
> *P2: Even myself I have it—rashes get part by part of my body.*
> *P3: Even me I have ever suffered from syphilis. It gets down in your private parts and it itches a lot. And as a result your way of walking changes.*
> *Moderator: How about gonorrhea? What are the symptoms?*
> *P4: Such a person cannot control urinate.*
> *P5: Pain [in] the fallopian tubes and feel pain while urinating.*
> *P3: If a man, he feels pain while urinating or fails to urinate because of the blockage. Pus also comes after or before urinating. If it is a girl, pus can be seen on her knicker [underwear].*
> *P5: A woman can develop a funny smell down if she had gonorrhea.*
> *—Uganda, FGD8, females, rural, out of school*

Some young people tended to hold misconceptions about STIs or cited nonsexual diseases as STIs. Two groups in Burkina Faso and one group in Ghana cited bilharzia as an STI because it leads to blood in the urine, which they identified as an STI symptom. Sickle cell anemia was cited in one group in Uganda and

shingles and scabies were cited in one group in Uganda and one group in Malawi. Ringworm was mentioned in one group in Uganda. Hernia was reported in three groups of young women in Burkina Faso as an STI. The identification of these diseases as STIs could possibly be due to how the moderators introduced discussions on STIs in the local languages. For example, in Burkina Faso in the Mooré language, STIs were described as "illnesses of the front." The "front" includes genitals, but also other parts of the body like the intestines and the bladder, and illnesses affecting those parts of the body—such as hernia and bilharzia—were possibly mentioned because of this. In Malawi, however, STIs are talked about as *matenda opatsirana* or "diseases that are shared," a phrase that is used solely for STIs.

Different symptoms were identified according to the type of illness, the physical changes (hair and skin) experienced, the physical pain and the behavior of the affected individual. In all of the countries, the most common symptom mentioned for STIs was scratching the private parts due to itching and pain. Walking badly or with difficulty (as a sign of an STI) was cited in three groups in Malawi and three groups in Uganda, and in some groups this was linked to a specific STI (gonorrhea or syphilis). In Ghana, walking with difficulty was mainly linked to swellings and pain in the genital area (and without respect to a specific STI). Some young people alluded to walking with legs apart to reduce the friction that caused a lot of pain.

> *When the tip of the penis swells, you find the man walking badly and then you will know that he has chancroids.*
> *—Uganda, FGD6, males, urban, in school*

Discharge and purulent urine were also identified as symptoms in all the countries except in Burkina Faso. Physical symptoms, including sores and blisters, revealed the health status of an individual. Sores on the genitals were cited mostly in Uganda and Burkina Faso (mentioned in seven groups). As noted by a young man in Ghana:

> *I remember that I took a girl to my house. Just as I was about to have sex with her I realized she had sores in her private parts, so I stopped.*
> *—Ghana, FGD5, males, urban, in school*

It is evident from the young people that physical manifestations of an STI determine their perceptions of who has an STI. This raises a big question regarding STIs that are asymptomatic, with the implication that the affected person can transmit the infection without raising suspicion in his or her partners.

A couple of other qualitative studies have looked at knowledge about STIs and found that young people are generally less knowledgeable about other STIs compared with HIV/AIDS[43] and that misconceptions about the symptoms and causes of STIs.[44] The results of this study confirm that young people know about STIs, but that the quality and depth of that knowledge varies.

HIV/AIDS

There was a lot of discussion on HIV/AIDS compared with discussion of other STIs across all four countries. Although young people knew about HIV/AIDS, some gaps in knowledge and misconceptions persisted. Some common misconceptions about how to contract HIV/AIDS included sharing chewing sticks, kissing and swimming in dirty water. A number of groups did not distinguish between HIV and AIDS. In French the word commonly used for HIV/AIDS is SIDA, and thus people in Burkina Faso do not speak about HIV, apart from those in the medical field.

Physical symptoms were predominantly used to identify a person with HIV/AIDS. Hair changes were mentioned in all the countries as a symptom of HIV/AIDS. Some reported that when a person has HIV/AIDS, the hair falls out, becomes scanty, changes texture and changes color. Weight loss was also mentioned as an important symptom of HIV/AIDS. The recognition of symptoms of AIDS as indicative of HIV infection implies that young people may expose themselves to the risk of infection, believing that their partners are healthy as they do not exhibit obvious physical symptoms even though infected with HIV. The assessment of physical appearance is also a determining factor in condom use (as noted later in this report). Deciding to use condoms based on whether or not a partner presents physical symptoms exposes young people to the risk of infection, not only for HIV but for other STIs as well. However, some groups pointed out that physical appearances alone could be misleading:

> *With AIDS the person grows lean. However, appearances can be deceptive and one cannot look at a person and say that he or she has AIDS. The surest way is to consult a doctor first.*
> *—Ghana, FGD1, females, urban, in school*

A group of young women in Malawi shared these sentiments:

> *Nowadays for AIDS—for somebody to know—it is difficult to know that this one is suffering from it unless he goes for a blood test at the hospital.*
> *—Malawi, FGD10, females, urban, out of school*

These sentiments, unfortunately, were not commonly emphasized in the discussion groups. Young people's discussions tended to focus on AIDS symptoms as a sign of HIV.

In general, the FGDs showed that young people were aware that their peers could be at risk of getting pregnant or contracting an STI or HIV. In some cases, young people expressed that they saw themselves at risk as well. The general awareness of risk matches other qualitative research findings about young people's views.[45] However, some young people tend to underestimate their risk and vulnerability to HIV infection, and, as in other studies of adolescents, determining risk by a partner's outward physical appearance (e.g., avoiding sickly and thin-looking people) or symptoms appears to still be commonly practiced.[46] For example, in one study in South Africa, trust was viewed as a "safeguard in contracting HIV."[47]

Protective behaviors

The FGDs also sought to elicit information on young people's knowledge about ways to protect themselves from STIs, HIV and unintended pregnancy. In all countries in this study, abstinence and condom use were mentioned as the main reasons that young people perceive themselves not to be at risk for HIV and other STIs. Some groups mentioned being faithful (fidelity and monogamy) as another means of protection. HIV testing was also discussed as a reliable way of knowing the HIV status of a partner and as an opportunity for behavior change, though in some groups there was misunderstanding about how often and when to get tested. We discuss HIV testing later under adolescents' views of sexual and reproductive health services.

In all countries but Malawi,* using condoms and oral contraceptive pills were most often mentioned by the young people as methods to prevent pregnancy. Young women were more likely than young men to mention the use of pills and young men were more likely than young women to talk about condoms as methods to prevent pregnancy. Young people also talked about abstinence and being aware of the menstrual cycle (using the safe period), though again there were indications that not everyone knew when in the menstrual cycle a woman was most at risk of pregnancy. Other pregnancy prevention methods, less often cited, were injections, Norplant (only in Burkina Faso) and withdrawal.

While most of the adolescents cited many different types of contraceptives, disadvantages were mentioned for using each method. These methods, particularly hormonal contraception, seem easier and more convenient to use when young people are in a union.

> *P1: Yes, now like us girls don't swallow like women. Now women swallow it daily because every day they sleep with men.*
> *P2: Me, I was told that you swallow the pill daily.*
> *P3: Also me, that is what I have heard. Now I wondered why should I swallow daily when I have no man [husband]?*
> *P1: Ones [that you] don't swallow daily; you swallow only when you are going to meet a man. And also when you play sex [have sexual intercourse] before swallowing pills and you swallow two pills after sex, you don't conceive.*
> *—Uganda, FGD9, females, rural, in school*

Taking a contraceptive pill may therefore not be perceived as the best option for a young person who is having sexual intercourse sporadically. In Burkina Faso, young women did not mention any specific modern contraceptive method, except condoms, though some knew about contraceptives for married couples.

Although less common, traditional medicine was another means of protecting oneself against pregnancy and STIs mentioned by young men in Malawi and both young women and men in Burkina Faso, Ghana, and Uganda. Young men tended to talk about traditional medicine in relation to STI and HIV prevention:

> *Sometimes other people, even if they know that a girl has buboes,† they will just have sex with her believing that they cannot get the disease. It is mainly those who have consulted traditional healers and they have been given traditional medicine that protects them from getting the diseases even after having sex with one who is infected.*
> *—Malawi, FGD9, males, urban, out of school*

*In Malawi, participants were mainly asked about methods to prevent HIV and other STIs.

†This is an enlarged lymph node ("swollen gland") that is tender and painful, particularly in the groin and armpit, and characteristic of a number of infectious diseases such as chancroid and syphilis.

Young women more frequently discussed the use of traditional medicine as a means of pregnancy prevention:

Others say that if you drink a sugar-solution after sex you will not get pregnant.
—Ghana, FGD9, females, urban, out of school

Other traditional medicines to protect against pregnancy varied widely: putting black powder in the vagina or on the penis before intercourse (Burkina Faso); drinking salt solutions (Ghana); and wearing medicine around the waist (Malawi). The use of herbs was mentioned as a way to prevent both pregnancy and STIs (Uganda and Ghana). There was some question though about the effectiveness of some of these traditional medicines.

Many of the young people expressed the possibility of HIV infection even with these preventive measures in place. Other, nonsexual modes of HIV transmission were identified as ways of contracting HIV, such as reusing or sharing objects or sharp instruments with blood (e.g., blades at the hairdressers or during female genital cutting). A group of young women in Burkina Faso illustrates this point in relation to abstinence:

P1: We do not agree because even people who abstain can get "diseases of the front."
P2: You can easily get AIDS if a blade with another person's blood cuts you. At the maternity ward, if you use the same scissors during delivery, women can get AIDS.
—Burkina Faso, FGD4, married females, rural, out of school

Another reason given by some young people in Burkina Faso, Ghana and Uganda as to why the use of protection does not guarantee prevention is that some methods are not 100% effective. Rhythm, withdrawal and the condom were methods described as being unreliable:

The condom or contraceptive may fail you and you can impregnate a girl even if [you] use them. Therefore we are at risk. It is the same with STIs.
—Ghana, FGD7, males, rural, in school

In short, adolescents spoke freely about a range of protective behaviors. Adolescents' more detailed views about two of the often-cited behaviors—abstinence and condom use—are described below.

Abstinence

While the ideal of abstinence until marriage was cited in FGDs in all four countries, the discussion groups showed that young people do not share one unified view of abstinence. Most of the groups did talk about abstinence as an important way of avoiding HIV, other STIs and pregnancy. A group of young women from Malawi illustrates this theme:

If you are not following what the young men are telling you, that means you have preserved yourself. If the young men tell you to have sex with them and you refuse, you cannot have AIDS or contract any other STI.
—Malawi, FGD4, females, rural, out of school

A less common sentiment was that young people should be abstinent until marriage and was expressed in such ways as being patient and waiting for marriage or if two people really love each other, they will wait until they get married. Abstinence until marriage was expressed more often among the male and female FGDs in Burkina Faso and Ghana than in the FGDs in Uganda and Malawi. A group of young women in Uganda also talked about the virtues of abstinence and the need to preserve oneself until marriage, but again linked it to the avoidance of pregnancy:

It is better to have sex when someone is married. OK, if you are not married and use safe days, you never know… by a mistake or due to changes in your body, you can get pregnant and no one will take care of the baby. And having sex before marriage is not good because the boy can drop you and end up marrying another girl. You end up starting your pregnancy or child rearing without help.
—Uganda, FGD11, females, urban, in school

Abstinence was also seen as something that one does when there is already a problem (after becoming sexually active). This was reported in the Malawi, Ghana and Uganda study sites with respect to young people who were diagnosed with STIs and advised by health providers or counselors to avoid sex until they were healed or until the problem disappeared.

P1: But it is good that a person should go for VCT [voluntary counseling and testing] because [they] change the behavior that [they] had before.
Moderator: What behavior is that?

P1: Aaah, if he liked sexual intercourse he changes to good behavior of which he can choose one well behaved woman or else leaving that bad way of having [sex] if he is found without AIDS.
P2: Some people change and begin using condoms.
P3: Sometimes they do change in order to avoid spreading the disease.
Moderator: Mmmh.
P3: Sometimes you do abstain, you don't do the sexual behaviors.
—Malawi, FGD5, males, rural, out of school

In short, abstinence was mainly viewed in Malawi and Uganda as something one does *after* having found out about one's HIV status. In two FGDs, the young people mentioned that abstinence is a behavior to adopt as a result of suffering from an STI. Whatever the results of the HIV test, going to a VCT center can help motivate young people to abstain:

If you have been in doubt yourself and you are told that you are negative, you will change your behavior and will stop having sex.
—Uganda, FGD6, males, urban, in school

Young people in Burkina Faso did not discuss this issue, possibly because many of them talked about how one could visit a traditional healer for STI treatment, and traditional healers do not usually talk about abstinence, because they are consulted for treatment.

How to maintain abstinence

Although abstinence was generally viewed as an ideal to achieve, many felt that it was hard to maintain. This was mentioned mainly by young men in Uganda and Malawi and young women in Burkina Faso and Uganda, who noted that it is difficult or impossible to abstain from sexual activity. The need to fulfill sexual feelings or desires was identified as one of the factors that make abstinence difficult.

P1: One has to abstain.
Moderator: Do you think it will be difficult to abstain?
P2: In any way, it will be difficult, but if it can be achieved (laughs), then that is the best solution.
—Burkina Faso, FGD13, females, urban, out of school

Various behaviors were proposed that could help a young person remain abstinent, ranging from focusing on school work to engaging in physical activities such as sports. Some proposed activities were learning to play games such as table tennis (Ghana) or cards (Uganda), football (Malawi, Uganda) and exercise (Malawi), engaging in physical activities to get over sexual feelings (Ghana), keeping busy (Malawi, Uganda) and working (Malawi, Uganda). Abstaining was viewed as more difficult for young people who were out of school or who had a lot of spare time because they did not have many other competing interests or activities to keep their minds off sex.

In Malawi, where specific questions about religion were asked, a few groups mentioned that people who were "saved" (born-again Christians or committed believers in Jesus Christ) could successfully use their faith to help them remain abstinent and that believers as a group were not at risk of pregnancy or STIs because of their abstinent lifestyle.

Abstinence was said to be advocated by family and through the mass media, specifically advocacy on HIV/AIDS in the media. Abstinence was often presented as the safest and essentially the only way for young people to manage their sexuality. However, the message on abstinence was found impractical by some of the young people. A group of young people from Malawi observed that:

P1: The things that we cannot be happy about include the fact that the hospital people do advise that if a person is found HIV positive, he should not engage in sexual intercourse. We hear that this is what they tell them…
P2: We young people see sexual intercourse as a good thing and if we are told that we should not have sexual intercourse, we do not feel okay.
—Malawi, FGD2, male, rural, out of school

Some young people saw abstinence messages coming from family members as an effort to control and therefore curtail their own movement and pleasure. This could also be linked to the inability and unwillingness of young people to discuss sexual matters with their parents:

Usually relatives tell you only problems of condoms even when you are using a condom, that it is not safe. It is not safe. They say you should abstain, so relatives control you.
—Uganda, FGD6, males, urban, in school

Other studies show that young men in Uganda and Zimbabwe describe abstinence as a practice that can fail and as an unrealistic option.[48] A focus group study in Cameroon found that it was not socially acceptable for young people to remain abstinent for a long period of time.[49] Another study in rural South Africa showed that abstinence was viewed more positively among young women than among young men.[50] Reasons for supporting abstinence among young women in Uganda and Zimbabwe were mainly linked to preserving oneself for marriage.[51] However, few studies go in depth as to what abstinence means to young people and how those meanings vary by gender.

Condoms

Most of the discussion groups mentioned condoms as a way to protect against STIs, especially HIV. To a lesser degree condoms were described as a way to protect against pregnancy as well. This section will focus on four specific aspects of condoms that arose in the discussions: perceived effectiveness, rationale for use and nonuse, rumors about condoms and negotiation of condom use.

Perceived effectiveness

Three groups of young women in Ghana and one in Uganda discussed the effectiveness of condoms, compared with 13 groups of young men (five in Burkina Faso, four in Ghana, one in Malawi and three in Uganda). This could be because the condom is a male-controlled method and young women may feel more hesitant and less knowledgeable to talk about condoms in detail. In four groups (three male and one female), young people cautioned that condoms were not 100% effective.

> *Moderator: Some people also think that they cannot be infected with HIV and STDs because they are young. What do you also think?*
> *P1: One can be infected if he/she has sex without protection. Even some of the doctors say that protection with condoms is not always 100%.*
> *Moderator: What are the ways you think young people can protect themselves against these diseases?*
> *P2: Abstinence.*
> *P3: You should not even have a boyfriend or girlfriend because they can influence you. Some of the boys may have other girlfriends and can contract an infection and also infect you.*
> *P4: Use of condoms.*
> *P5: To use condom but that is not even very reliable because condoms are not 100% effective.*
> *—Ghana, FGD11, females, rural, in school*

In another three groups (two male and one female) young people reported percentages of 99% effectiveness, indicating a slight doubt in the condom's effectiveness in preventing all types of STIs.

> *They say that condoms are 99% safe; you never know that the one you have had a hole or something so sperms may pass through and you get pregnant.*
> *—Uganda, FGD11, females, urban, in school*

Condoms were most commonly discussed among young men as a method that could be unreliable or ineffective because condoms can expire (Burkina Faso), can tear or burst (Ghana, Burkina Faso), can have holes in them (Uganda) or could be improperly used (Uganda). As with the young men, some young women in Uganda and Ghana said that condoms were potentially ineffective (two groups in Ghana), that condoms already have the disease (Uganda) or that condoms can be pierced (Uganda).

Reasons for use and nonuse

Young people spoke clearly about reasons that condoms should be used, and the prevention of STIs was commonly mentioned. It was also reported that some young people use condoms once they start experiencing STI symptoms or when they notice something about the outward appearance of a potential sex partner. However, some groups mentioned that looks can be deceiving and that the nonuse of condoms can lead to HIV/AIDS or pregnancy.

The young women and men had a lot to say regarding why they do not use condoms. One of the most pervasive views in all the countries and among all discussion groups was the notion of "you cannot eat a sweet in a wrapper." Groups in Malawi and Ghana described sex without a condom as "meat to meat," "flesh to flesh" and "real sex." Young men provided more reasons for nonuse of condoms related to a preference for "flesh to flesh sex" compared with young women. Some young people expressed that in order to show love for a partner one has to have sex without a condom:

> *They have a saying that you cannot buy a sweet and eat it in a wrapper…If you want to show your girlfriend full love you have to eat her live [sex without a condom]….*
> *—Uganda, FGD12, males, rural, out of school*

Moreover, among males, one group in Malawi and one group in Uganda mentioned that if a young man did not use a condom the first time he had sex with a particular partner, then he would see no need to use one subsequently.

One reason given for not using a condom for the first time with a new sexual partner was the anxiety around sex and what young people termed as "too much love"—in the process, young people forget all about using a condom.

Trust was another reason not to use condoms: If one trusts one's partner, there is no need to use protection. One group in Malawi reported that insisting on condom use could be interpreted as "having more than one sexual partner," thereby creating doubts in the mind of the current boyfriend or girlfriend. It could also be interpreted that the person pushing for condom use has an infection that he or she would not like to transmit to the partner.

Some of these remarks may stem from the view expressed in Ghana, Malawi and Uganda (one group in each country) that condoms are mainly used by prostitutes who have multiple partners. Two groups of young people in Uganda mentioned that even prostitutes charge lower amounts for sex with condoms than for sex without them, which lends support to the view that real sex is only attainable without condoms, or perhaps that the increased risk of HIV and other STIs that a prostitute faces in having sex without a condom must be compensated for by higher payment.

Rumors about condoms

One of the most common rumors about condoms raised in the discussions was that condoms could remain in the vagina or go to the womb; this caused a lot of fear, particularly among female participants. In one group in Uganda, it was reported that condoms contain a fluid that can cause cancer, and in Malawi it was reported that the condom can go all the way to the womb, where it can burst and cause cancer. A female group in Uganda reported that condoms can cause pain in the fallopian tubes, and another group reported that condoms have diseases that could be transmitted through sexual intercourse. Such misperceptions influence young people's understanding of condoms and may ultimately determine who uses condoms and how they use them.

A number of other qualitative studies have examined young people's perceptions and attitudes toward condoms, and results of those studies echo the findings presented here. Studies have overwhelmingly found that young people have negative attitudes toward condoms.[52] The main reasons cited include concerns about condom safety and breakage;[53] the belief that condoms are ineffective (i.e., they have small holes invisible to the eye, can tear or break, and can disappear into the vagina);[54] perceived decrease in enjoyment and pleasure when using a condom;[55] fear that the quality of condoms is low[56] or concern about the quality of free condoms;[57] and associating condom use with infidelity or having an STI.[58] In a number of other studies, trust was mentioned as a reason for not using condoms.[59]

Negotiation of condom use

Several issues emerged from the data that illustrate the negotiation between young men and young women with regard to condom use. In Ghana and Burkina Faso, young men more often than young women talked about safer sex being a woman's responsibility. In some cases, young men did not think it was their responsibility to initiate condom use:

> *If the male has the desire for sex, he forgets all about these things. It is the girls who have the courage to ask for safe sex… The girls know that they will be on the receiving end. They will get pregnant or contract a disease. Both the boy and the girl can contract an STI, but the boy cannot become pregnant.*
> *—Ghana, FGD3, males, urban, in school*

Although young men thought it was young women's responsibility to ask for condom use, young women voiced that it is difficult for them to refuse to have sex without a condom or to demand condom use. Some of the young women mentioned that they did not have the power to encourage men to use condoms, especially if the men were unwilling. In some cases, even when young women insisted on condom use, young men found ways of convincing young women to have sex without condoms.

A number of reasons were put forth as to why young women may not be able to insist on condom use. One reason is that if young women accept gifts or money from men, they lose the power to negotiate and have to give in to sex without condoms, even if it is against their will.

> *Some girls are poor so they cannot bargain. A girl in that category may think that if she asks for safer sex the boy will stop providing for her needs.*
> *—Ghana, FGD2, females, urban, in school*

Some of the young women also feared that the relationship would end if they insist on condom use. In addition, young women stated that if they insisted on young men using condoms, the men may wear them, but they may also put a hole at the tip to deceive the woman that she is protected. When asked why young men would pierce a hole in the condom, some respondents responded by saying that they do so in order "to feel the sweetness" (Malawi, Burkina Faso) and that the purpose may also be to infect a partner (Uganda).

Some young men put pressure on their future wives to have sex without a condom. In some cases, it seemed as if married women have little choice in negotiating condom use:

> *You just accept—you have nothing to do because you are married… You have to accept everything he says… Now if you are married—your husband might not be faithful to you. You might be faithful but your husband sleeps with an infected person and it becomes a problem… You see the problem you are already married.*
> *—Uganda, FGD10, females, urban, in school*

Yet in Burkina Faso, among a group of married adolescents, some participants said married women were able to ask their husbands to use a condom as a means of avoiding pregnancy and infections, when they doubted their partner's fidelity:

> *I have a baby and if I sleep with my husband without a condom, my baby would suffer. I ask my husband to use a condom and he accepts… If he has the baby's interests at heart, he will use a condom, because it is his baby… We can ask him to use a condom because we know he is sleeping with another girl.*
> *—Burkina Faso, FGD4, married females, rural, out of school*

The quotes illustrate that ensuring condom use is seen as women's responsibility or that they have a right to insist on use, but women, especially young women, often do not have the power to enforce condom use.

Other studies have reported that condom use is not common[60] and that young women have difficulties insisting on or negotiating condom use.[61] A South African study found that condom use was rarely discussed with a partner.[62] Some studies report that women who introduce condoms were perceived as "cheap" or "loose"[63] or as prostitutes.[64]

Condom availability

Condoms are, according to all the groups of adolescents, available in each of the countries. The issue of condom availability was mainly discussed by the male respondents. In Burkina Faso, none of the young women gave information as to where adolescents can get a condom, but there was some discussion among young women in the other countries.

There was a big difference between the young men in Burkina Faso and Ghana (little talk about condom availability) and the young men in Uganda and Malawi (a lot of talk about condom availability). Two groups in Burkina Faso reported that it was difficult to get information on and access to condoms. They also said that they were ashamed of asking for condoms from women or in shops where other customers might know what they were purchasing. In Ghana it was also reported that although condoms were cheap, it was difficult for young people to ask for them in shops due to fear of people knowing their intentions. In Malawi and Uganda, condoms were reported as being readily available but sometimes expensive to buy. Young people may also take condoms from the suppliers just to please them without any intention of using them. In all four countries the best locations to obtain condoms were health centers and drugstores or pharmacies.

> *OK, initially, some of us felt shy going to the drugstore to buy contraceptives. But due to the alarming rate of HIV/AIDS infection, some of us do not feel shy any longer about purchasing condoms. Everybody is talking about it so if you want to buy it, it is just a matter of walking into the drug store and saying I need a Protector. The seller will just pick it for you without querying you. But formerly, the seller will ask for your age and what you will be using it for. If they realize you are underage, they will not sell it to you.*
> *—Ghana, FGD6, males, urban, out of school*

Although it was reported that condoms were available at youth centers, hospitals and the shops, some young people (rural males, in and out of school) said they were limited from buying condoms because they lacked the money. In one of the groups a young man reported that one may be forced to take a risk because of lack of money:

> *Sometimes you can get your girl and you find you do not have money to buy condoms and some of us fear parents… So you decide 'kutera kitwe*

headmaster' [to have sex without a condom]… You can't ask for money for condoms from your parents.
—Uganda, FGD6, males, urban, in school

Other qualitative studies with findings on condom availability for adolescents highlight the shame young people have in getting condoms, even if condoms are offered free at clinics, and especially the shame that young women feel in getting or carrying condoms.[65]

Fidelity

The majority of discussion groups across all countries mentioned fidelity; in a few instances, having only one partner or reducing the number of sexual partners was discussed as another strategy for diminishing the risk of HIV and other STIs. However, this prevention strategy was less frequently mentioned across and within each group than abstinence and condom use, where follow-up questions were asked.

Being faithful was suggested as a possibility both within and outside of marriage. In Burkina Faso, Malawi and Uganda, being faithful was occasionally mentioned as a behavior to adopt after one has been tested for HIV.

Moderator: The ways that the youths see that they are preventing a virus of AIDS or STIs—what are they?
P1: Having only one sexual partner.
P2: Having one sexual partner but before this go for blood test and know the results after staying for some time go again for the test, maybe this can help.
—Malawi, FGD10, females, urban, out of school

In all of the countries, young men brought up the idea that a woman may claim to be faithful when in fact she is not faithful to her partner and thereby can possibly transmit an STI. One group of young men in Ghana mentioned that it is better to use condoms as a young woman may pretend to be faithful. Being faithful was also viewed by some young men as not being a guarantee against infection because that person may already be infected. Only one focus group of young men in Malawi talked about the difficulty in being faithful before marriage. Young men in Malawi, compared with young women and men in the other countries, talked more extensively about fidelity as a prevention strategy for married people.

Contexts of risk for STIs and pregnancy

The discussions highlighted how protective behaviors are compromised by contextual factors. A few of these contextual factors have already been addressed above: sex in exchange for money or goods and rape or forced sex. In this section we briefly describe other contextual factors that came up in the discussions: alcohol and drug use, poverty and peer pressure.

Alcohol and drug use

In all countries, and especially Uganda, the use of alcohol—and in some instances drugs—plays a significant role in risky sexual behaviors. Among young women, the discussion focused more on how young men take advantage of young women who are drunk in order to have sex with them or how young men may drug women. Both young men and young women discussed the negative impact alcohol has on the ability to engage in protected sex.

P1:…the men are very tricky because they make you drink a lot of alcohol. Like he may buy 4 bottles then he keeps asking you if you have finished. Even if the glass is still full, they keep adding [to your glass]. When you are drunk you cannot resist, you just accept.
P2: You just walk home with no objection at all and remember you could have refused the previous day. You are already drunk. When you get to bed you do not even have time to ask for condoms, you offer slight resistance and then give in.
—Uganda, FGD4, married females, rural, out of school

Even if young people have the intention to use a condom, they may forget or abandon these intentions because of the effects of alcohol or drugs, as reported by one group in Malawi and two groups in Uganda.

Poverty

Young women's discussions more often included talk about social conditions or events that increase their risk of unprotected sex than did young men's discussions. The discussions among young women in Ghana, Malawi and Uganda about risky sexual behavior linked it to poverty and the need for money:

And also poverty…We get born in poverty-ridden households. If you get born from a poverty-ridden household and you don't have patience, you can land into many problems. Because your par-

ents can be poor without money, you want a good dress but you can't have it. You end up playing sex [having sexual intercourse] and doing all other bad things to sustain yourself.
—Uganda, FGD9, females, rural, in school

A qualitative study in Nairobi slums similarly found that dire economic conditions contribute to sex-for-money exchanges and that these conditions normalize early sexual behavior and unhealthy sexual practices.[66]

Another aspect brought up by young women in Ghana was coming from "broken homes," where young women may be left to "fend for themselves." Young women may become involved in prostitution to meet their financial needs and in some cases (mentioned by one group in Ghana and one group in Uganda) may even be pushed by their parents to go into prostitution. Young men were also aware of young women's financial needs, but were more likely to link these financial needs to young men's own risks of getting an STI. This further highlights the gender divide in experiences related to risky sexual behaviors.

Peer pressure and other influences

In the Uganda and Ghana discussion groups, peer pressure was recognized as a contributing factor to engaging in risky sexual behaviors. Young women and young men mentioned that peers can encourage a young person to engage in sex even though that person might not be ready to do so.

Peer pressure, engaging yourself with so much thoughts of that kind of relationship might force you into it. He might be a person who due to his/her background does not want to engage in that type of activity, but as a result of peer influence the person might get himself into trouble.
—Ghana, FGD4, males, urban, in school

Other qualitative studies in Sub-Saharan Africa also show that peer pressure is a strong influence in encouraging premarital sexual activity and that young people gain social acceptance from their peers for having sex before marriage.[67] In a study in Senegal, while young people reported feeling pressure to initiate sex before marriage from their peers, they were also criticized for having sex before marriage by adults and other adolescents.[68] Several studies conducted in Ghana, Kenya and Senegal found that young women faced more criticism for having nonmarital sex than young men, yet young men were still condemned by adults and some peers.[69]

Sexual and reproductive health information

Young people said they obtain information about sexual and reproductive health from four main sources: (1) the media, (2) schools or teachers, (3) health care providers and (4) family and friends. There is some overlap between what young people identified as sources of information and their preferred sources of information. Barriers to getting information were most often linked to a particular source, but in some instances more general barriers were identified. Young people's preferences for information sources were mainly determined by the knowledge and confidentiality of the information source and by how entertaining the format was (e.g., dramas, film and television).

Mass media

In all countries, young people reported primarily receiving sexual and reproductive health information from the radio, generally through shows and sometimes through advertisements. A variety of shows exist, including "Capital Doctor" and "Straight Talk Show" in Uganda and a show in Burkina Faso that features a man nicknamed Sid Naaba ("king of truth") who sometimes speaks about sexual and reproductive health. FM radio stations were mentioned in particular. Not only is the radio a major source of information for young people, but it is also one of their preferred sources. For example, reasons why the radio is preferred are that it is a reliable source (Uganda), it reaches a wide audience (Ghana), information gets to young people quickly (Malawi), there is no need to go somewhere for the information (Burkina Faso) and parents can listen and learn and teach their children (Malawi). However, some barriers were associated with this medium of communication: radio shows do not talk about sexual and reproductive health issues every day (Burkina Faso), one cannot ask questions (Ghana, Malawi) and not everyone has access to a radio (Malawi, Uganda).

It is good to hear things from the radio but the problem we have concerning this source is that when something is not clear and you want to ask a question, that opportunity is not there. When we discuss issues the way we are discussing here, an opportunity is there for us to ask where we do not understand and this is not the same with the radios.
—Malawi, FGD2, males, rural, out of school

Newspapers were also mentioned as a source of information. In Uganda, a number of different newspapers and newspaper inserts, such as "Straight Talk" and "Young Talk," offer sexual and reproductive health information. The groups in Uganda had more extensive discussions about print media than those in other countries. "Straight Talk" was identified as a preferred source of information, and barriers related to this form of media were lack of money to buy newspapers, not having access to newspapers, information in a language one does not understand and illiteracy. Illiteracy was also mentioned by young men in Malawi.

Obtaining information from television or films was mentioned mainly in Burkina Faso, but less frequently than the radio or newspapers. Shows or advertisements appearing on television and films, such as those developed by PROMACO—a condom promotion campaign in Burkina Faso—provide sexual and reproductive health information. Although electricity is still uncommon in the rural areas in Burkina Faso, nongovernmental organizations (NGOs) show films and videos, and these are significant events (which also surmount the large problems of illiteracy in rural Burkina Faso). The show "Things We Do for Love" was mentioned in Ghana. Cinema and films were described as appealing because they present concrete cases (Burkina Faso), are entertaining and impersonal (Ghana) and can provide an opportunity to receive advice (Burkina Faso). Other forms of media cited were theater (Burkina Faso, Uganda) and dramas (Malawi), posters (Malawi), poems (Malawi), dances (Malawi), and singers, songs and singing in a choir (Malawi, Burkina Faso). Dramas and theater were mentioned in Burkina Faso, Malawi and Uganda as preferred sources of information because they are entertaining, encourage young people to talk to each other and are accessible to those who are illiterate.

Schools and teachers

Schools and teachers are also an important source of information about sexual and reproductive health for young people in all four countries. Regular teachers provide information to their students, or external nurses or health workers come in to speak specifically about sexual and reproductive health topics. In some cases, organizations come to the schools and speak to the students. Although most young people indicated that teachers and schools were a preferred source of information (Burkina Faso, Ghana, Malawi), a group of urban males in Burkina Faso contended that it was difficult to talk to teachers. When asked from whom young people prefer to receive information, a group of young women responded:

> *P1: Everyone but teachers.*
> *Moderator: Why?*
> *P1: With the teacher, one will be ashamed to ask the question in class.*
> *P2: But if you are in class, you can ask questions that you cannot ask when you are alone with the teacher.*
> *—Burkina Faso, FGD14, females, urban, in school*

Health care professionals

Young people also reported obtaining information from health care providers, hospitals (mainly mentioned in Ghana and Malawi), health centers (all countries), dispensaries (Burkina Faso), drug stores (Ghana), herbalists (Ghana) and traditional healers (Burkina Faso). Some young people said that contact with a health care provider gives them the opportunity to ask questions. Discussions of barriers indicated that young people face a number of problems with health care providers: Staff were overworked (Burkina Faso), there was a lack of explanations when obtaining information at hospitals (Ghana), young people were shy to ask doctors questions (Ghana, Uganda), a clinic was not a source for young men (Ghana) and it took time to go to a hospital (Malawi). Doctors and nurses were described as unfriendly or even harsh (Malawi), and health personnel as sometimes not forthcoming or patient (Ghana).

> *Doctors and nurses should also be taught about how to be friendly towards young people like us. At times they treat you like you are not a human being.*
> *—Ghana, FGD12, females, urban, out of school*

However, most of the young people's sentiments indicated that they know who the credible sources are and that they value a source's level of knowledge and experience with the problem at hand. In all countries, health care professionals at health centers or hospitals were identified as preferred sources of information and were described as being "reliable," "knowledgeable" and "trained." In response to being asked what are young people's preferred sources of information, young men in Burkina Faso and Ghana stated:

> *P1: We want to receive this information [on sexual and reproductive health] from doctors who*

know their work well.
P2: We prefer nurses.
—Burkina Faso, FGD12, males, urban, in school

We prefer going to the hospital. This is because the hospitals and clinics offer good health services and they are also knowledgeable about health issues.
—Ghana, FGD13, males, rural, out of school

Family and friends

Parents were identified as a source of information mainly by young women in Burkina Faso and Malawi, and by young men in Ghana and Uganda. However, there was a lot of debate about the role of parents in providing sexual and reproductive health information. Parents were seen as a good source of information because they were experienced (Ghana) and were a convenient source (Malawi). Parents were also viewed as being good at passing on general information. However, parents were also seen as unable to address young people's needs without being judgmental or uncomfortable sharing information. A group of young women in Malawi highlight the difficulties in approaching parents:

Moderator: What else? Now what are problems do the youth face when they are seeking information concerning pregnancy?
P1: Sometimes parents do not feel free to advise their children. It is better that at puberty girls should be told that if you do this, you will get pregnant…so a child feels free [can talk with] with her grandparents, but our grandparents live in the village and we only meet them once in a while. As a result of this we seem to lack information.
—Malawi, FGD8, females, urban, in school

The young women in this focus group also brought up the idea of seeking information from grandparents. Seeking information from grandparents or an elderly community member was infrequently mentioned throughout the other FGDs and was not at all discussed in Uganda.

There was the sense that it was easier for young women to get information from their mothers and for young men to get information from their fathers, although in general mothers were seen as more approachable than fathers by both young men and women. Fathers were viewed as strict, maybe as an expression of their protective approach to issues, and therefore not easily approachable for such discussions.

Moderator: Can young people speak to their dad [about relationships between boys and girls]? (Laughter)
P1: The dad can say that it does not concern him.
P2: It will get heated if one talks about those issues to the dad.
—Burkina Faso, FGD11, males, urban, in school

P1: Like for me, I cannot talk with my father… that I make him sit down and say you know what daddy, [I] am pregnant. I cannot even dare utter a word because when he comes back home he asks, so what necessities are missing. So you do not converse, you only answer; there is no salt, no food and no soap.
P2: Even when you have a problem you go to your mother first then she tells your father. Yeah, fathers are harsh.
—Uganda, FGD4, females, rural, out of school

Additionally, due to the nature of work, some fathers are not at home long enough or early enough for their children to talk to them.

When asked about preferred sources of information, parents were brought up, but again with mixed reactions. Some young people reported feelings of shame or were scared about asking parents for sexual and reproductive health information (Burkina Faso, Ghana and Uganda) because they feared being insulted or punished (Burkina Faso, Ghana) or because parents were strict or tough (Uganda). Parents were also described as not knowing everything (Burkina Faso, Ghana) and as not being free or open-minded with adolescents (Malawi); mothers were said not to keep the information shared a secret (Ghana).

Other family members—including older siblings (Burkina Faso), aunts (Burkina Faso, Ghana, Uganda) and grandmothers (Ghana)—were cited as people whom youth can consult for information. Older brothers were identified in Burkina Faso by four groups of young men as a preferred source of information. Older persons in the community were seen to have a role in providing sexual and reproductive health information in Burkina Faso, Ghana and Uganda.

Friends and peers were mentioned in all countries but Malawi, and were most often discussed in Ghana. However, overall they seem to play a less prominent role, given that they were less frequently mentioned

across all focus groups than other sources of information. One group in Uganda brought up the notion that friends are not a reliable source of information. This was also evoked by young people when discussing preferred sources of information. However, friends and siblings were also mentioned by some young people as preferred sources of information because they draw from their personal experiences. Even if friends might be deemed a less reliable source of information, young people expressed that friends were more approachable and tended to respond in a nonjudgmental manner:

> *I think some people ask their peers because when they ask their parents, they might think they want to indulge in such things. They will think they are naughty, so they turn to their peers who are not experienced in that field.*
> *—Ghana, FGD3, males, urban, in school*

Friends were only brought up as a preferred source in Burkina Faso and Ghana. In Burkina Faso, there was some debate as to whether or not friends were indeed a preferred source of information. Boyfriends and sex partners as providers of information were only cited in Ghana.

Other information sources

Various NGOs, such as SOS Sida in Burkina Faso, Banja la Mtsogolo (an NGO specializing in reproductive health services) in Malawi, World Vision in Ghana and The AIDS Support Organisation (TASO) in Uganda were mentioned as information sources for young people. Some organizations do outreach work in schools and communities and some are responsible for public education campaigns.

Less frequently cited sources were religious leaders (in Ghana they provide information on morality issues), the Church (in Burkina Faso it was mentioned once with respect to marriage; four groups mentioned the Church in Ghana and four in Malawi) and the Mosque (one group in Ghana). This source was not mentioned at all by groups in Uganda.

In all countries, youth clubs and centers and peer educators were talked about both as a source of information and as one that is preferred. Young people seemed particularly interested in seminars, discussion groups or organized gatherings, especially in Uganda. These were perceived as providing an opportunity to ask questions and to learn.

Confidentiality of information

Young people strongly valued confidentiality when receiving information on sex-related matters. In fact, the preference for health personnel is mainly due to the fact that they are trained to maintain confidentiality and those providing information may not be known to the recipients personally. The issue of confidentiality was also reflected during discussions on the role of young people in educating their peers on sexual and reproductive health. In Malawi and Uganda, the view was that it would be difficult for youth to train people in their own communities because people know them and would doubt the authenticity of the messages and potentially inhibit open discussions. Their proposal was to have people educate in communities outside their own to allow for open, unbiased learning and sharing of experiences:

> *The problem is that maybe the person telling you this is from the same village as you and then you are sitting there listening to your village mate! In such cases it is better to get someone away from your village, someone who is not even known in the village to talk to you about this.*
> *—Malawi, FGD9, male, urban, out of school*

In some cases certain sources were shunned because of their lack of confidentiality. The young people's views have implications for sources of information and require that whoever is vested with this responsibility ensures confidentiality and that places where this information is passed out should provide some privacy.

Other qualitative research in Sub-Saharan Africa shows that young people seek information about sexual and reproductive health from friends or peers,[70] school or teachers,[71] radio,[72] clinics or doctor and nurses[73] and local organizations.[74] Although a few studies mention that young people seek information from parents,[75] some young people in studies in Ghana and South Africa said that parents had difficulties discussing sexual matters with young people,[76] and in a study in Senegal, young people said they would like to be able to seek information from their parents.[77] One study of data from 24 FGDs with secondary school students in Nigeria found that the media was the most common source of STI information for young people; among young men, the most common sources were friends and peers.[78] The findings from our study support the existing evidence and make a valuable contribution to the literature by providing more details about young people's views of different sexual and reproductive health information sources.

Communication

The FGD guidelines included questions about who young people talk to when they have questions or problems about relationships with the opposite sex. The most commonly mentioned people in all four countries were friends, parents (especially mothers), grandparents and older people in the community. While parents, especially mothers, were mentioned in all countries as people to whom adolescents can talk about sexual matters, they were also the focus of the most disagreement and debate within the groups for many of the same reasons given about parents as sources of information about sexual and reproductive health. Reasons that some adolescents felt they could talk with parents were that parents were straightforward (Burkina Faso), they could keep secrets (Ghana), they tell the truth (Ghana) and they have experience or know a lot (Ghana, Malawi). Reasons that it is problematic to talk with parents were that parents gossip (Ghana), embarrass you (Ghana), shout at, punish or beat you (Burkina Faso, Ghana, Malawi, Uganda), adolescents are shy to talk about such things with parents (Ghana, Malawi, Uganda), it is culturally taboo or disrespectful to do so (Ghana, Malawi), and parents would think their sons or daughters were "bad" or "spoilt" (Ghana).

Friends were mentioned in both the female and male groups, with gender differences observed in Malawi (where friends were not as commonly mentioned in the male groups) and in Uganda (where friends were mentioned with some reservations in the female groups). Reasons for talking with friends were that they could be trusted, you feel comfortable with them, they would help you and they were experienced. The problems noted were that they might tease or criticize you and that they gossip.

Moderator: Whom do you talk to [about sexual and reproductive health]?
P8: My older friend in school... Such a person can help you because you can tell a sister who can easily leak information to parents.
Moderator: Why do you fear mothers?
P3: I would rather tell my mother than tell the father because the father will just beat you saying you are a spoilt girl while mother can advise me accordingly.
P9: Somebody talked about telling a friend in school but some friends cannot give good advice.
P5: I might tell my sister and she tells my mother about it but a friend may not do that.
—Uganda, FGD8, females, urban, out of school

Grandparents and elders were commonly sought by adolescents to talk about relationship problems because they showed interest and would listen to young people, they were experienced and knowledgeable, and they could act as intermediaries between young people and their parents in the case of a problem. Other family members that were important sources for adolescents were older brothers (mentioned in Burkina Faso in five out of six male groups and even in two female groups) and older sisters (mentioned by both male and female groups in Ghana and Uganda). Aunts were mentioned in both male and female discussion groups in Burkina Faso and Uganda, and "sengas" were specified in some discussions in Uganda. (Traditionally "sengas" were paternal aunts among the Bantu groups in Uganda who provided limited information about sexual and reproductive health.)[79]

Teachers were mentioned in every country by several discussion groups, but drawbacks to talking with teachers were also raised in discussions in each country; for example, teachers might spread rumors or tell parents (described in Ghana and Uganda). Interestingly, young men but not young women in Ghana mentioned religious leaders and pastors as people they would confide in, but reasons for not confiding in them arose as well. Other people mentioned less frequently were doctors and nurses, cousins and Muslim religious leaders (mentioned in one FGD in Ghana with respect to "Mallams," who also practice healing in some communities).

Sexual and reproductive health services

Like adults, young people seek care in different ways according to the type of problem, the barriers they face and their resources. In this section, we describe the sources of health care mentioned by young people for different types of problems or needs, and the main barriers to health care services.

STI-related services

When young people suffer from STIs, many go to a hospital or a public health center for services. However, many young people talked about problems with seeking care at a hospital or public health facility. These ranged from lack of confidentiality and costs (for consultation or prescription medicines)* to negative judgments and attitudes from providers and difficulties getting to a facility.

*The discussions had little detail about the costs associated with visiting and getting treatment at different types of providers. Instead, young people talked about some providers either being more expensive or cheaper than other types of providers.

P1: They even go to private clinics because at hospital they just shout "Those having STIs should go there" so the person feels embarrassed. [laughs]
P2: When you stay for a while like this, [the] consult medical officer saying "Eh! Those having gonorrhea whatever, there!" The way you know, so you stand amongst many people, so you feel embarrassed.
—Malawi, FGD7, females, urban, out of school

Traditional healers or herbalists were as frequently mentioned as sources of care for STIs as hospitals or public health centers. Traditional healers or herbalists were believed by some to successfully treat STIs: They were said to bring fast relief, have cheap services and allow the patient to pay in installments.

Moderator: Where can youth seek care for "chaude pisse" [hot urine]?
P1: If you go the public health services, you have to pay around one dollar before being seen by a provider.
P2: The traditional treatment is cheaper. Some traditional healers give you a treatment and you pay something when you recover from the illness.
—Burkina Faso, FGD4, rural, females, out of school

Herbalists and sources of treatment other than formal health centers or hospitals were also mentioned because adolescents were less likely to be identified by others as having sought treatment for STI-related problems. But some young people also admit that traditional healers are not as effective as medical doctors, and when seeking help from a traditional healer, young people also seek care from hospitals. They expressed the view that health providers are more reliable and knowledgeable.

Other less frequently mentioned sources of care were: buying medicine in a drugstore or pharmacy (Ghana, Uganda); prayer as a way of cure (Ghana, Malawi, Uganda); and people who sell medicines in the streets ("drug peddlers" in Ghana and "vendeurs ambulants de médicaments" in Burkina Faso). Surprisingly, there appeared to be no differences in sources of care based on urban or rural residence. Young people living in urban areas mentioned traditional healers and hospitals or public health facilities as often as those living in rural areas. In just a few discussions were friends mentioned (Ghana, Malawi), usually in the context of providing drugs or suggesting available places to get medicine or such traditional treatments as herbs.

Some they go to ask friends who once suffered diseases like that so that they can know its treatment. Some they do run away from such kind of a person, some because of shyness they do not disclose it.
—Malawi, FGD8, females, urban, in school

Other published qualitative studies have also shown that young people seek different sources of STI care and confront barriers in obtaining those services. A study in Ghana showed that young men went to the hospital for STI services, whereas a study in Nigeria found that young people most commonly reported seeking care from traditional healers.[80] Advantages to seeking care from a traditional healer included low cost and speed of delivery and cure. Young women in Zimbabwe said that they feared staff response when seeking STI treatment at health clinics.[81]

Contraception

In Burkina Faso, family planning services were mentioned in almost all discussions among female adolescents as sources for contraceptive methods, but young men were less talkative about female methods of contraception. In Ghana, young women and young men reported that friends were common sources for contraceptive methods, followed by pharmacies or drugstores and finally hospitals or health centers. In Malawi and Uganda, hospitals and family planning services were commonly mentioned as sources for contraceptives. Community-based distributors and traditional birth attendants were also mentioned in Malawi by young men.

Moderator: Who are the providers of these services [for contraceptives]?
P1: We can get them from drugstores.
P2: They are available at hospitals.
P3: Some from quack doctors.
P4: At times one can get them from friends.
Moderator: Why do young people use some of these services?
P1: Some prefer quack doctors. This is because they feel shy to go hospital. Some also feel that hospital officials will reveal their secrets to others.
P2: Those services are also cheaper than the services provided at the hospital.
P3: Some prefer to go to the hospital because that is safe.
—Ghana, FGD11, females, rural, in school

Abortion

Most young people reported being familiar with abortion methods or having experienced an abortion, even though abortion is legal only in a few circumstances in all four countries—the most liberal law being in Ghana, where abortion is legally permitted to save a woman's life or protect a woman's physical or mental health. Adolescents in Ghana and Burkina Faso mentioned that young people prefer to use home remedies to abort (e.g., in Ghana, mixtures such as Coca-Cola and sugar; sugar and salt; seawater; and Guinness or milk and sugar were described); in Malawi, young people seek help from traditional healers or old women who sell herbs, and use home remedies or go to the hospital. The hospital is also a common source of care in Malawi and Ghana, but in Burkina Faso, young men reported that they prefer to buy drugs from peddlers, while young women indicated that they prefer to go to private clinics. Only in Malawi did young women cite traditional birth attendants as a source for abortions. Compared with young people in rural areas, those in urban areas mentioned a medical source of care for abortion more frequently.

According to young women in Malawi and Uganda, it is not unusual for a young woman to abort more than once. In the discussions there was little shame in talking openly about abortion, but in Burkina Faso this kind of conversation was mentioned as taking place only with best friends.

Three other qualitative studies on abortion services and care that specifically focus on young people show common knowledge of home remedies and formal services to terminate pregnancy. In a Ghanaian study, young people reported using various "concoctions" to abort, and financial cost was an important factor in choosing the method of abortion.[82] Henry and Fayorsey provide more detailed information about young women's abortion experiences in a set of 29 case studies in one area of Accra, Ghana (chosen because adolescents in urban areas have levels of "pregnancy loss" twice as high as those in rural areas in Ghana).[83] Most young women reported seeking an abortion at a hospital or clinic. In some instances, the use of failed home remedies or herbs was followed by seeking an abortion at a clinic. Findings of a case study on abortion in Kenya show that young people know where to get abortions, who performs them, the methods used and the possible consequences of having an abortion.[84]

AIDS treatment

Although antiretroviral programs are currently being rolled out in all four countries, the estimated number of people who need antiretroviral drugs far outweighs the number who are receiving treatment. In the FGDs, young people talked about the hospital as the primary source of care for AIDS (as they did for other STIs). Seeking help from a traditional healer or witch doctor and using traditional medicine were other options that were seen as being cheaper than formal medical treatment, even if many young men and women do not think traditional healers can effectively treat AIDS.

In Burkina Faso and Uganda, such NGOs as TASO in Uganda were cited, although less frequently than other sources of care. However, this sentiment should be interpreted with caution because NGOs and churches run some of the most successful health facilities in these countries. Church and use of prayer were brought up as offering healing powers. More young women than men in every country cited prayer as a way to be healthy again.

Voluntary counseling and testing

Although not widely available in the study sites (and more so in some countries than in others), VCT was discussed by young people in all countries. However, in Burkina Faso, Ghana and Malawi, the youngest adolescents admitted that they did not know what VCT was. When defined, it was still not understood as a test to determine one's HIV status but was understood as a simple blood test.

HIV testing was mentioned by at least some groups in all countries as a preventive strategy. The groups saw HIV testing as something that should be done with a partner prior to engaging in sexual activity. Ideally, after testing, partners should be faithful to each other:

> *You can abstain until you are old enough to be interested in girls. When you have a girlfriend, you will go and get tested with her. That way you can stay together, she does not betray you and you do not betray her. I think it is the only remedy against diseases of the front ["maladie du devant"].*
> *—Burkina Faso, FGD9, males, urban, out of school*

In all countries, some groups mentioned the advantage for someone to find out that he or she is HIV negative. VCT may lead to behavior change in sexual relations: A young person may decide to use protection or even to abstain:

> *P1: The person may not be sure whether he is infected or not. So when he goes to test and finds*

he is free, he will feel good and may leave sex altogether. There are those who do not trust their partner, after testing they will be sure, then they will take care.
P2: It makes you get encouraged to abstain and be more careful and you actually feel good.
—Uganda, FGD7, males, rural, in school

One other advantage mentioned was to know one's HIV status before marriage. Discussion groups in all four countries mentioned this, but in Uganda it was also mentioned that the negative partner can leave the positive one. In some cases, religious leaders require an HIV certificate before solemnizing a marriage. In Uganda, where adolescents seemed more aware of VCT and antiretroviral treatment, advantages for those testing positive were mentioned in the discussions, such as seeking treatment to live longer and being able to better plan for one's future and for one's children.

In all four countries, one of the disadvantages of VCT mentioned was that some people might intentionally spread the illness for reasons of revenge if they learn they are HIV positive. The strong negative stigma attached to being HIV positive also remains: Some groups expressed that life can become hard and people will "fear you." In Burkina Faso and Ghana, many groups said that people who find out they are positive may commit suicide. This was mentioned to a lesser degree in Malawi and Uganda, perhaps because the higher prevalence of HIV/AIDS in those countries makes it a relatively larger and less-stigmatized health issue facing the population and may encourage more public activism on the part of HIV-positive people. The idea that a diagnosis of HIV could trigger suicide may also be related to the feeling that there is no available treatment or cure for AIDS. In Burkina Faso, seven different groups mentioned that lack of treatment for AIDS was a major disadvantage to VCT.

In one group in Malawi and four groups in Uganda, the results of the test were discussed in terms of having repercussions on the life of children: Children may end up being neglected and suffer the consequences of a family member being HIV positive because money is spent on care:

Also see that blood test, aah, it's not good also because that person who has been found with the virus, suppose he was rich. At this point he does not care even about his own children. If he had a house he will just sell it. You do not really care about the future of the people you leave behind.
—Malawi, FGD9, males, urban, out of school

Even when adolescents are aware of the availability of VCT, there are obstacles, such as cost and distance:

Moderator: How accessible are the places where VCT services are provided?
P1: In some cases while the youth would want to go and have their blood tested, the major problem is that the place is very far.
Moderator: Where do the youth go for a blood test?
P2: District headquarters.
Moderator: Oho, so how do they travel to get there?
P2: Transport is a major problem and hence the majority doesn't go there.
—Malawi, FGD1, males, rural, in school

Very little qualitative information from other studies is available on young people's views about VCT services. A Horizons study in Kenya and Uganda examined whether VCT services were appropriate for young people.[85] In the FGDs conducted during our study, youth expressed concern about the confidentiality of services and indicated that cost was a barrier to getting tested. Young people liked getting counseled when getting tested (some had not received counseling during testing).

In light of the continued rollout of antiretroviral programs in a number of Sub-Saharan African countries, there is likely to be a rising demand for VCT over time. Given this promising development and the fact that VCT continues to play an important preventive role, it is critical to identify the strongest barriers to young people's actually finding out their HIV status. Is it a matter of building more test sites or training more people to provide tests, or are the strongest barriers more psychological or sociological (e.g., the fear of results being made public or the stigma of being HIV positive in one's community)?

Barriers to services

The findings described thus far about the different sources for sexual and reproductive health services highlight common barriers adolescents say they face in getting these kinds of services. One key barrier young people identified was the shyness and shame that young people felt when obtaining these types of services. Shyness and shame were frequently mentioned by youth and may help explain their preference for traditional healers rather than health workers, because traditional healers were seen as being more discreet than other medical providers. Traditional healers do not collect as much personal information as clinics and hospi-

tals. In Ghana, youth considered quack doctors more discreet than health care workers.

Young people also talked about lack of money and distance as main barriers to using services and the problem of health personnel paying more attention to or giving better service to their relatives, other people they know or people who are willing to pay a little extra. The lack of relevant and accurate information was also a barrier. In rural areas in all the countries, the range of health services for youth was mentioned as being more restricted than in urban areas.

Finally, young people, especially young men described being poorly received by health care providers, especially in the public health centers. In each country, young women as well as young men complained about the bad welcome from health care providers when young people are suffering from STIs. Focus groups indicated that some health workers humiliate them, insult them or shout at them. These barriers are similar to those found by other qualitative studies of young people seeking sexual and reproductive health services: cost,[86] negative attitudes from providers[87] and lack of confidentiality.[88]

Conclusion

Findings from the 55 focus group discussions (FGDs) with young people highlight how youth view sexual and reproductive health issues, such as abstinence, condom use and sexually transmitted infections (STIs), and what they think about sources of sexual and reproductive health information and services. Given that Sub-Saharan Africa has been hardest hit by the HIV/AIDS epidemic and that the majority of new HIV infections occur among young people aged 15–24, our study is a crucial step in strengthening the evidence base to ensure that policies and programs help young people protect their sexual and reproductive health. The findings have several implications for programmatic and policy approaches to improving adolescent sexual and reproductive health.

HIV/AIDS and other STIs: Overall, young people are familiar with STIs, including HIV/AIDS, but the quality and depth of their knowledge varies, and misconceptions persist. Efforts are still needed to educate young people about STIs and the ways that HIV is (and is not) transmitted; about the consequences of untreated STIs, including infertility and increased susceptibility to HIV; and that people may have an STI but not show any physical symptoms.

Information: A variety of mass media sources (i.e., radio, newspapers and television) remain important in transmitting information to young people, and these efforts should be continued. The FGDs showed that young people value a source's level of knowledge, experience with sexual and reproductive health issues, and trustworthiness. Efforts to address adolescents' information needs (apart from mass media campaigns) could be better linked to doctors, nurses and other kinds of health personnel who have been well trained and are knowledgeable about such matters. Given young people's discomfort with talking about sexual matters and their concerns about confidentiality, the evidence also supports devoting resources to implementing comprehensive sex education in schools and supporting other methods to reach adolescents who are out of school in ways that do not identify and stigmatize young people who are sexually active. Linking schools with health clinics could also strengthen the information provided and improve health care utilization among young people, a suggestion arising from earlier research of interventions to increase young people's health care utilization;[89] nevertheless, issues of confidentiality remain.

Parents were the focus of the most disagreement and debate within the discussion groups, and many reasons were given why adolescents were unable to talk with parents about sex-related matters. Although parents were not described as the best source of information, improving information outreach to adults could indirectly strengthen parents' support of accurate and comprehensive sexual and reproductive health education for their children.

Services: Young people mentioned that they seek reproductive health services from a variety of sources. For STI problems, hospitals, public health centers and traditional healers were commonly mentioned sources of care. A wide range of sources was described for contraceptive methods. For abortions, young people turn to home remedies, hospitals and traditional healers. Key barriers to reproductive health services included young people's shyness and shame, distance to the health care source and cost of services, and negative attitudes from providers. Other studies have found similar barriers.

An important implication of our findings for improving health services—both for STI-related treatment and contraceptive methods—is the need for better training of health providers in terms of meeting young people's demand for providers with relevant skills and accepting attitudes and in terms of providers' receptivity to serving young, unmarried clients and protecting adolescents' privacy. The discussions about

abortion indicate a demand among young people for abortion services, and the wide range of methods described by young people to terminate pregnancy suggests that medical sources for postabortion care deserve continued investment.

Voluntary counseling and testing (VCT) services for HIV are still rare in Burkina Faso, and despite greater availability in Ghana, Malawi and Uganda, young people do not see the personal advantage to getting tested, given limited available treatment. Nevertheless, they do understand the link between VCT and HIV prevention (i.e., know your status, adopt protective behaviors and, if positive, take specific action to prevent transmitting the virus to others). Programmatic implications are to increase awareness of and access to VCT services in Burkina Faso, increase the accessibility of VCT services in rural areas of Ghana, Malawi and Uganda, and, for all countries, ensure adequate posttest counseling and the creation and maintenance of support groups for those who test positive (especially groups for young people only). Our findings also support a continued push for more widely available and affordable antiretroviral treatment: The personal advantage to getting tested—and thus the demand for testing services—is linked in young people's minds with the real possibility of getting treatment.

Abstinence: It is clear from these findings that young people know and understand the benefits of abstinence. They know that it is an effective means of protection against STIs, including HIV/AIDS, and unwanted pregnancy. However, the FGDs also showed that delaying sex until marriage was not commonly talked about as the motivation for being abstinent. Even though young people may choose to abstain, this decision is based more on the goal of avoiding infection and, for young women, unwanted pregnancy than on the aim of preserving oneself until marriage. Therefore, the message "abstain until you are married" is something that young people may not think is attainable. Given that the age at first marriage has been increasing in these countries, advocating abstinence until marriage is becoming increasingly insufficient within the context of many single young people's lives. A continued focus on providing and encouraging other protective measures (e.g., male and female condoms and, in the near future, microbicides) must accompany abstinence promotion.

Condoms: Most of the discussion groups mentioned condoms as a way to protect against STIs and especially HIV. Reasons not to use condoms mainly focused on a preference for sex without condoms because of enjoyment, forgetting to use condoms and trusting or loving a partner. The prevailing ideas about what constitutes enjoyable sexual intercourse have negative implications for increasing condom use among young people in general. Our findings suggest that condom promotion efforts must explicitly address young people's views of what is enjoyable sex. Moreover, although it was recognized that young women had the right, and often the responsibility, to ask for or insist on condom use, exceptions were talked about (e.g., if a young woman has received money from her male partner) and young women described difficulties in trying to get their male partners to use condoms. There is need for in-depth research to understand what motivates those adolescents who use condoms and the degree to which condoms are used consistently and correctly, in order to know how to improve use among other sexually active adolescents who may be reluctant condom users.

Overall, our findings point to a continued need in HIV/AIDS prevention efforts to coordinate with other activities that address the pervasive poverty and gender inequities that encourage young people to engage in sexual relationships that potentially threaten their health. Placing these adolescents' views in the broader context of gender inequity suggests that improving the social status of and economic opportunities for young women will in turn improve young women's ability to lead healthy sexual and reproductive lives. Numerous examples from the discussions across these four, widely varying social and cultural contexts support this broad type of investment: from the continued negative consequences for young women (but not young men) of bearing a child outside of marriage to the frequent mention of young women having sex in exchange for money or material goods. Strong arguments have been put forth by organizations such as the Joint United Nations Programme on HIV/AIDS and the United Nations Children's Fund that a key part of the HIV/AIDS epidemic is driven by gender inequity, especially among young people.[90] The evidence provided by young people themselves in these 55 discussion groups supports continued investment in young women to increase school enrollment and educational attainment, encourage income-generating opportunities and expand legal rights. The likely payoff of such investments will be reflected in young women's sexual and reproductive health and, as a further benefit, the health of their male partners.

Appendix 1: Focus Group Discussion Guide

Warm-up and explanation

A. Introduction (by the moderator)

"You are all welcome to the venue of this discussion. We are happy that you are able to spare some time to come have this discussion. Let's begin by introducing ourselves."

The moderator should introduce himself/herself first and then each member of the research team should do the same. The moderator should ask each focus group discussion (FGD) participant to introduce themselves, using a nick name, and emphasize that this is the only name that should be used for the purpose of the discussion, and that participants should not use anyone's actual or real name in the discussion group. Participants should not refer to individuals outside of the discussion group—the point of the discussion is to talk about how young people think and behave in general.

The moderator should ask participants to mention their favorite hobbies as an icebreaker (5–8 minutes).

B. Purpose of the discussion (by the moderator)

All the issues that we will be discussing are of importance for young people of your age. Some of the issues that we will be discussing are sexual activities, knowledge about symptoms of HIV and STIs, reproductive health information and services, perception and management of risks of HIV and STIs. We are interested in all your ideas, comments and suggestions. This research is mainly to have more information that will enable improvement in the quality of health of young people. All information will be treated as confidential (3 minutes).

C. Explain the ground rules for discussion (by the moderator)

We would like you to have a friendly discussion amongst yourselves about these issues. There is no right or wrong answer. Everyone should feel free to air his/her views and opinions. We would like to have one speaker at a time and there should be no side discussions during the session. Anyone can contribute to the discussion at any time. You all should feel free to agree or disagree in a friendly manner. We are asking for your permission to tape the discussion. We will spend between two to three hours in total and some refreshments will be served midway through the discussion. I will let you know at least 10 minutes before we end the discussion (3 minutes).

1. Activities engaged in (including sexual activity)
Young people your age usually engage in many activities. We would like you to tell us the kinds of activities that young people in this community do during their free time.

Probe: (if not mentioned) ask about sexual activities, types of sexual activities and relationships and terms used to describe them, types of sexual partners, location and events surrounding sexual activities, and consequences of sexual activities.

(About 20–25 minutes on this section)

2. Sexually transmitted infections
Are young people in this community aware about sexually transmitted infection (Moderator: if possible, use local terminology to describe STIs)? What signs or symptoms may tell young people that they or their partners have sexually transmitted infections? (Moderator, ask this question only if participant did not mention STI in section one, otherwise make a smooth transition from there.)

Probe: where or from whom do they learn about this, names given to symptoms, and what adolescents do

when they have symptoms

(About 15 minutes on this section)

3. Health services
We would like to know from you whether youths your age seek reproductive health services. Do young people of your age seek health services concerning pregnancy or abortion, HIV, STIs or contraceptives?

Probe: what types of services available/not available to young people, what types of providers are accessible and affordable, where do young people prefer to go for such services, what do they or their friends like and dislike about the services, what services do they or their friends prefer, whether they or their friends know about VCT (voluntary counseling and testing for HIV), access to VCT services, and advantages and disadvantages of VCT

Probe: for sources that are outside of the formal medical care system (traditional healing, faith-based treatment and other forms of alternative medicine).

(About 20–25 minutes on this section)

4. Perceptions and management of risks
Some adolescents think that they can't get pregnant, contract HIV and STIs, while others think they can. Do adolescents like you think these can happen to them? We would like you to tell us what youths your age consider risky behaviors.

Probe: risky sexual behaviors, what kinds of situations and factors increase young people's risk of HIV and STIs, what do young people like you see as ways of protecting yourselves from HIV and STIs, and of prevention (probe about abstinence, fewer sexual partners and condom use); risk of unplanned pregnancy, perceptions about young unmarried pregnant girls, perceptions about unmarried adolescent fathers.

(About 20–25 minutes for this section)

5. Information about reproductive health
We would like to know about the types of sexual and reproductive health information that are available to young people your age in your community. From where do they get this information?

Probe: formal and informal sources, who do young people talk to about this topic (probe about parents and other adult relatives, peers, sexual partners, media, teachers, health providers); how often do they discuss these issues; preferred sources, problems with access to information, the types of information that they would like/not like, preferred medium of delivery; are some sources better/more accurate than others?

(About 15–20 minutes on this section)

6. Communication about problems related to sexual and reproductive health
When adolescents your age have questions/problems about relationships with girls/boys whom do they discuss with?

Probe: people that they discuss sexual and reproductive health issues with, people that they prefer to discuss sexual and reproductive health issues with (parents, teachers, health workers, peers, partners, religious leaders, etc), what makes adolescents talk to or not talk with parents, peers, teachers and counselors, adolescents' ability to negotiate safe sex

(About 20–25 minutes on this section)

7. Request help with STI questions
We are doing this research to help us prepare for a survey all over the country and we would like your help. We usually ask adolescents about their experiences with STIs but many do not like the way we phrase the questions. How best could we phrase questions on STIs so that adolescents can respond freely?

(About 10 minutes on this section)

Thank you for taking the time to discuss with us issues affecting adolescents.

Appendix 2: Survey Questionnaire and In-Depth Interview Guide Development

One purpose of the focus group discussions (FGDs) was to inform development of instruments for two separate data collection activities: a national survey questionnaire for young people and a guide for in-depth interviews with young people. In this appendix, we discuss the influences of the FGD evidence on the development of these materials.

First, the nature of the discussions indicated that young people in the four countries were generally comfortable talking about sexual activity and sexual relationships. For the survey, this finding led to the development of detailed questions about sexual behaviors and partner characteristics. Recommendations from the Uganda and Malawi FGDs in particular were to make survey questions very specific to the type of sexual activity, because young people mentioned a wide range of behaviors under the general phrase "sexual activities," from just talking together, to visiting with boyfriends or girlfriends to forced intercourse. The one group who was not comfortable talking about sexual activity was 14–16-year-old females in Burkina Faso. The hesitancy among these young women led to the inclusion of a set of questions asked only of young adolescents (12–14-year-olds) in the survey about awareness of specific sexual activities; questions about personal experiences were asked only if the participant indicated an awareness of the relevant sexual activity. Qualitative findings about sexual activities also encouraged the research team to find out more about the nature of intimate relationships among adolescents (e.g., how boyfriends and girlfriends interact in a relationship) in the in-depth interviews.

Second, feedback from the FGDs confirmed that a wide range of informal sources for diagnosis and treatment of sexually transmitted infections were relevant to adolescents' lives, including traditional healers and herbalists, drug shops and drug peddlers. As a result, survey questions about sources of care were broadened to include informal sources. In developing the in-depth interview guide, a focus was placed on understanding the health care–seeking process, and interviewers were trained to be as inclusive as possible when asking about sources of care that adolescents sought or obtained for sexual and reproductive health problems.

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