PEER EDUCATORS' PERCEPTION OF THE '100% YOUNG' PEER EDUCATION TRAINING PROGRAMME

by

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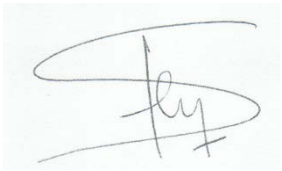
DECLARATION

I declare that **PEER EDUCATORS' PERCEPTION OF THE '100% YOUNG' PEER EDUCATION TRAINING PROGRAMME** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



08 February 2016

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Ngo Ibom Salome Clemence **Date**

PEER EDUCATORS' PERCEPTION OF THE '100% YOUNG' PEER EDUCATION TRAINING PROGRAMME

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ABSTRACT

Preventing teenagers' pregnancies and improving teenagers' reproductive health are important as pregnancies in teenagers still represent an important health challenge in Cameroon.

The purpose of this dissertation of a limited scope was to describe the perception of peer educators who underwent the '100% young' peer education training and the effect it had on their own sexual behaviour.

A qualitative descriptive, explorative and contextual research design was conducted. Data collection was done using in-depth interviews. Fifteen peer educators were purposively selected. Two questions were asked namely; please describe how you perceived the peer education training that you underwent and, describe how this training affected your own sexual behaviour.

Findings revealed that participants had a positive education experience, positive personal growth and for many, that was enough to become mentors for their peers and build awareness. Recommendations propose that interventions such as the '100% young' are urgently required to prevent teenage pregnancy.

KEY CONCEPTS

Teenagers; peer education; peer educators; sexual behaviour; teenage pregnancy; perception.

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- Thank you to the participants for sharing their perceptions (of the '100% young' peer education training programme they underwent and the effect it had on their own sexual behaviour) with me and trusting me with the information they provided. This made it possible for me to explore their challenges in the training programme and develop strategies to meet these challenges.
- I thank my family: my Father, Ibom Ibom Aloys Marie, my Mother, Nguimbock Odette, my Child, Lindiwe Israelle Bawana, my sisters and brothers for giving me support and encouragement to realise my dream.

Dedication

This dissertation is dedicated to my parents for their love, endless support and encouragement

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ANNEXURES

LIST OF ACRONYMS

HIV	Human Immunodeficiency Virus
PMSC	Programme de Marketing Social au Cameroun
PSI	Population Services International
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNISA	University of South Africa

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Substantial proportions of young people in Sub-Saharan Africa are sexually active (Pradhan, Wynter & Fisher 2015:45). In most countries it is not the age at marriage, but the age at first intercourse outside marriage, which is an important factor determining the occurrence of teenagers pregnancies (Sedgh, Finer, Bankole & Singh 2015:223-225).

In sexual relationships between teenagers, gender imbalances often increase the risk of unwanted pregnancies and sexual transmitted disease (STD) faced by young females. Young females are widely perceived to have premarital sexual experiences with a variety of partners (Ward & Biggs 2009:129-135). The need to conform to these practices may cause young females to fear disclosing their sexual activity, and may result in reluctance among them to report sexual experience. The fear of losing a partner or incurring his anger appear to be important factors inhibiting young females from exercising the choice to engage in sexual activity or negotiating the use of condoms or other contraceptives (Jejeebhoy & Young 2007:15-17).

In 2006 there was evidence in Cameroon that teenager pregnancy rates were rising for the first time since 1993 (Kamtchouing & Takougang 2007:798-801). This is a concern, as the risks and consequences of teenage pregnancies are numerous and babies born to teenage mothers are at risk of abuse and neglect. Poverty also becomes a problem, as the mothers do not finish high school and become stay at home teen parents (Foumane & Chiabi 2013:85-89).

Unplanned pregnancy in Sub-Saharan Africa, and especially in Cameroon, is critical and should be prevented (Population Reference Bureau 2009), because teenage sexuality almost invariability leads to unwanted pregnancy, therefore prevention through education is critically important to prevent unwanted pregnancies. The nature of the message, as well as the nature of a teenager, highlights peer education as an approach

that shows particular promise with young people (Svenson, Burke & Johnson 2008:12-18). Peer education programmes can be a powerful approach to educate youth and change their attitudes (Flanagan & Mahier 2007:12-15). Some studies indicate that teenagers receive most of their information about sexual expression from the media and other youth, and that peer influence becomes increasingly important as teenagers mature (Shonert-Reichi & Howard 2013:165-168). Peers are an important aspect of teenagers' transition to adulthood as youths move away from dependence on the family, and closer ties with their peers give them the social support they need during these transition years (Kar & Talbot 2009:12-14).

Peer education is one strategy to address both teenage pregnancy prevention and sexual health promotion for this population (Kar & Talbot 2009:19-21). It builds on the strong ties between age mates fostered during socialisation and by-passes adults, who are reluctant to talk to youths about sexual matters (Bastien & Klepp 2008:185-187).

In reaction to the increase in the incidence of teenagers pregnancy in Cameroon, the government has put in place "100% Young", a peer education programme to address health issues that affect teens, especially HIV, sexually transmitted infections (STIs) and pregnancy prevention (Van Rossem & Meekers 2010:383). These "100% young" peer education programmes involve teenagers (13-19 years old) and tend to follow the peer leader's model, with some peers acting as assistants to adult trainers or facilitators. It is therefore important to seek an understanding of peer educators' perceptions regarding the programme they underwent, and whether the training impacted on their own sexual behaviour.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

There is concern about teenage' pregnancies, particularly in Sub-Saharan Africa, where teenage pregnancy rates are the highest in the world. About 27% of women aged 13-19 years are either pregnant or have children already, while teenage pregnancies in other parts of Africa, like the Middle Eastern countries are only 12% (Demographic and Health Survey 2007).

The incidence of teenage pregnancy remains high in Douala, a city in the Littoral province in Cameroon, where the teenage pregnancy rate is 28% (Neukom & Ashford

2008:75-83). Increased sexual activity among teenagers is manifested in this increased teenage pregnancy rate and an increase in sexually transmitted diseases (Blum 2008:230-238).

In order to address the problems pertaining to unwanted pregnancies and sexually transmitted diseases under teenagers, a number of reproductive health programmes were implemented in Cameroon. One such programme is “100% young”, a social marketing reproductive health programme targeting 13-19 year olds living in Douala and Yaoundé, the two largest cities in Cameroon. This programme, supported by the Bill and Melinda Gates Foundation, was launched in Yaoundé and Douala in 2000 by the programme de Marketing Social au Cameroon (PMSC), an affiliate of Population Services International (PSI). The programme aims to motivate at-risk urban and rural youth to engage in healthier sexual behaviour and focuses on reducing barriers to condom use. The programme focuses on promoting discussions on teenage reproductive health issues within their relationships. Others topics addressed in the programme are sexual history as a risk factor for contracting STDs and HIV, female responsibility for their own reproductive health, abstinence and consistent condom use as strategies to prevent HIV, STIs as well as the risks and implications of unwanted pregnancies. Mass media and radio call-in peer education sessions are used as tools in this programme to deliver the message to youths.

Reproductive health programmes often use popular theories such as a Social Learning Theory, the Theory of Reasoned Action and the Health Belief Model to identify behaviour change programme objectives and activities. The ‘100% young’ peer education training programme is based on a comprehensive theoretical framework that borrows various elements from these behaviour change theories that were perceived to be amenable to change through social marketing and behaviour change programmes. The framework assumes that behaviour change is a function of a combination of individual, environmental and social factors, including perceived severity of sexual risk, perceived personal risk (susceptibility), perceived condom attributes and access, perceived social support and self-efficacy (Blum 2007:230-238).

1.3 THE STATEMENT OF THE PROBLEM

There has been a flurry of media reports currently highlighting teen pregnancy in the Cameroonian community, particularly in schools. Numerous studies have documented that Cameroonian youth experience high rates of unwanted pregnancies, abortion and pregnancy-related school dropouts (Tsala, Dimbuene & Defo 2012:351-361; Foumane & Chiabi 2013:87-90; Sidze & Defo 2013:613).

Girls in Sub-Saharan Africa know little about contraception and the family planning services are frequently unsupportive and refuse to provide them with contraceptives services (Kaufman & Stadler 2008:14-16). In Cameroon, although the major problem appears to be the defective and inadequate practice of contraception, prevention of teen unwanted pregnancies is both biomedical and psychosocial in nature (Ross & Kelley 2008:504-517).

Peers are highly important in influencing teenagers' values and behaviours. One study on condom use among teenagers found that teen perceptions of other teen's condom use was the best indicator for determining their own condom use (Davies, Schraudragel & Kajumulo 2014:631-643) and therefore a positive attitude by peers can have a positive influence on condom use and other health behaviour.

A variety of interventions have been developed in an effort to reduce the incidence and ultimately the harmful consequences of teenagers' pregnancies. Many of these interventions have not been carefully evaluated to determine their efficacy, safety or cost effectiveness (Shreffer & Cox 2015:30-43), despite the fact that teenage pregnancy invariably leads to poverty (Mawer 2008:1713).

In Cameroon, young people involved in the '100% young' peer education training programme are trained by adult facilitators to become future peer educators. This education emphasises participatory methods like small group discussions and role play; workshops on condom education, community outreach, teen theatre, as well as radio shows. The research questions that now arise are: How do these future peer educators perceive the '100% young' peer education training programme they underwent, and how has their own sexual behaviour changed?

1.4 DEFINITIONS OF KEY CONCEPTS

1.4.1 Education

The term ‘education’ refers to the knowledge or abilities gained through being educated (Rooney 2011:32).

1.4.2 Peer education

Peer education is a popular, often ubiquitous, concept that implies an approach, a communication channel, a methodology, a philosophy and a strategy to use the same age and background educators to convey educational messages to target groups (Barr & Layzer 2014:570-577).

1.4.3 Peer educators

The concept peer educators refers to someone who shares characteristics of his or her peers but receives special training to function in a different way; it stands for a group or person, selected or who volunteered to pass on information to others peers (Stevens 2009:19-21).

1.4.4 Peer

The English term ‘peer ‘refers to an equal in civil standing or rank; equal in any respect (Shiner 2009:555-557).

1.4.5 Perception

Bergh and Theron (2009:104) describe perception as a selective process by which people interpret and give meaning to external factors.

1.4.6 Sexual behaviour

Human sexual activities or sexual practices, or human sexual behaviour refer to the manner in which a person experience and express their sexuality (Jemmott & Fong 2010:152-159).

1.4.7 Teenager

The term “teenager” is often used synonymously with “adolescents” and refers to a person between 13 and 19 years, who has not reached full maturity (Mills 2008:243).

1.4.8 Teenage pregnancy

A pregnant teenager is defined as a female person aged between 13-19 years who is pregnant (Pradhan et al 2015:45).

1.5 OPERATIONAL DEFINITIONS

1.5.1 Education

In the context of this study the concept ‘education’ is used to describe the training of a teenager in the ‘100% young training programme and the ‘knowledge’ pertaining to this educational process.

1.5.2 Peer education

In this study, peer education is described as an approach where peer educators, who underwent the ‘100% young’ training actively attempt to inform or influence their peers to adopt healthy sexual behaviour.

1.5.3 Peer educators

Peer educators are teenagers who underwent ‘100% young’ training, trained to initiate informal conversations with their peers, during which they convey educational messages by endorsing “healthy” behaviour within their own peer community.

1.5.4 Peer

Peer, in this study, is a person between 13 and 19 years of age, who is of equal standing with others; belonging to the same societal group and having same mother tongue.

1.5.5 Perception about '100% young' peer education training

In this study, the focus is on perceptions regarding the beliefs, opinions, ideas and views expressed by peer educators living in Douala, who underwent '100% young' peer education training.

1.5.6 Sexual behaviour

Sexual behaviour refers to conduct and activities used by teenagers in their personal sex interactions between each other.

1.5.7 Teenagers

In this study the concept teenager and not adolescent will be used and refers to young females and males between the ages of 13 to 19 years.

1.6 THE '100% YOUNG' TRAINING PROGRAMME

The '100% young' training programme is a social marketing reproductive health programme targeting 13-19 years olds living in Douala, one of the largest cities in Cameroon. This programme is supported by the Bill and Melinda Gates Foundation and was launched in Douala in 2000 by the programme de marketing social au Cameroon (PMSC), an affiliate of Population Services International (PSI). Since 2000, the programme has trained 50 teenagers (peer educators) every year to motivate at-risk teens to engage in healthier sexual behaviour and in an attempt to reduce the cultural barriers to condom use.

This programme is a comprehensive peer driven programme that focuses on sexuality and healthy sexual behaviour, with the purpose of preventing teenage pregnancies and STIs, promoting family planning and reducing personal as well as socio-cultural obstacles associated with teens' non-use of condoms during intercourse; also it raises teenagers' awareness of reproduction health. The programme is offered by peers and the information shared with other teenagers in discussion groups, in one-on-one meetings as well as at sport and other gatherings. The specific objectives with the implementation of this programme were to

- reduce the sexual risk behaviours of teens
- delay the initiation and frequency of intercourse
- increase the use of contraceptives
- motivate the use of condoms, thus reduce the incidence of unprotected sex
- increase abstinence among sexually experienced teens
- increase partner communication skills

by demonstrating behavioural impacts among all teens who underwent the '100% young' training programme (Chandra-Mouli et al 2013:517-522).

The programme provides factual information about sexuality, reproduction and sexually transmitted infections. The curricula are delivered in five separate workshops (Tarkang 2013:34-36) with the following content addressed in each workshop:

Human reproductive organs: this session provides teens with information on anatomy and physiology as well as on puberty issues. The content is covered in a four day workshop.

Sexually transmitted infections: the second four day workshop addresses sexual health issues such as: STD; STI including HIV/AIDS. Prevention strategies such as avoiding unprotected sex, by either postponing sexual involvement or using condoms, are emphasised.

Communication skills: the third workshop focuses on supporting teens in the development of specific communication skills to enhance their handling of risky

interpersonal situations, including negotiation skills. This workshop also runs over four days.

Sexual decision-making: the fourth workshop is a four day workshop; where teens are provided with skills to resist peer pressure that led them into early sexual involvement.

Goal setting and making: in the last workshop, peer educators are given a message about the role of education in socio-economic status. In four days they are taught about the benefit of education as a key for a better prospect in life.

The 20 days (five workshops of four days each) are conducted annually during the July holidays to accommodate 50 teens without disturbing the school or university schedule. The workshops are all facilitated by both a male and a female facilitator.

This peer education programme, similar to others, has advantages that ensure that the set objectives, as stipulated, are met.

1.7 PURPOSE OF THE STUDY

The purpose of this study is to describe the perception of peer educators about '100% young' peer education training they underwent and the effect it had on their own sexual behaviour.

1.8 OBJECTIVES OF THE STUDY

The following objectives were formulated in accordance with the purpose of the study:

- To describe peer educators' perception of the '100% young' peer education training programme.
- To describe the effect of the training on their own sexual behaviour after completion of the '100% young' peer education training programme.
- To write recommendations that could possibly contribute to improvements in teen sexual behaviour.

1.9 RESEARCH METHODOLOGY

1.9.1 Research design

Creswell (2009:301) states that the characteristics of a design should capture a definition of design, the unit of analysis used, data collection process, reporting formats and any other special characteristic of the specific design (Neuman 2008:104). A qualitative, explorative, descriptive and contextual (Babbie & Mouton 2009:133) research design is adopted when attributes likes perceptions or views of human sources are studied (Brink 2009:11; Talbot 2008:93), as was the case in this study. A qualitative design was selected as it focuses on aspects such as experiences and trying to understand the viewpoint of every research participant (Brink 2009:22).

1.9.2 Population

The concept 'population' can be defined as the specific pool of cases that the researcher wishes to study (Neuman 2008:220). The population was the total number of participants from which the sample was selected; namely all the peer educators who received peer education in the '100% young' training in Douala. In total, 50 young people underwent the '100% young' training.

1.9.3 Unit of analysis (sample and sample selection)

Sampling is the process used to select cases for inclusion in the research study (Terre Blanche & Durrheim 2009:374). The inclusion criteria were developed to guide the inclusion of participants. The inclusion criteria were:

(1) Teenagers between 13-19 years old
(2) Involved as peer educators at the time of data-gathering
(3) Unmarried
(4) More than six months of active involvement in the programme
(5) Able to communicate in French or English

Due to the qualitative research design the size of the unit of analysis was based on saturation of data. The sampling technique was purposive sampling (see chapter 2, page 16) and saturation was achieved after 15 interviews were conducted.

1.9.4 Research technique

After receiving ethics approval from the Research Ethics Committee of the Department of Health Studies at UNISA to conduct the research (see annexure E), the researcher obtained approval from the Manager of the '100% young' peer education training programme (see annexure B). Informed consent was obtained from peer educators aged 18 and above (see annexure D), while parents of the minors 13 to 17 gave parental consent and the children accent agreed to participate in the study (see annexure F and H). Data were collected by means of in-depth interviews.

Interviewing is the predominant mode of data or information collection in qualitative research (Kvale & Brinkmann (2009:4). In this study, the researcher, trained as an interviewer, used face-to-face, one-on-one in-depth interviews to collect the data. The interview was conducted in French or in English and attempted to understand the peer educators' point of view, to unpack the experience of their perceptions and to "uncover their world prior to scientific explanation."

The following two questions were asked:

- Please describe how you perceived the peer education training that you underwent?
- Please describe how this training affected your own sexual behaviour?

1.9.5 Exploratory interview

An exploratory interview with three (3) purposively selected participants, who met the selection criteria, was conducted. In this way the feasibility of this data collection method as well as the interviewer's skills and the technique were determined and were confirmed as described (Mc Niff 2013:320). The question could be tested to ensure that the desired information was obtained.

1.10 DATA ANALYSIS AND LITERATURE ANALYSIS

Tesch's method of open coding (Creswell 2009:142) was employed. All data derived from the verbatim transcribed interviews (Polit & Beck 2011:332) and field notes (Polit & Beck 2011:382) were reviewed in the context of the entire interview sessions with words, phrases descriptions and terms central to research topic noted. These were coded and analysed separately by the researcher as well as an external independent coder who has extensive experience in qualitative research methods.

Themes and sub-themes were established and described according to significant categories, which emerged. To enforce sub-themes and provide referential adequacy, direct quotations of the participants' responses were used as sub-themes.

A literature analysis was performed and the results of this study were integrated in the light of present literature to establish similarities and differences, as suggested by Morse (2012:44).

1.11 TRUSTWORTHINESS OF THE DATA

In qualitative research, it is important to develop strategies to ensure the trustworthiness of research findings. In this study, the researcher was guided by Guba's model of ensuring trustworthiness as described in Krefting (1991:214-222) and Marshall and Rossman (2014:323). This model is based on four criteria; namely credibility, dependability, confirmability, transferability (see chapter 2, page 24 for detailed description).

1.12 ETHICAL CONSIDERATIONS

Ethical and legal considerations have to be addressed in any research study. Ethics deal with beliefs about what is right or wrong, proper or improper, good or bad. Research should therefore be conducted in such a way that the rights and welfare of the participants are always protected (McMillan & Schumacher 2014:203). Ethical aspects that were taken into account while conducting the study (Babbie & Mouton 2009:675; Terre Blanche & Durrheim 2009:94; Brink 2009:75) are explained in detail in chapter 2, page 25.

1.13 SIGNIFICANCE OF THE STUDY

This research is of significance as knowledge about peer education, as an intervention for teenage pregnancy, extends the knowledge base that currently exists in that field. Peer education as a strategy is relatively new to the majority of teenage pregnancy prevention programmes (Driscoll 2007:32-35). This study of peer educators' perceptions can be a learning paradigm for youth in urban and rural communities to enhance educational and health information about their sexual behaviour.

Communities, who choose to embrace this strategy and implement it, can benefit from the educational and health outcomes it has to offer.

1.14 CHAPTER LAYOUT

This research study is presented in four chapters.

Chapter 1: An overview of the study
Chapter 2: A description of the research methodology
Chapter 3: The data analysis and the literature analysis
Chapter 4: The conclusions and the recommendations of the study

1.15 CONCLUSION

Teenage pregnancies remain a concern in the modern world and research at various levels in the health care system is needed to address this problem. The focus in this study is on one peer education programme, the '100% young' peer education training programme, as one attempt by the government in Cameroon to address teenage pregnancies. Chapter 2 will described the methodology that was utilised to gather the data from the participants.

CHAPTER 2

METHODOLOGY

2.1 INTRODUCTION

A brief overview of the study was presented in chapter 1. This chapter outlines in more detail the research methodology that was utilised, thus a step by step description of the processes involved.

2.2 RESEARCH DESIGN

Yegidis and Weinbach (2011:99) assert that a research design is a plan for conducting research and informs the researcher what methods to use to study the nature of the problem under investigation. This study assumed a qualitative design to ensure that the purpose and the objectives of this study were achieved.

Qualitative research is a systematic subjective approach used to describe life experiences and give them meaning (Creswell 2009:186). Its subjectivity is due to the fact that participants are able to express their feelings and views about their experience (Tully, Rothery & Grinnelli 2014:62) with no intention to quantify these experiences. The major assumption in qualitative research is that there is no single reality and each narrative is knowledge on its own. A qualitative study is normally conducted when a researcher seeks to “gain understanding of the perspectives of the person being interviewed. It is relevant when the researcher wished to explore experiences, behaviours or feelings” without the intention to quantify findings (Marshall & Rossman 2014:323).

In executing this research, the researcher employed a qualitative explorative descriptive and contextual research design. The researcher sought to understand and describe the perception of peer educators, who underwent the ‘100% young’ peer education training programme and how or whether it affected their own sexual behaviour after completion of the programme.

The focus is on their perceptions about 100% young' peer education training, as these were 'experienced' or 'felt' or 'undergone' (Welman & Kruger 2011:17; Mitchell & Jolley 2012:34). Qualitative researchers view social phenomena holistically (Creswell 2009:192), thus the researcher utilised qualitative research to explore the perceptions of peer education as perceived and defined by peer educators themselves. Peers educators were allowed to speak for themselves, thereby emphasising their human capacity. Through probing and encouragement by the interviewer (the researcher), they were able to share experiences.

According to Polit and Beck (20011:30), exploratory research is aimed at investigating the full nature of the phenomenon, the manner in which it is manifested and the other factors with which it is related. Burns and Grove (2011:357) indicate that exploratory studies are designed to increase the knowledge of the field of study.

An explorative design was used, as little is known in Cameroon about the peer educators' experience in the '100% young' peer education training programme, that was researched. Concepts were explored as they were perceived, as indicated by Hoskins (2008:4) and defined by the peer educators themselves.

A descriptive strategy is defined as a collection of accurate data on the problem to be studied; it is defined as a way of discovering new meaning, describing what exists, determining the frequency with which something occurs and categorising information. A researcher who conducts a descriptive investigation observes, counts, describes and classifies (Burns & Grove 2011:339). The descriptive strategy is ideal for discovering new meaning by providing an accurate portrayal or account of teenage pregnancy from the perspective of the peer educators in Douala. In this study, a descriptive design provided a description of the phenomenon of interest, namely the perceptions of peer educators toward the '100% young' peer education training programme they underwent in Douala municipality, Cameroon.

The data for this study was gathered within the context of the district in Douala in Cameroon, for the contextual significance thereof (Babbie & Mouton 2009:143). The methods of data collection involved active participation by peer educators. The researcher sought to build rapport and credibility with the individuals in the study (Creswell 2009:181). The interviews were conduct in a natural setting and therefore this

study was conducted in Douala, in a separate and private room at the Douala Municipality Hall. The participants were familiar with the venue because the '100% young' peer education training programme used it as a youth centre, and they considered it the most natural and comfortable setting.

2.3 POPULATION

Marshall and Rossman (2014:323) describe a research population as a clearly defined set of potential objects or events from which a sample can be drawn.

The population consisted of 50 educators, who already underwent the '100% young' training in Douala. Only 30 of them complied with the set inclusion criteria and could be asked to volunteer to participate in the study.

Due to practical and financial considerations, it is rarely possible to study all the members of the population (Mitchell & Jolley 2012:270) and therefore it is necessary to select a sample of the population; in qualitative research this is called the unit of analysis.

2.4 UNIT OF ANALYSIS (SAMPLE)

A sample is a selected group, out of a large population, to be included in a study (Graziano & Raulin 2009:20-22). According to (Hoskins 2008:42), the concept sample is an element of the population considered for actual inclusion in the study. It can be viewed as a part of measurements drawn from a population from which we want to conduct the study. For the purpose of this study the sample consisted of teenagers that are from different contexts, urban and rural, living in Douala and who underwent the '100% young' peer education training programme. The sample of peer educators who participated in the study was purposively selected to enable the researcher to obtain the richest possible source of information to answer the research question.

Purposive sampling involves the conscious selection by the researcher of certain subjects, elements, events or incidents (Polit & Beck 2011:243). According to Burns and Grove (2011:452), information-rich persons are to be selected for the purpose of the study. The researcher used the coordinator of the '100% young' training programme to

act as a gatekeeper and recruit possible research participants who met the inclusion criteria. Thirty possible participants complied with the inclusion criteria. The gatekeeper ensured that the participants met the following inclusion criteria:

(1) Teenagers between 13-19 years old
(2) Involved as peer educators at the time of data-gathering
(3) Unmarried
(4) More than six months of active involvement in the programme
(5) Able to communicate in French or English

If the volunteer participant was younger than 18 years of age, the gatekeeper sent an information leaflet and consent form to the parents, and those older than 18 years received these documents from the gatekeeper. The gatekeeper received the signed consent forms of the volunteers and provided the researcher with the contact details of these possible participants. Of the 30 participants who met the criteria, 20 were willing to participate and provided their contact details via the gatekeeper to the researcher.

After receiving the names and contact details of the volunteers, the researcher made an appointment with the participants on a specific date and time at the venue that was agreed on.

The sample size was determined by saturation of data. Saturation refers to the condition where data was collected, thus interviewing participants, at least to the point where the researcher can intuitively say that she had thoroughly explored the data and had acquired a satisfactory sense of what was going on (Terre Blanche & Durrheim 2009:442). Saturation was reached after 13 interviews; two more were conducted, thus 15 interviews were transcribed and analysed.

2.5 RESEARCH TECHNIQUE

The research technique or data gathering technique was an in-depth interview.

2.5.1 In-depth interview

In-depth qualitative interviews are excellent tools to use in planning and evaluating extension programmes because they use an open-ended, discovery-oriented method, which allows the interviewer to deeply explore the respondent's feelings and perspectives on a subject. This result in rich background information that can shape further questions relevant to the topic (Ekman & Friesen 2010:288). To gather rich information about peer educators' perceptions, the researcher used in-depth interviews. The in-depth, face-to-face interviews provided the structure to ensure that conversations were well-organised and well-suited for the research.

The researcher used in-depth interviews because they had the following advantages for this study, as was also indicated by Bowling (2014:404):

- The open-ended questions gave the peer educators the freedom to answer questions in their own words.
- Probing questions were possible when these flowed from previous responses which enriched the data.
- Active listening skills were used to reflect upon what peer educators were saying.
- The interviews were audio-recorded and complemented with written field notes to ensure that none of the data was lost.
- The responses was recorded and documented to probe for deeper meaning and understanding.

Although in-depth interviews can have disadvantages, as mentioned by Bowling (2014:450), the following were not experienced as disadvantages:

Although in-depth interviews may require more time than questionnaires due to the detailed nature of the questions and responses, in this study each interview took only about 60 minutes to complete.

The interviewer bias can be disadvantageous as the in-depth interview tends to be less standardised and relies on the interviewer's own questioning style and choice of subject matter. This interviewer was trained to conduct the interviews, in addition, the questions

to be asked and skill of the interviewer were tested in the exploratory interview to prevent bias.

The interviewer could intentionally or unintentionally introduce her personal biases into the process. To prevent this disadvantage, the researcher used bracketing, thus putting aside her own feeling about the topic and used a co-coder to assist with the coding of the verbatim narrations as evidence of interpretations.

There might be inconsistency between interviews, because the interview is not as standardised as a questionnaire. The researcher used various communication skills to ensure that the formulation of the questions remained consistent, and with probing questions, followed to ensure that all data were captured, as she was speaking appropriately, maintaining good eye contact with the participants as well as listening effectively to their responses.

Each participant could be probed according to their response which may lead the interview in a different direction for each participant. To prevent this, the researcher focused on the two main questions that formed the objectives of the study.

2.5.2 The interviewer

The interviewer was trained to conduct an in-depth interview. Three exploratory interviews were conducted and assessed (see 2.5.4) by an expert in in-depth interviews to ensure that no leading questions were asked and that the interviews were conducted in a trustworthy an ethical manner.

2.5.3 Field notes

Filed notes are a written account of the things the researcher hears, sees experiences and thinks about during the course of the interview (Morse 2012:44). In this study, field notes were taken by the researcher during interviews. These notes assisted the researcher to remember and record the behaviour and the non-verbal communication of the peer educators that were observed during the interviews. When reading the verbatim transcripts thoroughly, these field notes were added to provide meaning and

understanding of, for example, silent periods during the interview, or non-verbal responses that were noted.

The researcher implemented the following important steps when she took the field notes:

- The notes were written down as soon after observation as possible.
- The notes of every interview were written down on a new page in the field note book, with the date and time of the interview and the number of the participant (interview number) on top of the page.
- A few words or short sentences were jotted down just to recall an observation, but without impacting on the flow of the interview. After completion of the interview a preliminary analysis of notes was made while still in the room to enhance self-reflection for emergent themes.

2.5.4 Exploratory interview pilot study

Janesick (2010:33) states that the pilot study (exploratory interview) in qualitative research allows the researcher to focus on specific areas, like testing the question, assessing the skills of the interviewer and the feasibility of the study (Hulley 2009:168). After obtaining permission to conduct the study from all the relevant parties, the Higher Degrees Committee (Ethics) of the Department of Health Studies at UNISA (see Annexure E), and the Manager of the '100% young' peer education training programme (see annexure B), participants were recruited to conduct an exploratory interview. The exploratory interviews were conducted after the relevant ethics approval permission and informed consent and assent letters were signed (see annexure D), as described in section 2.6. Participants for the exploratory interviews were purposively selected by the gatekeeper of the '100% young' peer education training programme, among teens who usually gather in the Douala Municipality Hall and who were willing to participate. (The same process as described in 2.6 was followed, and the first three interviews were done as exploratory interviews.)

With these exploratory interviews, the nature of the questions were tested to ensure that modifications could be made to the questions and to test the ability of the researcher as interviewer to conduct the interviews. The two questions were tested to ensure that the

desired information could be obtained. The verbatim transcript of the first two exploratory interviews had evidence of leading questions as well as gaps, because the researcher did not recognised where probing could have been used to obtain more in-depth understanding. After consultation, and training a third exploratory interview was conducted. After the third exploratory interview was done, the expert was satisfied with the interview skills of the researcher as well as questions that were formulated. The data obtained from all the exploratory interviews were not used in the final study.

2.6 DATA GATHERING

After ethical approval was obtained from the Research Ethics Committee of the Department of Health Studies at UNISA (see annexure E), and the Manager of the '100% young' peer education training programme (see annexure B), the researcher did the following to start with data gathering:

Since the '100% young' peer education training was done regularly in the Municipality Hall, the researcher asked the gatekeeper to arrange for a slot in one of their meetings to introduce herself and explain the extent of the study, the purpose as well as other relevant information pertaining to the ethical aspects of the research. The researcher then left the Hall and the coordinator of the '100% young' peer educators programme, who acted as the gatekeeper, provided the teenagers with the inclusion criteria. She then asked the teenagers who wanted to voluntarily participate in the study, to take the information leaflets (see annexure C) and consent forms for themselves, and/or their parents, where appropriate, to read through. Minors were requested to ask their parents to sign the consent letters (see annexure F) and bring back the signed documents as well as their assent letters to the gatekeeper. Those 18 years and older, were asked to sign the consented forms and give it back to the gatekeeper if they consent to participate. The gatekeeper then provided the details of the willing participants to the researcher, who arranged for a date and time for the interviews to be conducted. It was agreed that the interviews would be conducted in a separate room at the Douala Municipality Hall, from 9:00 to 12:00 from a Tuesday to Friday (2 June 2014 to 30 June 2014).

The coordinator of the '100% young' peer education training programme organised for this separate room for the interviews to be conducted and assisted the researcher with

other logistical arrangements. A private room, to ensure that no interruption took place, was arranged. A table was placed in the middle of the room with two comfortable chairs facing each other. A small table was placed in the back of the room, but out of sight of the participant, with another tape recorder, in case the one placed underneath the table was full or malfunctioning. The participants were made aware of these tape recorders to ensure that they gave informed consent to be tape recorded.

In front of the interviewer a note book was placed to jot down the field notes. Bottled water was provided for both the interviewer and participant.

2.6.1 The interview

After the researcher met with a participant at the door and introduced herself, she allowed the participant to also introduced him or herself. The participant was then accompanied into the room, and the interviewer ensured that the participant was comfortably seated. The room was well ventilated with a comfortable temperature for the participant, there was enough light and the door was kept closed to enhance privacy. The aim of the interview was again explained and the signed consent forms collected. The researcher explained the purpose of the tape recorder, assured the participant about the confidentiality of the information and mentioned that the tape will be kept locked away (security code), and nobody will have access to the key except the researcher. Participants were made aware that the tapes and the transcripts would be destroyed (burned) after the study was completed. They were reminded of their right to withdraw without being victimised. Then the interview stared with the first question, namely:

- Please describe how you perceived the peer education training that you underwent?

After this question was exhausted and no more information emerged after relevant probing and communication skills were utilised, the next question was asked.

- Please describe how, if relevant, this training affected your own sexual behaviour?

The interviewer was open-minded to maintain openness during the interview process so that peer educators openly share their opinions. She was flexible and responsive, thinking on her feet, responding to challenges and making sure that the core purpose was served. She was patient and observant, and allowed participants to speak freely and open up at a pace that was comfortable, while she observed, picking up subtle cues like facial expressions, body language and tone of voice. She demonstrated good listening skills, and focused on what the speaker was saying. Skills like paraphrasing and summarising were used. The researcher reflected back on the peer educator's emotions inherent in the message, paying attention to tone and emotional content; hence she gained a greater understanding of the verbal messages being delivered by utilising the field notes. The researcher concluded the interviews with general questions such as, "is there anything further that you feel is important?"

When the researcher was satisfied that the interview was complete she thanked the participants, greeted and accompanied them out of the room. The participants were assured that they can contact the researcher if they wished to have a future interview or for any other purpose. None of the participants requested a follow-up interview. The average interview lasted for more or less 40 minutes and the participants were allowed to do must of the talking.

2.7 DATA ANALYSIS

Qualitative data analysis involves an examination of words, and this was done concurrently with data collection (Brink 2009:292). The interviews done in English were audio taped to provide a permanent full record of the question that was asked, the probes, and the peer educators' responses/reactions to questions.

A verbatim transcript was done immediately after the interview and all the field notes and non-verbal communications were added to the transcription. Four types of field notes were taken in order to help the researcher to synthesise and interpret the data (Polit & Beck 2011:373): observational notes; theoretical notes; methodological notes and personal notes. The data analysis strategy used was open coding (De Vos & Van Zyl 2011:271).

The researcher utilised the eight steps described by Tesch (in Creswell 2009:185) for data analysis. She listened to all the recorded interviews. Then she read through all the transcripts carefully to get the sense of the interview. She grouped topics with the same idea and label, and assigned them to themes. She selected one interesting interview, read again and wrote her thoughts in the margin. Themes, categories, and sub-themes were then identified. Direct words of participants were used as sub-themes, to indicate the real data obtained. The data was also analysed by an independent coder, who met with the researcher to discuss and reach consensus on the identified theme categories, and subthemes.

2.8 TRUSTWORTHINESS

According to Lincoln and Guba in Krefting (1991:218), trustworthiness is a method of establishing rigor in qualitative research without sacrificing relevance. The authors further suggest that the concept of trustworthiness be utilised to guide the quest for quality in qualitative research and propose four alternative constructs that more accurately reflect the assumptions of the qualitative paradigm, namely: credibility, transferability, dependability and conformability.

2.8.1 Credibility

In order to ensure the credibility of the study the researcher had to prove the truth value of the study. Truth value means that the researcher is confident that the findings are a true and honest reflection of the views, thoughts and experiences of the participants in view of the research design, and the setting that was used (Lincoln & Guba in Krefting 1991:115). The strategy used to ensure truth value was credibility, which was achieved by using an experienced, independent co- coder who assisted with coding and analysis. The co-coder received the transcriptions and did the co-ding. The coding of the researcher and that of the co-coder were then compared to identify similarities and to agree upon the final themes, categories, and sub-themes. No translation was done as all the interviews were conducted in English as the participants had no problem speaking English. This was done to confirm the researcher's own analysis of the transcribed data. The interviews were tape-recorded to capture verbatim accounts by participants (Krefting 1991:218-220). Triangulation of the data sources was achieved

through interviews with participants of different ages, and sexes and from different backgrounds (urban and rural).

2.8.2 Transferability

Transferability was ensured by applicability. It is the extent to which the research finding can be generalised to other populations, contexts and other situations (Krefting 1991:216). This criterion was assured by the detailed background information about the setting, and the context of research. A pure data trail and description were provided to assist with transferability to similar contexts. This will enable other researchers to assess similar groups and contexts. The onus to determine transferability of the findings therefore lies with those who wish to transfer the findings to similar context.

2.8.3 Dependability

Dependability is the strategy used to ensure consistency in qualitative research; to prove that the researcher included a detailed description of the research methodology and the questions that were asked. She also used a code-recode procedure through which she re-checked the accuracy of her coding. She used the services of a co-coder in order to verify her coding and analysis; also the involvement of an experienced researcher (supervisor) in qualitative methods, who followed the progression of the study to analyse and evaluate the decisions made, as well as to determine whether comparable conclusions could be reached given the same data and research context.

2.8.4 Confirmability

Neutrality was ensured through the strategy of confirmability. It means that the findings are a true reflection of the participants' experiences only and that there are no external influences (Krefting 1991:216). Neutrality entails freedom from bias in the research procedure and findings. It also refers to the degree to which the findings reflect the true data obtained and not the biases of the researcher (Babbie & Mouton 2011:278). The researcher tried to be open minded and made use of a co-coders to limit bias. The findings were also shared with the participants to ensure that the data revealed a true reflection of the opinions of the participants. The researcher made use of reflective thinking by putting aside her own speculations, feelings, problems, ideas, prejudices

and impressions when analysing the data. In her report the researcher put verbatim narrations to substantiate statements made and to provide an audit trail or chain of evidence for interpretations.

2.9 ETHICAL CONSIDERATIONS

Neuman (2008:458) defined ethics as what is or is not legitimate to do in research and what “moral” research is about. The following ethical principles were followed to ensure that ethical research was conducted.

2.9.1 Permission to conduct the study

Institutional approval was obtained from the Research Ethics Committee of the Department of Health Studies at the university where the researcher was enrolled for her study (see annexure E). Approval was also obtained from the Manager of the ‘100% young’ peer education training programme (see annexure B).

2.9.2 Informed consent

The research participants have a legal right to give informed consent. They were provided with an information leaflet with information about the purpose of the study as well as their rights as participants. The participants were informed about the goal and the methodology of the research, what their participation involved. They knew that they may refuse to participate or may withdraw from participating at any stage (Schurink in De Vos, Delport, Fouché & Strydom 2011:16; Tully et al 2014:30). Participants were informed about the duration of the interviews as well as the study and how the information would be recorded. Participants were asked to sign informed consent forms (the process whereby a competent individual agrees to participate in the study) as was the case for participants of more than 18 years. Parental assent was from participants between 13 and 17 years, as is required if minors agree to participate in the study according to the institutional Review Board.

2.9.3 Violation of privacy

Privacy can be defined as “that which normally is not intended for others to observe or analyse” (Levy & Lemeshow 2013:71). The privacy and identity of research participants were respected. Interviews were conducted in a private room, without interruptions. The names of the participants did not appear on any document or field note and therefore the data could not be linked back to any individual. The interviews were conducted in a private room, behind closed doors to prevent interruptions and enhance privacy.

2.9.4 Anonymity and confidentiality

Anonymity and confidentiality are inherent in the concept of privacy, which refers to an agreement between persons that limits others’ access to confidential information. Information that is given anonymously also ensures the privacy of participants (Levy & Lemeshow 2013:87). The researcher was responsible to protect all the data, within the scope of the research, from being divulged. Anonymity was maintained in that no one could link the names of the participants with any information that was given to the researcher although the researcher knew the peer educators. The transcribed interviews were numbered with no identifiable data. It was impossible for anybody to link the data transcript and the final analysis with a specific participant.

2.9.5 Freedom from harm

When research is conducted on any sensitive issue, the researcher must be concerned about the safety of the participants; because the nature of social and health research could be emotionally harmful (Babbie & Mouton 2009:375; Terre Blanche & Durrheim 2008:34), the researcher treated the participants with respect when asking questions about their personal views and they were assured that they would not be exposed to any harm or exploitation (Polit & Beck 2011:76). It was not necessary to refer any of the participants for counseling as the subject was not sensitive in nature.

2.9.6 Restoration of respondents

The researcher convened a meeting with all peer educator volunteers after the completion of the study to clarify any misconceptions that might have been created in

the process of the study. This is necessary to give research participants an opportunity to review and evaluate their experience of the study (Levy & Lemeshow 2013:56). All the participants were present, none of them raised an issue of concern; they showed their positive feelings about their participation in the study.

2.9.7 Management of the data

Management of the data refers to the conservation of the tapes, the field notes and the transcripts both during the study and after it was completed (Tully et al 2014:49). The participants were assured of the proper safe-keeping of information in a locked store for data documents. The only people who had access to it were the researcher, academic supervisor and the independent coder. The tapes and notes were kept for a period of one year and destroyed after the study was completed and examined. Although the research report will become a public document it will not contain any information that can be linked to the identity of an individual participant.

2.10 CONCLUSION

In this chapter the researcher described the methodology that was utilised to gather the data from the participants in an ethical manner. A data trail about data gathering and analysis was given to assist with the possible transferability of the data to similar contexts.

Chapter 3 will focus on the themes, categories, and sub-themes that emerged from the data analysis.

CHAPTER 3

DATA ANALYSIS, INTERPRETATION OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

The data analysis of this dissertation, of limited scope, as well as the literature control will be presented in this chapter in a very integrated way.

The available literature on peer education as well as contraceptives were integrated with the study findings to ensure easy reading and understanding, as well as to provide an overview of where the study findings (83 direct quotes) fit into available literature.

Two open-ended questions were asked to meet the purpose of this study, namely:

1. Please describe how you perceived the peer education training that you underwent, and
2. Please describe how this training affects your own sexual behaviour.

Data analysis, organisation and interpretation were done using Tesch's eight steps (Creswell 2009:189). The researcher listened to audiotapes to get an overview of the extent of the interviews. Thereafter all interviews were transcribed verbatim. The researcher read and re-read the verbatim transcripts, to yet again get a global understanding of the interviews and to familiarise herself with the data. Thereafter, the researcher read carefully through every individual transcript. Key concepts, key events or ideas were circled and color codes were used to group together the key ideas into themes and categories. This process was repeated with all the transcripts, adding new themes and changing themes as the researcher worked through all the transcripts. After coding, similar ideas were grouped together into four main themes, namely: positive education experience, challenges that influence contraceptive use, positive personal growth and a mentoring role. Under each of the themes, categories were identified, accompanied by sub-themes that were the direct words as expressed by the participants (see Table 3.1). A co-coder also used the raw data to do an analysis and came up with similar themes, categories and sub-themes, as indicated in Table 3.1.

Table 3.1 Categories, themes and sub-themes

Themes	Categories	Sub-themes
1 Positive education experience	Knowledge of:	
	1.1 Anatomy and physiology	"I know now how my body works." "I have learnt about ovulation and menstruation." "The physical aspects of the male and the female body" "I know when it is a safe time to have sex, and the fertility time" "I know what the menstrual cycle is."
	1.2 Family planning	"With family planning knowledge I receive, all my sexual worries were history." "I know how to use a condom." "Actually at our age abstinence is the best." "I know to use condoms if we want to escape unwanted pregnancies." "I know now the difference between facts and myths around fertility." "I have learn different contraceptive methods; that will help me to planned when and how many children I will have."
	1.3 Implications of teens pregnancy	"Having a baby is life changing." "Being a mom is a full time job."

Themes	Categories	Sub-themes
		"I learn about the consequences of teen pregnancy." "Economic and educational implications."
	1.4 Prevention of sexually transmitted diseases	"I know about sexually transmitted disease now, I mean the type, the manifestation and the mode of transmission." "I learnt how to prevent against sexually transmitted disease and HIV/AIDS." "We learnt to recognise signs and symptoms but to be sure go and check yourself at the clinic if you feel bad after intercourse… or not, sometime it is good to just know where you stand."
2 Challenges that influence contraceptive use	2.1 Attitude of nursing staff	"At the clinic it is worse there is no privacy, he nurses are rude and chase us." "If you come for condoms often at the health clinic, the nurse gets worried that you are having too much sex and can tell you parent."
	2.2 Accessibility of contraceptives	"It is not easy to have contraceptive" "some teens agree on use with their partners but the contraceptives are expensive people are too poor here…sometimes the clinic is out of stock you have to spend on transport to town…it is very expensive."
	2.3 Attitude of the partner	"I am scared to talk to my boyfriend about condoms - he will think that I am sick or I am having another man." "If I ever find my girl using the family planning it is over…" "I have heard very bad things about them! What if after that I cannot have a child?" "I do not want my girl to use contraceptives and this can even lead to a separation…I am ready to have a child; I can look after my child if it happens."
	2.4 Lack of knowledge	"Condoms are not free where I come from so you can understand how thing are difficult." "If my partner is looking beautiful and healthy, there is no method used…even any

Themes	Categories	Sub-themes
		HIV test is done, we check with our eyes…I just look at and I know everything is alright." "Condom is difficult to propose; trust me, you can use it at the beginning or with a quick encounter but it reaches a time when you stop." "Partners view using a condom as a sign that she is sick or you don't trust them." "Over time you stop, also condoms are expensive to obtain…time to stop using condoms depends on the individual you trust." "I don't like anything, pills, condoms, injections, all are dangerous. They go through the tube where eggs come from. When they arrived in the middle of the eggs, they burn them all, the womb is dry, someone may die without a baby." "Family planning causes abnormal swelling in the uterus and also cancer…my Aunty was using these methods, and she was operated on because of this." "They remove fat and contraceptives in the womb, when you take pills for a long time they stuck in your body…that is why I cannot use family planning." "If I ever find my girl using family planning it is over…I have heard very bad things about them! What if after that I cannot have a child?" "Some guys do not want their girls to use contraceptives and are very tough on that this can even leads to separation." "I heard a scenario where a boy reproached the girlfriend who had told him that she was not ready to have a child yet, the boyfriend said he could look after his child and wanted one."

Themes	Categories	Sub-themes
	2.5 Socio-cultural expectations and contradictions	"In my community my parents and elders are against contraceptives. If they find you with a condom, they lose confidence in you." "The pastor in our church emphasises that use of family planning methods is killing, it is a big sin in front of God."
3 Positive personal growth	3.1 Self-respect	"I have my self-esteem back." "better alone than a boyfriend who does not respect you." "Actually I am my own boss, I can even teach my boyfriend how to be in a healthy relation without fighting." "I am now in control of my body and mind."
	3.2 Assertiveness	"I can say no to sex." "I can now say no to sex if I am not in the mood." "I have the power to make my own decisions." "Have learned to communicate and overcome peer pressure." "For the first in my life I am in control." "He is not the boss, telling when and how things must be done."
	3.3 Negotiation skills	"Sex is not the only way to have fun." "I learned about sex negotiation." "I can negotiate when to have fun, sex or go to a movie." "I learnt that communication is the key of every relationship, from then everything is in

Themes	Categories	Sub-themes
		the open."
	3.4 Behaviour change	"I adopted healthy sexual behaviour." "I am scared about what I did in the pastif I was angry with my boyfriend at a party I had sex with another boy." "I am on top of this sexual game." "If not for this training...I am a fan of TV, seeing people have babies…I nearly fall for that."
4 Mentoring role	4.1 Shared experience and knowledge	"I want to be a role model for my peers." "I was too scared to talk to my mom and had nobody to guide me in sexual relation … I want to guide my peers now." "I want to empower young girls." "I am empowered and can't wait to share." "I am armed and ready to guide the youth of my community, I will open a friendly youth center of communication to share with my peer the knowledge that I acquire." "I want to share my knowledge." "I was thinking about starting a peer education club together with the youth club in the church."

3.2 FINDINGS

After 15 in-depth interviews were conducted, no new information was obtained and it was decided that saturation was reached. No further interviewers were arranged.

3.2.1 Biographical profile of participants

Ten females and five males participated and were interviewed. In order to build awareness throughout the Douala municipality, peer educators were selected both from rural and urban areas, as there might have been differences in opinion between participants from these two diverse areas. In a developing country such as Cameroon, the social, cultural and economic realities are not the same for urban and rural teens and therefore teens, in certain ways, are not a totally homogenous group. How they communicate and share information is different as their access to information varies (Chandra-Mouli, Camacho & Michaud 2013:517-522), thus the reason for including participants from both areas. Seven peer educators were from the big municipality area (urban) and eight were from the less developed areas (rural) as reflected in Table 3.2.

Table 3.2 Biographical data of participants

Participant code	Age	Gender	Grade	Address
A	13	Female	8	Rural
B	14	Male	9	Rural
C	16	Male	10	Urban
D	14	Male	9	Urban
E	17	Female	11	Urban
F	18	Male	12	Rural
G	19	Female	University	Urban
H	13	Female	8	Urban
I	14	Female	9	Urban
J	16	Female	11	Rural
K	15	Female	10	Urban
L	17	Female	12	Rural
M	18	Female	University	Rural
N	14	Female	9	Rural
O	19	Female	12	Rural

The ‘100% young’ training programme targeted specially teenagers, therefore the ages of the participants in this study ranged between 13 and 19 years old, with an average age of 16 years, as indicated in Table 3.2. This correlates with the average age distribution of the 50 peer educators who underwent the programme between 2 June 2014 and 30 June 2014, the year of data gathering.

The lowest academic achievement of the participants was grade 8, and only two participants were enrolled at a university at the time of data gathering. This data just represents the academic achievement of the participants and it was expected that achievements could varied significantly due to the age distribution of the participants. It was encouraging to see that all the participants over the age of 18 at least had grade 12 with a better socio economic prospect. Because education is a key in individual socio-economic status, it provides a pathway out of poverty as well as a good labour market performance. Performance in the labour market, being literate and numerate, empowers people to meaningfully participate in society (Campbell 2010:1734-1739).

In order to interpret and describe the findings of this research study, it is necessary to provide literature about peer education and the specific ‘100% young’ training programme. A literature control to compare, support or contradict the study findings from other contexts is also provided for a better understanding of the study findings.

3.2.2 Peer education

Peer education programmes have been in place for at least 30 years in various forms. They were originally used as support mechanisms in delinquency and drug and alcohol treatment programmes. Peer education programmes, however, have emerged more recently as an effective way to address other health issues that affect teens (Boyer & Chang 2007:499-505), especially in the education of teens and more specifically pertaining to the risks and transmission of HIV infection and other sexually transmitted infections (STIs). It seems as if peer education has an important role to play as peers are used to educate their peers. Peer education can thus be utilised as a way to educate youth and teens to prevent unwanted pregnancies (Shiner 2009:550-556).

Typically, the term “peer educator” refers to someone who shares characteristics of his or her peers but receives special training on a topic or skill so that he or she can

function in a different way and act as an educator (Boyle, Mattern & Lassiter 2011:519). In this study the peer educators were teenagers aged between 13-19 old, who underwent the '100% young' training programme from 2012 to 2013. They were trained to become the peer educators responsible for educating other peers in the very same '100% young' training programme that they underwent (see 1.7, page 9).

3.2.3 Advantages of peer education

Peer education is very effective in promoting the adoption of certain behaviours of teens. The peer educators and their peers (teens) can mutually identify with each other as individuals and as members of a specific socio-cultural reality (Boyle et al 2011:519). This identification with peer educators can contribute to making strong role models for promoting behaviour change such as sexual behaviour, because teens can identify with their peers (Wilcox & Angelis 2009:112). Peer educators can promote and educate their peers to prevent unwanted pregnancies and sexually transmitted diseases (McCarter & Hubbard 2009:85-88). Participants emphasised this advantage by saying:

> "I want to be a role model for my peers."

> "I am empowered and can't wait to share my knowledge."

One participant even said:

> "I was thinking about starting a peer education club together with the youth club in the church."

Teens normally have a more positive perception of their risk behaviour if the message is delivered by their peers (Wilcox & Angelis 2009:117). In this study, the '100% young' training programme facilitates the involvement of peer educators in programme planning, implementation and evaluation. This is empowering for both the facilitator and the peer educator because of its horisontal and participatory approach to learning (Shiner 2009:555-566). One participant argued that:

> "The programme really opens my mind about the importance of life and the part I have to play for my own good and peers; sharing the information I got with them."

One of the advantages of peer education is that teens can gain knowledge from their peers (McCarter & Hubbard 2009:88). It is, however, important that this knowledge should be obtained from reliable sources, like a formal peer education programme (McCormick 2011:5-8) to ensure that misconception and incorrect myths and information are not spread among teens (Dicenso, Guyatt, William & Griffith 2009:14-26). The participants in this study also indicated that they had a positive education experience and they have obtained knowledge (see Table 3.1).

3.3 POSITIVE EDUCATION EXPERIENCE (THEME 1)

3.3.1 Knowledge (category 1)

Peer education helps teenagers to be less dependent upon their parents and family members for information and knowledge; therefore it can postpone the age at marriage and the age of beginning sexual relationships (Williams & Guest 2008:163-165).

Educational programmes that are focused on the prevention of teen pregnancies and behaviour, however, must also contain theoretical knowledge. Knowledge about the reproductive organs, anatomy and physiology, menstrual cycle, contraceptives, family planning, sexual relationships, negotiation and communication skills, as well as sexually transmitted diseases (Brooke, Braford & Meston 2009:860-872), should be included.

It is evident from the data (Table 3.1) that according to the participants' perceptions, they obtained valuable knowledge that can contribute to the set objectives of the programme.

A participant reported that:

> "The programme helps me to have factual information about sexuality, reproduction and sexually transmitted infection."

Another one came to the conclusion that:

> "100% Young training gives me new skills, confidence, and positive behaviour as well as knowledge about sexuality."

Knowledge is needed to inform and assist decision making regarding sexual behaviour, and higher educational levels will then contribute to fewer teenage pregnancies (Sedgh et al 2015:151-159).
For families and teens in developing countries, education means that an early start to childbearing is less desirable because there is a need to further educate girls. Girls can then at least go to secondary school, ensure a better possibility for jobs and give their children better opportunities for education. Education will eventually change the socio-economic status of teenagers (Sedgh et al 2015:157).

The knowledge of young girls is important because it empowers them to make choices and obtain decision making skills as indicated by a participant:

> "I am in control of my future and I feel I have the choice in life…."

> "I can choose who and when to have sex without fear of being pregnant or having STD, for the first time in my life I feel that I am in control."

Knowledge enables them to plan their behaviour and make informed choices. Another participant explained as follows:

> "I went to be tested, after I knew my status; I decided to use all the prevention I can have to stay alive and healthy."

The second aspect that teens need to be empowered on is **education.** Teen girls need good education through secondary school attendance and access to economic opportunities in order to be seen as actors in society beyond their reproductive capacities. The lack of education on safe sex whether it is from parents, school, or otherwise, is a cause of many teenage pregnancies (Malamitsi-Puchner & Boutsikou 2010:170-171) as many teens were not taught about methods of birth control and how

to deal with peers who pressure them into having sex before they are ready (Oringanje, Meremikwu & Eko 2009:50-54). Participants ascertain that:

> "I became totally aware of what being a young responsible girl means…"
>
> "The training had a very positive effect on me, beside the knowledge I acquired I learnt all the methods of birth control and especially how to use a condom…"
>
> "After the programme I spoke to my boyfriend and we decided to wait until we finish school and got married, no more sex without protection."

Teens also need to be empowered on ***practical knowledge*** in sex education. A lot of pregnant teens do not have any cognition of the central facts of sexuality, or of use of contraceptive methods; they lack knowledge of or access to conventional methods of preventing pregnancy, as they may be too embarrassed or frightened to seek such information; even though some often think of contraception as the pill or condom, they have little knowledge about options (Kohler, Manhart & Lafferty 2008:344-351). Participants stated:

> "Before the training I was embarrassed to talk about sex to my parents, ask about birth control, not knowing the consequences of my actions…"
>
> "The facilitators explained to us the family planning, the planned parenthood, the condoms if we want to escape from STD, HIV, and unwanted pregnancies…"
>
> "He showed us female and male condoms, how to use them and ascertained that if used correctly they are 99% effective".

3.3.2 Anatomy and physiology (category 1.1

All teens need correct information about the anatomy and the physiology of the reproductive organs. They therefore need knowledge about the **menstrual cycle**.

Menstruation is a monthly shedding of a female's urethral lining; it lasts about 3 to 5 days (average) and contains blood and tissue that exits the body through the cervix and

vagina – the first day of menstruation is the first day of your period (Weschler 2009:240-241).

Menstruation is not just about having a period; it is a sign that a girl is physically capable of becoming pregnant. The fertility time covers the time from five days before until one to two days after ovulation (Weschler 2009:242-244). Knowledge about the menstrual cycle informs teens about important information regarding the relative safe time to have unprotected sex as well as the high fertility times. With this knowledge it is possible to make use of natural methods to prevent unwanted pregnancies, as a participant indicated:

> "The facilitator taught us how to control our body around our menstruation so that we don't fall pregnant…he said that a girl's body is divided in two time periods, the fertility time and the safe time".

Knowledge about the **anatomy of the male and female reproductive organs** is also an important component of the curriculum. Theoretical knowledge about reproduction is necessary so that teens can understand the physiology of the male and female reproductive systems and organs. Teens often have inadequate information about their own and/their partners bodies contributing to them wanting to investigate (Selling & Oscarsson 2009:117-125). Knowledge is important to ensure that curiosity and a lack of information is not the reason why teens experiment with sex (Quinlivan 2009:25-26) and then become becoming either pregnant or contracting a disease. They need this information so they can make informed decisions about sexual expression, sexual behaviour and how to look after their own health (Swartzendruker & Zenilman 2010:1005-1006). Teens need to understand their own sexual development, both physically and emotionally. Having knowledge and understanding will assist in the prevention of unwanted pregnancies and might increase their intentions for abstinence and safer sex choices (Kaufman & Stadler 2008:18-24).

Peer educators in the '100% young' training programme receive this type of knowledge as participants explained:

> "I have learned about the biological function of my body, the whole physical aspect of the male and female body, ovulation and menstruation."

> "The programme helps me to have adequate knowledge of issues relating to human sexuality and sex education."

> "The programme helps me to have factual information about sexuality, reproduction and fertilisation the whole thing how the baby grows in our womb from day one to birth."

Essential knowledge about **conception and fertilisation** is needed to make informed choices about when to become pregnant. Unwanted pregnancies will then be prevented. Humans are sexual, and therefore sexuality and pregnancy is a normal element in the relationship between them. The anatomy as well as the physiology of the human body allows for reproduction (Blank & Brosens 2013:412) but informed choices need to be made. The '100% young' training programme provides peer educators with the necessary knowledge to talk to their peers about sex, learn how to be a responsible and proud teen. Their decision to become sexually active or pregnant should be an informed choice and therefore knowledge of family planning is also essential.

3.3.3 Family planning (categories 1.2 and 1.3)

Family planning services are defined as educational, comprehensive medical or social activities which enable individuals, including teens, to determine freely when they want to start a family, the number as well as the spacing of their children. The aim with family planning is to plan for parenthood (Kirby & Lepore 2008:113). Family planning services assist with and provide a selection of different types of contraception, suitable for a diverse group of health care users, including teens.

Knowledge about family planning is very important if teenage pregnancies are to be prevented (Jones, Korst, Singh, Henshaws & Finer 2009:119-129). Knowledge enables teens to increase their understanding of how to prevent a pregnancy, plan for a pregnancy at a specific time that a person chooses to become pregnant (Cleland & Ndugwa 2011:137-143), or prevents pregnancy altogether.

Teens need to be knowledgeable about all the effective methods of contraception that are available for their use. They need to know how to use it correctly, where to obtain it

and they need to have an understanding of the effectiveness and the possible side effects or complications (Rodriguez, Moreau & Bouyer 2009:1387-1392) that may occur. Not only can contraceptives prevent a pregnancy but they can and should be used to prevent sexually transmitted infections (Frost & Darroch 2008:94-100), like HIV, specifically in teens.

The participants perceived that they did gain this knowledge:

> "100% young training programme teaches us about the prevention solutions such as easy access to birth control, the friendly clinic and free access to condoms."

Participants also were taught about the importance of family planning as a participant said:

> "I learned about the consequences of a teen pregnancy."

> "Having a baby is life changing that has economic and educational implications."

They were taught that:

> "Being a mom is a full time job,"

and therefore a teenage pregnancy should be prevented as teens are not yet ready to be mothers (Agyei & Epema 2010:23).

A participant said:

> "I have learn different contraceptive methods; that will help me to planned when and how many children I will have."

3.3.4 Contraception (category 1.2 continue)

Due to the complexity of contraception and the various methods available a short literature review will follow under this category. Where applicable the responses of participants are included.

Contraception, also known as birth control and fertility control includes methods or devices used to prevent pregnancy (Rowan, Someshwar & Murray 2012:95-96). Two main groups of contraceptive methods are available and need to be known by teens. Barriers methods, like condoms, which physically prevent fertilisation by preventing a sperm to fertilise the egg and hormonal methods on the other hand, that alter the female hormonal cycle to prevent fertilisation (Carr & Gates 2012:80-82).

3.3.5 Barrier methods of contraception

Unlike other methods of birth control, barrier methods are used only when there is actual sexual intercourse. There are several methods available such as the diaphragm, the cervical cap, the cervical shield, the male and female condom, spermicidal foam, sponges, and the film (Trussell & Guthriek 2007:19-47). The three main barrier methods of contraception used by teens are male condoms, female condoms and spermicides (Abramowicz 2010:55-62).

3.3.5.1 Condoms

Condoms are barrier device that may be used during sexual intercourse to reduce the probability of pregnancy and spreading sexuality transmitted infections. When properly used, condoms are effective against most STDs (Gallo & Kilbourne 2012:18-26). Teens may have temporary sexual relationships and multiple partners, which puts them at high risk of contracting STD/HIV and unwanted pregnancies (Rivera, Cabral & Chandra 2010:149-163). Teen girls are at even greater risk as they are emotionally and financially vulnerable; therefore sexually active teens need to be aware of the double protection that condoms can offer them against pregnancy and STD/HIV (Trussell & Guthriek 2007), as a participant states:

> "The facilitator in '100% young' training programme showed us men and female condoms, he showed us how to use them and ascertained that they are 99% effective to prevent STI, HIV, and unwanted pregnancy."

- **The male condom** is most commonly used. It is the only method of contraception that men and teenage boys both can use as they can be in different sizes, shapes, and flavours. Male condoms are made from very thin latex (rubber), polyisoprene or polyurethane, and are designed to stop a man's semen from coming into contact with his sexual partner (Corinna 2009:207-210). When male condoms are used correctly during vaginal intercourse, they are effective to protect against an unplanned pregnancy and sexually transmitted infections (Cates & Steiner 2009:184). As a method of birth control, male condoms have the advantages of being inexpensive, easy to use, having few side effects, and offering protection against sexually transmitted diseases (Beckerleg & Gerofi 2009:6-9). Another advantage is that men and teenage boys can take an active part in using contraception. In Cameroon male condoms are widely available (100 cfa) in the public sector, with expanded access via social marketing and the private sector (Tarkang 2013:55-58).

- **The female condom,** also known as femidon, is a device that is used during sexual intercourse as a barrier contraceptive to reduce the risk of sexually transmitted infections (gonorrhea, syphilis, HIV) and unintended pregnancy (Beksinska & Smit 2009:652-659). Female condoms are made of a polyurethane sheath or pouch 17cm (6,5 inches) long (Gallo & Kilbourne 2012:30-34). Female condoms are not as widely available as the male condom and are more expensive. Only one female condom (FC1) is currently marketed, but it is poorly utilised, due to the difficulty with insertion, discomfort and suboptimal functional performance during intercourse (Beksinska & Smit 2009:660-665). These condoms give women control and choices over their own sexual health and are useful when the male partner either will not or cannot use condoms.

The '100% young' training programme teaches teens not only about the type of condoms and the advantages thereof, but also how to use them correctly as indicated by a participant:

> "The facilitator told us that when used (condoms) correctly and consistently, condoms are the most effective method of preventing infection for those engaging in sexual intercourse, and can be highly effective in protecting against pregnancy as well."

"Being in the programme I learnt how to use condoms if we want to escape STD and unwanted pregnancies."

Advantages of condoms

Condoms have the following advantages

- Condoms are safe and effective in preventing both pregnancy and some sexually transmitted infections when used correctly during intercourse (Ogbe & Mutihir 2012:11-15).
- No prescription is needed to use a condom.
- They are cheap, if not free (Beckeleg & Gerofi 2009:6).

Disadvantages of condoms

There are disadvantages and teens need to be informed about these disadvantages as is the case in the curriculum of the '100% young' training programme.

- Condoms do not provide complete protection against genital herpes, syphilis, and chancroid, because the STIs can be transmitted across infected skin surfaces that are not covered by the condom (Warner, Gallo & Macaluso 2012:4-9).
- Condoms are very sensitive and can tear when putting them on. No oil based lubricants such as Vaseline or sun tan oil can be used, as these products can cause a hole in a condom (Sanders, Yarber & Kaufman 2012:81-85).
- Low quality of sex due to lack of physical sensation (Davies, Schraufnagel & Kajumulo 2014:631-643).
- Some teenagers are sensitive or allergic to the latex from which the condoms are made.
- Males must pull out soon after ejaculation or the condom could fall off and spilt or be left in the vagina (Milhausen & Graham 2012:81-85).

3.3.5.2 Spermicides

Spermicides are contraceptive substances designed to prevent fertilisation by killing or inactivating sperm as they ascend through the female genital tract. Spermicides come in different forms such as cream, foam, tablets, and gel, which is squirted into the vagina by using an applicator (Frost, Darroch & Remez 2008:1-8).

All spermicide products have two components: a chemical toxic to sperm (nonoxinol-9) and a formulation for its delivery (Cates & Harwood 2011:391-400). Spermicide products are inserted deep into the vagina before intercourse. Instructions for use vary by product; tablets, suppositories and film need time to melt to allow dispersal of the spermicides in the vagina, the spermicides must therefore be inserted from 0 to 30 minutes before intercourse (Best 2014:9). While some jellies, creams and foams may protect for as long as eight hours, tablets and suppositories may be effective for only one hour (Speroff & Darney 2010:45).

Frequent use of spermicides containing nonoxynol-9 may actually cause irritation and small tears to the genital tissue allowing for easier transmission of HIV and other STDs (Gaither 2014:1-5).

When used together, the spermicides and the male condom can be a great combination for effective protection against both pregnancy and sexually transmitted infection such as HIV (Coetzer 2011:24-27).

Advantages of spermicides

Spermicides do have the following advantages:

- Spermicides give the women control over the use of a contraceptive, like in the case of the contraceptive pill (Farrer 2011:22-26).
- They are available over the counter, therefore no prescription needed for teens to have and use them (Miklavcic 2011:1-5)
- Foam is safe to use and has no hormones in it.

- Spermicides can be put into the vagina up to 20 minutes before sexual intercourse but it is also effective just before the intercourse (Luoto, Barnhart, Martens & Creining 2009:438-442).

Disadvantages of spermicides

Spermicides have disadvantages that teens need to be aware of:

- The foam can be messy and irritating to the vagina.
- Spermicides may not be protective against HIV/AIDS.
- Some teens will not be able to and or will not appreciate placing an applicator up into their vagina (Kestelman & Trussell 2009:226-232).

Spermicides have been used by teenagers and have not been shown to cause any other side effects or problems as during adult use (Whitaker & Gilliam 2014:268 270). However, teenagers need extra counselling and information on the importance of using spermicides exactly as they are supposed to be used so they will work properly (Whitaker & Gilliam 2014:269), bearing in mind that they do not prevent sexually transmitted diseases.

3.3.6 Hormonal methods of contraception

Two types of hormonal contraception are available and regularly used by teens; namely the birth control pill and the injectable hormonal contraceptive; these two methods, however, do not provide protection against sexually transmitted infection. When used accurately, both are extremely effective in providing protection against pregnancy (Frost et al 2008:1-8). In this study the programme focused only on certain methods; namely the pill and injection, because those are the ones teens normally prefer, but all will be discussed briefly.

3.3.6.1 The birth control pill

Also known as “The Pill”, the birth control pill is a prescription method of birth control. It consists of a month-long series of pills containing the synthetic hormone-progesterone

with or without estrogen (mini pill) that are taken every day (Huber & Walch 2009:23-29). The combined hormonal contraceptives work by preventing ovulation and thickening cervical mucus to keep sperm from entering the uterus (Glasier, Cameron & Scherrer 2011:363-367).

Combination pills have a variety of schedules, including monthly packs where they might have 21, 24, or 28 day cycles, or extended regimens like 91 day cycles (Levin & Hammes 2011:1163-1164).

In the case of the combination pills, one pill is taken each day at the same time. The pills are specially marked in different colours where the white ones usually do not contain hormones and are called the placebo pills.

There are 28 pills in a packet. The first 21 contains the hormones that must be taken the first 21 days of the month. The other 7, called the placebos, contain no hormones, and allow the menstrual period to happen. For the best results the pills must be taken every day at the same time (Levin & Hammes 2011:1166-1167). The pill is a prescription method of birth control and pregnancy can occur if the pill is not taken 100% as prescribed.

Progestin only pills, also known as “mini pills”, thicken the cervical mucus to make it harder for the sperm and egg to meet, and thin the uterine lining to hinder egg implantation in the uterus if fertilisation did manage to occur (Speroff & Darney 2010:55). Due to the lack of estrogen this method can be prescribed to women who are breastfeeding or to those who experience nausea when estrogen is given (Glasier et al 2011:373).

These pills also come in packs of 28 pills. One pill is taken at the same time every day, but no placebo as all the pills contains hormones.

The incorrect use of birth control pills is a major reason for unplanned pregnancies (Speroff & Darney 2010:19-24). Not taking pills at the same time of the day, every day; missing pills in a cycle and the number of pills missed in a row and having unprotected intercourse around these times (Levin & Hammes 2011:1163-1194), increased the chances of a pregnancy.

The highest risk of ovulation occurs when the placebo is prolonged for more than seven days. This can occur by either delaying the start of the pack or by missing active pills during the first or third weeks of birth control pill use (Glasier et al 2011:363-367). Teens need to be taught that they rather need to abstain from intercourse or use another birth control method such as condoms or spermicides until they can discuss the best options to prevent a pregnancy with a health care provider (Nelson & Cwiak 2011:253-254)

When a pill is missed, teens should know how to act. The action depends on the type of birth control pill used and is illustrated in Tables 3.3 and 3.4 below (Hanson & Burke 2010:382-385).

Table 3.3 Actions after missing a pill from a 21-28 day pack: Combined hormonal birth control pills

Number of missed pills	**Action required**
1 active pill (more than 24 hours and up to 48 hours late)	Take your missed pill as soon as remembered (which means take two pills in 1 day) Continue with the rest of the pack as usual
2 or more active pills in a row	Take the last pill missed right away (which means take two pills In a day) Do not take any earlier missed pills Continue with the rest of the pack as usual If 2 or more pill are missed in the third week (pills 15-21) omit the pill free interval by finishing the pills in the current pack and starting a new pack the next day (discard placebo pills)
One or more reminder pill	Throw away the missed reminder pills Take the next reminder pill at the usual time

Table 3.4 Actions after missed pills from progestin only pills

The progestin only pill must be taken at the same time each day (no more than three hours late).

Number of missed pills by more than 3 hours	Time	Action required
One or more	Anytime	Take a pill as soon as remembered Take the next pill at the usual time (which mean two pills in one day)

A pill not very commonly used is the extended-cycle birth control pills with 84 active tablets and 7 inactive tablets; in Cameroon the combined pills and the mini-pills are the most popular teen birth control methods (Ngoh & Yakam 2009:798-801).

Advantages of contraceptive pills

The contraceptive pill has the following advantages:

- It lowers the chances of having benign breast masses.
- It relieves premenopausal symptoms.
- The menstrual periods are more regular (Huber, Bentz & Tempfer 2008:2317-2325).
- It decreases the amount of menstrual flow.
- It decreases the severity of dysmenorrheal (Marnach, Casey & Long 2013:295-299).
- It reduces bone loss associated with aging.
- It decreases acne (Huber & Walch 2009:23-29).
- It can be taken by women who had side effects or complications when using estrogen-containing pills as well as lactating women (Truitt, Fraser & Grimes 2009:59-62).
- Using the pill reduced endometrial cancer, ovarian cancer and Pelvic Inflammatory Disease (PID) (Havrilesky, Moorman, Loweery & Gierish 2013:139-147).

Disadvantages of contraceptive pill

- Smokers and hypertensive clients are at significantly higher risk of suffering a stroke and /or heart attack (Brito, Nobre & Viera 2011:81-84).
- Pills can be expensive and usually require a prescription.
- Headaches, depression or decreased enjoyment of intercourse are common side effects (Ammer 2009:340-343).
- During the first month women may have nausea and /or spotting
- Pills have to be taken every day at the same time.
- Gives no protection against STIs.
- Irregular menstrual cycles, weight gain and bloated feeling.

3.3.6.2 Injectable hormonal contraceptives

The contraceptive injection is an injection that contains hormones, either progestin alone, or a combination of progestin and an estrogen. It is injected into the muscle in the biceps or in the gluteus maximus every three months (Trussell & Guthriek 2007:41-45). Injectable hormones prevent pregnancy by suppressing ovulation, by making it more difficult for the sperm to swim through the cervical mucus, and by destroying the endometrium. It prevents the fertilised eggs to implant (Levin & Hammes 2011:1163-1194). It has the following ***advantages*** for the teenager.

- It reduces heavy and painful periods.
- It does not require daily or weekly attention.
- It provides reliable contraception for up to three months.
- It reduce iron-deficiency anaemia.

Disadvantages of the injectable contraceptives

The following possible disadvantages should be communicated to ensure that they can be prevented on the long-term:

- It may cause headaches, weight gain, and abdominal discomfort as well as mood swings (Burrows, Basha & Goldstein 2012:2213-2227).

- It may take several months, up to nine months, before women start to ovulate (Marnach et al 2013:295-299) after they decide to stop the contraception.
- Disrupted menstrual periods, which can take up to a year for normal menstrual cycles to resume (Burrows et al 2012:2013-2014).
- It requires a specific follow-up date.
- Common side effects such as fatigue, dizziness, hair loss and loss of bone density are noticed (Shulman 2011:59-63).

Other hormonal contraceptive methods that need to be mentioned, but are usually not used by teens, include contraceptive implants, the birth control patch, the vaginal ring, the emergency contraception (morning after pill).

3.3.6.3 The contraceptive implant

The contraceptive implant is a small flexible tube measuring about 40mm in length which is inserted under the skin on the inside of the biceps of a woman, after she is given a local anesthetic by a health care professional (Trussell & Guthriek 2007:19-23).

The implant prevents pregnancy by constantly releasing progestin into the bloodstream, to maintain hormone levels that prevent ovaries from releasing ovum and by thickening the cervical mucus. The implant can prevent pregnancy for up to three years, but unfortunately, although it prevents unplanned pregnancy, it does not provide protection against STIs including HIV (Oringanje et al 2009:50-60). Implants, like other methods of contraception have advantages as well as side effects or disadvantages.

The advantages of the contraceptive implant

- Women have fewer and or, lighter periods.
- 30% of women have amenorrhea (Glasier et al 2011:363-367).
- Protects against pregnancy for up to three years (less if the client is overweight).
- It is safe to be used while breastfeeding (Truitt et al 2009:39-42).
- It reduces dysmenorrhea.
- Fertility will return to normal as soon as the implant is taken out (Speroff & Darney 2010:17-19).

Disadvantages can be described as follows

- Irregular bleeding for the first 6-12 months.
- Depression, moodiness, hormonal misbalance sore breasts and weight gain (Cleland, Conde & Peterson 2012:150-153).
- Does not protect from HIV/AIDS or others STIs.
- Lose hair, develop headaches or arm discomfort (Huber et al 2008:2330-2332.
- It may cause acne or worsen existing acne.
- Dizziness, pregnancy symptoms and a lethargic feeling (Shulman 2011:59-63).

3.3.6.4 The morning after pill

Although the morning after pill was not mentioned by any of the participants as an option to prevent a pregnancy, this method could be used very effectively if intercourse was not planned, and the teen had unprotected sex (Trussell & Guthriek 2007:58-64). A participant supported this view as he indicated that he was told:

> "There is no patience during courtship…if you want to delay sex, the partner may think that you are not serious about the relationship and you can lose the party."

It should therefore be included in any programme involving the prevention of unplanned pregnancy. The emergency contraceptive can prevent pregnancy up to five days (120 hours) after unprotected sex (Cheng, Che & Gulmezoglu 2012:37-40). It is a stronger dose of progestin and estrogen used in regular birth control pills and is more effective the sooner after unprotected sex it can be used. It should be taken within 24 hours of unprotected sex and then delay ovulation, as well as preventing the ovum from being fertilised (Levin & Hammes 2011:1163-1196).

Teens should not use it regularly or rely on it as it can have side effects. It is however effective in a case of emergency. It is pure for emergency contraceptive purposes and will not protect any person from HIV or STI (Atuyambe, Mirembe, Gemzell & Faxelid 2009:300-309).

The side effects that can occur include: nausea, vomiting, abdominal pain, fatigue, headache, dizziness and breast tenderness. It can also delay menstruation for a few days.

All the above mentioned contraceptives are recommended to be used for women after menarche. Before menarche, condoms are the preferred method of choice as it prevents sexually transmitted infections as well as pregnancy. Although some contraceptive methods are not suitable for teens, they need to be informed, so that they have enough knowledge to make informed decisions in order to protect their own health.

3.3.7 Contraceptives not suitable for teens

Permanent methods of contraception are irreversible, therefore they are not recommended for teens. Teens should be informed about the benefits and risks of irreversible methods, because these methods are not suitable for young, fit women (Mc Niff 2013:145-159) who still want to become pregnant in future.

Age alone should not limit contraceptive choices; hence the following most important information should be given to teens and young women so they can make informed choices about contraceptives method they would like to choose.

3.3.7.1 Hormonal contraceptives

It is not advised to use hormonal methods of contraception to prevent teen pregnancy (King 2009:157-159). In this population, hormonal contraception is used imperfectly, with some estimates that 10% of teens on hormonal contraception still get pregnant (Olsen 2008:195-196).

It is also noticed that discontinuation rates for hormonal contraception in young girl are high, with many girls complaining about side effects, particularly breakthrough bleeding (Vitzthum & Ringheim 2009:13-16). Over concern about side effects, for example, weight gain and acne, often affect choices; missing up to three pills a month is common, and in this age group the figure is likely to be higher. Restoring after the pill free week,

having to hide pills, drug interaction and difficulty getting repeat prescriptions can all lead to method failure (Truchart & Whitaker 2015:263-273).

3.3.7.2 The combined contraceptive vaginal ring

For women between 13-18 years, the combined contraceptive vaginal ring is not recommended. This method's safety and efficiency is proofed and tested for women between 18 to 40 years of ages (Starks, Payton, Golub, Weinberger & Parsons 2013:711-713).

3.3.7.3 The fertility awareness method

The fertility awareness method, also known as the Rhythm Method, concerns the understanding of the reproductive cycle, by writing down the fertility signs. These fertility signs include cervical fluid, consistency position of cervix, and the awaking temperature (illustrated in Table 3.5). These need to be observed to determine whether or not a woman can become pregnant on a given day. A woman is actually fertile during only about a quarter of her cycle (Weschsler 2009:25-27).

This method is very relevant to woman in order to understand the female hormone cycles and fertility; but it is not recommended for teens because this method requires strict discipline and sex should be avoided for a few days. Teen sexual activity is usually sporadic and unplanned (Kahn, Brindis & Glei 2009:29-34) and therefore this method is not recommended.

Table 3.5 Fertility signs before and after ovulation

Time	**Waking temperature**	**Cervical fluid**	**Position of the cervix**
Before ovulation	Low	Looks similar to raw egg white and becomes wet and then dry	Rises and becomes softer and open
After ovulation	Rise for 12 to 16 days	Quickly dries up	Quickly dries and becomes firm and closed.

3.3.7.4 Sterilisation

Sterilisation is a permanent method of birth control. It is a tubal ligation for women and vasectomy for men, with permanent infertility. It is a specific surgical procedure that is not meant to be reversed (Curtis, Tepper & Steenland 2013:650-654).

3.3.8 Prevention of sexually transmitted diseases (category 1.4 continue)

Sexually Transmitted Infections (STIs) is sometimes called Sexually Transmitted Diseases (STDs). However, an STD is when the infection leads to an established disease. Having sexual activity at a young age, lots of sex partners as well as unprotected sex increase a person's chances of getting an STD (Shafer & Moscicki 2008:27-32).

Sexually transmitted infection can be transmitted by having sexual contact with someone who is infected through vaginal, oral or anal sex (Marston & King 2009:1581-1586). It takes only one unprotected sexual act to be infected. Sometimes STIs are asymptomatic and can be spread without knowing about the infection (Gross & Tyring 2011:20-22). Visible STI symptoms can be found either on the genitals or in and around the mouth of the infected individual; however the only way to be sure is to get a sexual health check-up, as a participant said:

> "I went for a test and after I knew my status, I decided to use all the prevention I can have to stay healthy."

There are various different STIs among young people and they need to have knowledge about them to ensure early diagnosis and treatment (Naidu & Nzuza 2013:32-40). The known signs and symptoms, as well as how to prevent the transmission of these infections, are included in the '100% young' training programme; as one participant stated:

> "During the programme I learnt many sexuality transmitted diseases that we teens can contract…herpes, syphilis, HIV, Gonorrhea, Chlamydia…"

Another participant said:

> "We learn to recognise signs and symptoms but to be sure go and check yourself at the clinic if you feel bad after intercourse or not, sometimes it is good to just know where you stand."

Knowledge about STDs is important to ensure early prevention, diagnosis and treatment.

Genital herpes is an STD that is transmitted through skin contact, usually during sexual intercourse. It is a viral disease caused by the herpes simplex virus (Balasubramaniam & Kuperstein 2014:265-280) and causes itching or tingling sensations in the genital or anal area, as well as small fluid-filled blisters that burst. It leaves small painful sores especially when passing urine over them. Other symptoms of herpes might be headaches, backache and flu-like symptoms, including swollen glands or pyrexia (Chayavichitslip, Buckwalter & Krakowski 2009:119).

Gonorrhea, also known as the clap, is a common sexually transmitted infection caused by the bacterium Nersseria Gonorrhoeae (Shmaefsky 2009:52) and affects both men and women. Some people who become infected will experience no symptoms. Females may experience a change in vaginal discharge, a burning sensation or pain whilst passing urine, or irritation and discharge from the anus. Symptoms for males may include a white or yellow discharge from the penis, a burning sensation or pain whilst passing urine, irritation and a discharge from the anus (Shmaefsky 2009:54).

Syphilis is a sexually transmitted infection caused by the spirochete bacterium Treponemia Pallidum. The primary route of transmission is through sexual contact and causes congenital syphilis (Coffin & Newberry 2010:20-27).

Syphilis is a slowly progressing STD that has several stages. The first stage symptoms include the appearance of painless ulcers at the place where the syphilis bacteria entered the body. Those ulcers, known as chancres, are highly infectious and are usually found on the vulva or on the cervix in women. In men, they appear on the penis and around the anus and mouth (Kent & Romanelli 2008:226-236).

The second stage symptoms may include a flu-like illness, a non-itchy rash, patchy hair loss, and flat, warty-looking growths on the vulva in women and around the anus in both sexes. If it remains untreated, it will progress to a dangerous tertiary stage.

Chlamydia is a sexually transmitted disease caused by a bacterium, Chlamydia Trachomatis, and is one of the most common STDs. Due to a lack of specific symptoms; people can be unaware of being infected. Chlamydia can be transmitted through sexual intercourse, oral genital contact, body fluids that contain the bacteria as well as from mother to child during birth (Gross & Tyring 2011:20).

Less often, symptoms are present and may cause unusual vaginal discharge or pain during urination, mild fever, muscle aches or headache. Girls with chlamydia also have pain in their lower abdomen, pain during sexual intercourse, or bleeding between menstrual periods. Boys have fewer symptoms such as discharge from the tip of the penis, itching or burning sensations around the penis (Torrone, Papp & Weinstock 2014:834-838).

Pelvic Inflammatory Disease (PID) is an infection of the fallopian tubes, uterus, or ovaries. Most girls develop PID as a result of sexually transmitted diseases (STDs) such as Chlamydia and Gonorrhea. Girls with multiple partners and those who do not use condoms are most likely to get STDs and are at risk for PID (Soper 2010:419-428). If PID goes untreated; it can lead to chronic pelvic pain, infertility or an ectopic pregnancy. Symptoms go from pain during sexual intercourse, loss of appetite, frequent and painful urination, to nausea, vomiting and diarrhea.

Teens need to be informed and gain knowledge about sexually transmitted diseases (STDs), including HIV/AIDS (Driscoll 2007:32-35), as they may have temporary sexual relationships and multiple partners, which put them at risk of contracting STD/HIV (Trent, Rich, Austin & Gordon 2009:33-37). Teenagers should receive information about sexually transmitted diseases before they get sexually active (Kim & Kols 2013:11-19) to improve their perceptions about the benefits of preventive measures.

Sexually active teens, especially teenage girls who are vulnerable to get infected, (Garenne & Zwang 2009:64-74) need to be aware of the importance of protection against both pregnancy and STD/HIV. In the ‘100% young’ training programme,

participants were of the opinion that they learned about these diseases and protection thereof; as indicated by their responses:

> "I know about sexually transmitted disease now."

> "I know now how to prevent them and I also know the difference between facts and myths about STDs."

3.4 CHALLENGES THAT INFLUENCE CONTRACEPTIVE USE (THEME 2)

A large proportion of teenagers worldwide, who are sexually active, have sex without using modern contraceptives or protection against sexually transmitted infection (STIs) (Williamson, Parkes & Wight 2009:109-110). In many cases, these results in too early and often unwanted pregnancies at different levels. Teens in general find it difficult to obtain the contraceptives they need and health workers are often unaware of the special needs of teens, hence contraceptive services are only rarely provided in a manner that is accessible to teens (Rivera et al 2010:160).

In Africa, only about 30% of all women use birth control although more than 50% of African women would have like to use contraceptives if they were available (Bruckner, Martin & Bearman 2008:248-257).

The participants identified five categories of obstacles to contraceptive use that include attitudes of nursing staff, attitudes of the partners, lack of knowledge as well as socio-cultural expectations and contradictions. These challenges are supported by Fusi-Ngwa, Payne, Azakizi & Katte (2013:137-148).

3.4.1 Attitude of nursing staff (category 2.1)

Paternalistic judgmental views by contraceptive service providers, coupled with a lack of privacy and confidentiality, were said to inhibit teens from seeking contraceptive services and using contraceptives since some providers do not keep confidentiality and can give information to the parents (Nalwadda, Mirembe, Byamugisha & Faxelid 2010:530). A participant said:

> "If you come for condoms often at the health clinic, the nurse gets worried that you are having too much sex and can tell your parents."

> "At the clinic it is worse there is no privacy, the nurses are rude and chase us."

3.4.2 Accessibility of contraceptives (category 2.2)

Healthcare clinics are sometimes out of stock of contraceptives or only have the high cost choices available, particularly in rural areas (Peer, Morojele & London 2013:406-412), as participant confirmed the case to be in this study:

> "Some teens agree on use with their partners but the contraceptives are expensive…people are too poor here…sometimes the clinic is out of stock you have to spend on transport to town…it is very expensive."

Another challenge regarding access is the long waiting times as well as limited opening hours at clinics (Creanga & Karklins 2011:89). Youth friendly services should be available, as some young people feel ashamed and reluctant to ask for contraceptive services from busy health care professionals who also have to attend to sick people (Ketende, Gupta & Bessinger 2009:130-137).

3.4.3 Attitude of partners (category 2.3)

Many teens do not use contraceptives because of gender inequalities in terms of power, roles, decision making and negotiation. Girls reported a lack of power in decision making as a key obstacle to contraceptive use (Kham, Shah & Saba 2009:23-25). A participant who underwent the training programme reported what he heard in the community while educating peers:

> "If I ever find my girl using the family planning it is over…I have heard very bad things about them! What if after that I cannot have a child?"

Unfortunately, male teens are of the opinion that girls fear the risk of not having children following the use of contraceptives and therefore oppose contraceptive use and react negatively. Girls, on the other hand, sometimes see early pregnancy as a positive

incentive for early marriage and no longer perceive it as a problem (Atuyambe et al 2009:300).

Participants expressed views about decision making and cited power struggles as obstacles to contraceptives use. Bankole and Singh (2008:15-24) indicated that the final decision regarding the use of contraceptives belonged to men as the role of women is to produce children. This is supported by a participant who reported that during mentoring he had been told:

> "Most men do not like contraceptives, they want children, he gets a baby with you and asks you for another…if you tell him about contraceptives he leaves you."

3.4.4 Lack of knowledge (category 2.4)

Teens have various beliefs and misconceptions about contraceptives. They believe that contraceptives interfere with fertility, they will harm their ability to reproduce; pills burn their eggs, accumulate in the body and cause swellings such as fibroids, cause cancer, as well as abortions (Moronkola & Fakeye 2008:229-238).

While training peers a participant reported that he heard some teens saying:

> "I don't like anything, pills condoms, injections, all are dangerous. They go through the tube where eggs come from. When they arrive in the middle of the eggs, they burn them all. The womb is dry; someone may die without a baby."

> "Family planning causes abnormal swelling in the uterus and also cancer…my aunty was using these methods, and she was operated because of this. They remove fat and contraceptives in the womb, when you take pills for a long time they stick in your body…that is why I cannot use family planning."

Misconceptions in the developing countries also include aspects like condoms stuck in the reproductive tract and cause death; "whites" had infected condoms with HIV; the oil on the condoms is infectious to woman and condoms have pores or grooves with actual perforations that will allowed transmission of HIV (Williamson et al 2009:111-118).

Side effects as well as knowledge about contraceptives can be a concern for teens. Their own experience with contraceptives, that of their peers', as well as misinformation provided by parents or elders in order to discourage intercourse, can cause teens to fear the use of contraceptives. Some teens in Uganda expressed more fear of the side effects of contraceptives, than of an unwanted pregnancy (Malus & Lachance 2009:159-162).

It is of concern that so many teens in the Douala community lack knowledge about contraceptives as a participant reported what one peer told him while trying to convince her otherwise:

> "I prefer the injection method but it had many problems like palpitations, craving for foods like a pregnant woman and dizziness that can even make you sometimes fall at school…class takes long hours before a meal, the pill can make you too weak to focus, you therefore can stop using them, anyway for me it is safer to just get pregnant and have a baby."

Peer pressure and the pleasure from sex sometimes override the fear of pregnancy, HIV and other sexually transmitted infections. Teens often indicate that young women who look healthy do not need contraception since there are no risks (Holland & Ramazanoglum 2013:125). A peer educator who attended the '100% young' training programme report that during a mentoring session in his community, a peer told him that:

> "If my partner is looking beautiful and healthy, there is no method used…even any HIV test is done, we check with our eyes…I just look at her and I know everything is alright."

Male participants felt that their peers prefer sex without a condom as they claim that:

> "They cannot eat a sweet in plastic wrapping."

Teens tend to build trust and confidence in their relationships and therefore abandoned the use of condom with stable partners that they trust and love. A participant reported that when educating other peers, the following was said to them:

> "A condom is difficult to propose, trust me, you can use it at the beginning or with a quick encounter but it reaches a time when you stop…"

> "Partners view using a condom as a sign that she is sick or you don't trust…"

> "Over time you stop, also condoms are expensive to obtain, plus time to stop using condom depends on the individual you trust."

Teens also feel that they do not have the time to purchase a condom after convincing the partners to have sex, as they usually have to do it fast in the club or in the car; while others reported poverty to override the need for protection (Blanc, Tsui & Croft 2009:63-71). A participant supported this view as he indicated that he has been told that:

> "After convincing the young woman to have sex at the disco, I am not prepared with contraceptives…by the way I would rather spend my money on new shoes or clothes than on contraceptives."

3.4.5 Socio-cultural expectations and contradictions (category 2.5)

In African society, the purpose of women is to bear a child (Burke & Ambasa 2011:67-78). Traditional societal norms, however, prohibit sexual activity and pregnancy for teens (Sedgh & Hussaim 2014:151-159). Society expects young people to be virgins till marriage, but teens are sexually active (Saxena, Copas & Mercer 2009:224-225). Cultural norms condemn parents talking with their children about sex. A participant supports this when she said:

> "In my community my parents and elders are against contraceptives. If they find you with a condom, they lose confidence in you."

The values in African society, furthermore, do not support the use of contraceptives. Teens are stigmatised if they use family planning, as contraceptives are perceived to be for married couples who have had a number of children. Often parents use scare tactics about contraceptives to keep their children from using contraceptives; although parents reject contraception, they do not want teen girls to become pregnant (Wright, Plummer, 2012:788). A participant stated:

> “My parents were shocked when I asked them about sexuality. My mum told me that children do not talk about those things, especially when you are single.”

It is therefore clear that in Cameroon, like in other countries, the key obstacles to the use of contraceptives are the contradictory messages from health workers, partners, parents, clergy, teachers, and cultural leaders (Sidze & Defo 2013:613). Participants were of the opinion that the churches added to the confusion and contradictory information with messages of opposition to contraceptive or silence about it. Participants said that the churches are very pro-natal with statements like:

> “Go and multiply, contraceptive use is murder, children are a blessing.”

Another participant also said:

> “The pastor in our church emphasises that use of family planning methods is killing, it is a big sin in front of God.”

Young people are in a dilemma as they are stigmatised if they use contraceptives. The community links the use of contraceptives to promiscuity and prostitution as well as to future infertility leaving young people afraid to tell their parents or boyfriends that they need contraceptives (Thompson & Holland 2014:78-79). This poses a major challenge to the peer educators in the ‘100% young’ training programme, as indicated.

Teens can be fearful that their parents discover that they use contraceptives as they fear their reaction (Abdul, Marrone, & Johansson 2011:9-14). A participant said:

> “It is very hard to take pills every day when you still stay with your parents, unless you keep them with friends…my parents get into my room, check my suitcase as they please. Really it is not easy to have contraceptives.”

Another one ascertained that:

> “My mum she also has comments; she cannot even tell my dad!”

The ‘100% young’ training programme specifically focuses on education regarding these barriers in an attempt to enhance the effective use of contraceptives. The training programme addresses key empowerment dimensions, as empowerment is urgently required, if teens’ contraceptive needs are to be solved (Neukom & Ashford 2008:40-50) and unwanted pregnancies prevented, but the socio-cultural norms remain a challenge.

In Cameroon as in other sub-Saharan African countries, early pregnancy is often seen as a blessing as it is proof of the young woman’s fertility (Foumane & Chiabi 2013:85-89). A participant stated that the common responses from teens while educating them are:

> “My grand mum told me that she wants to see my baby before she died…”

> “School and money don’t talk to you…children bring you the entire joy in life; trust me…are you not happy with your brother and sister?”

> “It a blessing to have a baby, you are a woman therefore a man will quickly marry you.”

3.5 POSITIVE PERSONAL GROWTH (THEME 3)

Positive personal growth refers to the impact of stretching, learning, growing and applying personal knowledge as well as other people’s experiences in order to change for the best (Branden 2011:66). In this study identified personal benefits of being a peer educator, they affirmed that they gained knowledge that was valuable for jobs, reference letters, and in some cases education, career direction, skills, as well as character. A participant affirms:

> “Having this valuable knowledge under your belt is very useful when you are applying to universities or for a job.”

The peer educators interviewed also proclaimed that they acquired transferable skills in communication, counselling, presentation, development, facilitation, listening, leadership and problem solving. A participant said:

> "Skills in communication and organisation, training in facilitation and leadership, teaching experience and counselling are just some of the benefits that I gained from the 100% Young training programme."

Many claimed that being in the programme contributed to their personal growth by helping them build confidence, develop a sense of fulfillment and become more open-minded as well as self-aware and mature. One participant acknowledged that:

> "I think we were certainly given knowledge and practical skills to change attitudes, to become critical thinkers on dominant messages about sexuality; it built character."

The programme, according to a participant, transformed the way she view the world and social interaction:

> "The training has totally changed the kind of person I am, the values I have. The way that I approach other teens who are different. The way I listen when they talk and answer."

The categories identified regarding personal growth were self-respect, assertiveness, negotiation skills and behavioural change.

3.5.1 Self-respect (category 3.1)

Self-respect can be defined as having dignity and morals to make the correct choices to ensure happiness. Individuals should be proud, in control and overcome past mistakes (Chaternoud 2014:1343-1344). The participants in this study were confident that the programme gave them their self-esteem back, they were of the opinion that:

> "I have myself-respect back, my self-esteem, what can I say? I am actually in control now more than ever before, I learn to negotiate sex. I therefore know that it is better to be alone than dating a boyfriend who does not respect you."

3.5.2 Assertiveness (category 3.2)

Peer pressure is widely recognised as a major contributor to risky sexual behaviour and teens need to be assertive if their voices are to be heard.

Peer educators who underwent the '100% young' peer education training programme felt that the programme empowered them to be assertive and be able to handle the peer pressure. Participants said:

> "Always afraid of what will happen after sex. Pregnancy or STD, however, I can't tell anyone, the programme empowered me with the right answer, now I am in control."

> "I have learned to overcome peer pressure; you see for the first time in my life I am in control; my boyfriend is not the boss, telling me when and how thing must be done."

Assertiveness is a learnable skill and way of communication. It refers to being self-assured and confident without being aggressive (Khama 2010:135). Assertive teens aim to be neither passive nor aggressive in their interactions with other peers, respecting boundaries of oneself and others (Pfeiffer 2010:23), but still they will make informed choices; for example pertaining to their sexual behaviour.

The '100% young' training programme empowered teens about their right to seek sex information, contraceptive methods and or abortion. Fusi-Ngwa et al (2013:141), in a study done in Cameroon, taught teens about the law against child marriage, non-governmental agencies such as the International Planned Parenthood Federation, the Population Service International, Marie Stopes International that provide contraceptive advice for young people worldwide. Participants confirmed this when they reported:

> ''Actually I know my right as a teen…the programme empowered me with the right answer..."

and

> "I am aware of the youth initiative of public health to fight teen pregnancy (condoms, contraceptive)…and the support they put in place for those who fall pregnant (social grant, abortion, adoption)…"

One of the toughest decisions that teens face is whether to have sex or not (Lamb & Peterson 2012:703-712). They also have to make informed choices regarding protection from unplanned pregnancies, but also avoiding sexually transmitted diseases (STDs) (Deardorff, Tschann, Flores, De Graot, Steinberg & Ozer 2013:182-190). The '100% young' peer education training programme curriculum developed peer educators with decision-making skills to contribute positively towards assertiveness (Plautz & Meekers 2007:1). Participants indicated:

> "Young people need information with discussions about decision making and clarification of values regarding sex and sexual relationships including improving communication between them and their parents …"

> "The programme was not only about us just listening to the facilitators, they taught us how to communicate with our parents and especially how to negotiate sex with our partners, and actually I have the power to make my own decision."

3.5.3 Negotiation skills (category 3.3)

Conflict and disagreement between humans are inevitable, because they have different needs, aims, and believe (Lewicki, Saunders & Minton 2011:82). Without negotiation or intervention, conflict may lead to arguments and resentment. Through negotiation agreement can be reached without causing barriers to communication between individuals in future (Alberts, Nakayama & Martin 2012:24). Communication is vital in creating and maintaining a relationship and essential in negotiation, as stressed by a participant:

> "I learnt that communication is the key of every relationship, from then everything is in the open."

Communication skills affect how problems are solved and the level of trust that is generated in a relationship (Kumpfer & Alvarado 2009:457). The '100% young' training programme provided strategies for teenagers to assist them to foster effective

communication skills, especially pertaining to safer sex negotiations. Participants mentioned:

> "The programme encouraged us to create dialogue, to reflect on the ways sexuality is represented and the relevance for safer sex practice."

> "I can negotiate when to have fun, sex, or go to a movie".

> "I learned about sex negotiation, and my boyfriend and I decided that sex is not the only way to have fun. Moreover we decided to talk about all the issues about our relationship and reach a common view suitable for both of us…He agree with me that it takes two to build a relationship."

3.5.4 Behaviour change (category 3.4)

Sexual behaviour change, to prevent HIV, sexually transmitted diseases (STDs) and unwanted pregnancy, is difficult (Agyei & Epema 2010:18-22). The curriculum of the '100% young' training programme includes aspects that contribute to behavioural change. However, some participants did not express any change in their behaviour regarding the use of condoms, as mentioned by a participant:

> "If my partner is looking beautiful and healthy, there is no method used…even any HIV test is done, we check with our eyes…I just look at her and I know everything is alright."

Other participants did take the knowledge to heart and change their behaviour as indicated by a participant:

> "By the way sex is not the only way to have fun. I told my boyfriend, we therefore decided to slow things down until we got married after school; in the mean time we can visit friends, go to clubs or movies, if it happen that we make love we use protection."

> "I am sexually active and since we started having sex, my boyfriend and I use condoms. I think it is the best prevention method ever. I do not have stress; I feel that I am safe; no worries about STD, HIV or unwanted pregnancies."

Interpersonal relationship skills are skills that teens need to be empowered with. Teens are pressured into having sex with their partners at a very young age and cannot deal with the pressure or negotiate when to have sex or not (Cleland, Bernstein & Ezeh 2009:1810-1827). The '100% young' training programme provided participants with these skills as indicated:

> "The programme helped me to break the ice with my boyfriend, we are now talking about the relationship, contraception sex and…more…future…children so openly…''

> "After the programme I had a long chat with my mom about life, sex, boyfriends, the dating game…and moreover about the way of preventing pregnancy…she went with me at the clinic!"

The programme teaches young people to be assertive and have the ability to make correct choices due to the knowledge gained. A participant proclaimed that:

> "Seeing all these celebrities on TV with babies at a young age, I nearly fell for that, if it wasn't for the training programme. Should I actually be able to care for my child? Only God know."

Human beings are sexual, sexuality is important for individual development, health and happiness as well as for the preservation of the human race. As teens mature, sexuality takes new dimension so does sexual behaviour (Finer & Philbin 2013:886-891).

Sexual behaviour has changed dramatically in recent decades, where sexual activity is initiated at a younger age (Schields & Pierce 2009:122). This has resulted in many unplanned and unwanted pregnancies among teens.

The '100% young' training programme focuses on contraception in an attempt to prevent unplanned and unwanted pregnancies. Sexual behaviours like early initiation of sexual intercourse, as well as number of sexual partners, are some of the aspects that are addressed in the training programme. The programme also addresses STDs

including HIV. The intention is to facilitate behaviour change in teens as was indicate by the personal behaviour change expressed by one participant:

> "The programme changed my whole sexual behaviour, it made me a new person forcing me to adopt a healthy sexual behaviour. I therefore learnt to limit boyfriends, protect myself against STD/HIV and unwanted pregnancy."

3.6 MENTORING ROLE (THEME 4)

A youth mentoring role aims to help peers to make informed decisions while providing them with support and accurate information. Mentors draw from their personal experiences and provide valuable counsel to peers from the point of view of someone who has experienced similar situations (Thompson & Morgan 2008:15-17).

They often share the challenges, interests and experiences of the youth they are trying to reach and can communicate in a youth-friendly style (Stakic, Zielony, Bodiroza & Kimzele 2009:57).

Many teens are more likely to ask questions about sexual health from peers, whom they perceive as having a better understanding of their situation, than authority figures such as teachers or service providers (Herman & Purvis 2012.3-20). In general what constitutes mentorship can range from informal conversations with peers to formal referrals to service providers (Bluhm, Volik & Morgan 2009:10-11).

In this study, a peer educator, as a mentor, may share with his peers information about his or her own training perceptions, as well as provide guidance, motivation, emotional support and role modeling to influence other teen's sexual behaviour.

The '100% young' training programme focuses on the education and training of teenagers from the age of 13 to 19 with a philosophy that sees youth as "at promise" instead of "at risk". The intention is to develop the peer educator's capacity and desire to personally avoid pregnancy (Bankole & Konyani 2007:198-220), and to mentor others to change their behaviour in order to avoid a pregnancy or STDs. Participants were of the opinion that they will and can be a mentor to others:

> “I am armed and ready to guide the youth of my community, I will open a friendly youth center of communication to share with my peers the knowledge that I acquire.”

One participant affirmed that:

> “I was shy and afraid of being called names or judged. Too scared to talk to my mom (about sex).Actually I want to be there for my peers. I am empowered and I cannot wait to give back to my community”.

Overall, the ‘100% young’ training programme invests in the young people of Douala and Yaoundé supporting teens to learn the knowledge and skills they need to enable them to take care of themselves, their family and their communities for the rest of their lives, as participants ascertained:

> “I want to be a role model for my peers. Give them the knowledge that no one gave me while I was in need.”

> “I was thinking about starting a peer education club together with the youth club in my church.”

> “There is a big community of youth…I will tell them not to be in a hurry, they must have a lot of information before jumping into sex.”

The programme, by means of the involvement of the peer educators in the workshops, provides teens with essential education, support for academic achievements, encouraging parent/teen communication, promoting responsible citizenship and building self confidence among peer educators who underwent the training. They can then play the role of a mentor and peer educator to all other teens.

3.7 CONCLUSION

High fertility among teenagers is a public health concern in Cameroon. Unwanted pregnancies, unsafe induced abortions that are associated with a high morbidity and mortality rate among young women, may be attributed to low contraceptive use.

Reducing obstacles and challenges, reinforcing enabling factors through peer education as well as culturally sensitive and sexual behaviour changes have the potential to enhance contraceptive use, thereby reducing teen unwanted pregnancies.

This study explored the perception of teenagers after the completion of the ‘100% young’ training programme they underwent and the effect that the programme had on their own sexual behaviour and the use of contraception. Even though numerous positive changes were identified, there are still concerns as some participants voiced the fact that in the communities some young people’s perceptions regarding contraceptive use did not change completely.

This chapter presented the themes, categories, and sub-themes that emerged from the data analysis. Thorough literature reviews, integrated with the data obtained were presented as a control for the research findings, but also included important information not mentioned by participants. This was done to ensure a thorough knowledge of the research topic and ensure comprehensive recommendations. Chapter 4 will focus on the summary of findings, the conclusions drawn and the recommendations made.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

The purpose of this dissertation of limited scope was to describe the perceptions of peer educators after completion of the '100% young' peer education training programme they underwent as well as to access the effect it had on their own sexual behaviour. Data were gathered through 15 individual face-to-face interviews with participants who underwent the training programme.

4.2 CONCLUSIONS AND RECOMMENDATIONS

The findings of the analysis of the data gathered from the peer educators revealed four major themes; namely: a positive education experience, challenges that influence contraceptive use, positive personal growth and a mentoring role.

4.2.1 Positive education experience

Participants emphasised the positive experiences that they had pertaining to the peer education programme (100% young) that they underwent and identified personal benefits of being a peer educator.

The data revealed that the '100% young' peer education training programme provided them with knowledge regarding anatomy and physiology, family planning, implications for teenage pregnancies as well as the prevention of sexually transmitted diseases. Obtaining knowledge contributed to a positive educational experience. Understanding anatomy and physiology, and how to protect themselves against unwanted pregnancy and STDs, assisted them to make informed choices about the use of contraceptives.

Despite the challenges and all the misconceptions regarding contraceptive use in their context, they felt informed and able to make informed decisions which positively changed their own sexual behaviour and the choices that they made. Some of them still

experience difficulty in convincing their peers to use contraceptives as was illustrated by the quotes provided in Chapter 3.

Recommendation

The data proved that peer educators gained knowledge, but that, despite their own knowledge, it is not easy to convince the peers that they teach, to use contraceptives. Recommendations to address this problem will be addressed under 4.2.2.

To sustain the knowledge gained and assist the peer educators to keep track of new developments it might be useful to have refresher courses for peer' educators every six months. These refresher courses can also provide an avenue to share new knowledge and experiences and discuss possibilities to address the challenges. Six monthly refresher courses, that can be made available online and online discussion forums, can contribute to the sustainability of the '100% young' peer education training programme. This recommendation will be made to the organisers of '100% young' peer education training programme.

4.2.2 Challenges that influence contraceptive use

Several years after the introduction of family planning in Cameroon, utilisation is still low due to many challenges that influence contraceptive use. Teenagers that underwent the '100% young' peer education training programme described multiple challenges with contraceptives use. Challenges mentioned were the attitude of nursing staff, accessibility to contraceptives, the attitudes of partners, the lack of knowledge of peers as well as socio-cultural expectations and contradictory messages received from male partners, parents, clergy, teachers, peers as well as health workers.

Participants described paternalistic, restrictive and judgmental attitudes among health care providers, as well as unfriendly staff as obstacles to the use of contraceptives.

One of the main obstacles pertaining to decision making and negotiation for contraceptives use as described by the participants still is conventional gender inequalities. They still described men as the decision makers in the family. The quotes

used in the analysis chapter are an illustration of what the participants hear when educating their peers and are proof of this existing practice.

Peer educators who underwent the training acknowledge the benefits of education and were motivated to use contraceptives.

Recommendations

It is recommended that common myths pertaining to condom use, misperceptions, fears and negative attitudes that act as barriers to the correct and consistent condom use must be addressed already at school level. Factual and correct information to demystify the misconceptions around contraception should be available and visible. This can be done by making use of information on social media. The '100% young' peer education training programme organisers should develop a website where information is available and discussion forums are active. A 24 hour helpline to assist with information should be established.

Integration of contraceptive services in social congregations, schools and other communal points is a plausible low-cost strategy for lowering the incidence of teenage pregnancy. Easy access to birth control and free condoms may be more successful at preventing teen pregnancies as well as the spread of STDs.

All young people must be reached and educated at an early age before they become sexually active. Parents must be involved as primary sex educators or refer their children to attend peer education programmes. By being involved in their teens' lives and maintaining close and open relationships, parents can be key in helping teens to differentiate between what is fact and what is myth concerning sex, pregnancy and STDs instead of leaving them to discover such things from their friends who may not be as well-informed.

4.2.3 Positive personal growth

The '100% young' peer education training programme trained peer educators in decision making skills and communication skills. Peer educator interviewed confirmed that they developed skills in communication, leadership as well as problem-solving.

These skills empowered them to be responsible regarding sexuality and the choices that they made. They claimed that being in the '100% young' peer education training programme contributed to their personal growth, improved their self-confidence, and they became open-minded and mature. The experience contributed to a change in their own sexual behaviour, which have changed from being part of the teens that are at risk because of their choices, to the teens that make informed choices about their sexual behaviour and protect themselves against pregnancies and sexually transmitted diseases.

For some, the experience transformed the way they view the world and their social interactions. As they claimed in the analysis chapter, they gained a strong sense of belonging in a community and became part of a social network, meeting other peers with similar interest.

Recommendation

Due to the positive influence that the '100% young' peer education training programme had on peer educators, it is recommended that workshops on development of interpersonal skills and information sessions should be included in the school curricula to enhance knowledge and understanding of contraceptives, but also other life skills. This can be included in sessions that can be presented in various extra school courses such as life sciences, life skills and life orientation.

4.2.4 Mentoring role

Participants were of the opinion that they acquired enough experience to become role models or mentors to their peers. The '100% young' peer education training programme offered peer educators the opportunity to benefit from taking on this very meaningful role as a peer educator. They felt that they can act as enthusiastic advocates for the programme and that they can share their knowledge with their peers.

Recommendations

The researcher recommend that the '100% young' peer education training programme should include sessions on mentoring skills or skills to influence behaviour changes.

4.3 LIMITATIONS OF THE STUDY

The dissertation of limited scope was limited to peer educators living in Douala, who underwent the '100% young' peer education training programme and cannot be generalised to the community at large. However, generalisation was never the intent, as the study was qualitative and contextual in nature, thus a specific context was researched. Transferability to similar contexts is possible as a data trail of the research process and context is provided.

4.4 CONCLUSION

Teenage pregnancy is a reality; the sad fact is that this reality has been ongoing for decades and frequently results in unfulfilled potential and perpetuates the cycles of unemployment and poverty.

The evidence produced by the study suggests that ignorance and failed communication, coupled with persistent religious, cultural and social values are prevalent factors to not using contraceptives and thus still contribute to teenage pregnancies. Though some interventions were implemented to reduce the incidence of teenage pregnancy, very little success has been achieved.

Interventions based on education and developed with the support of teenagers such as the '100% young' peer education training programme, are urgently required to prevent teenage pregnancy. The implications of the findings are that the '100% young' peer education training programme should embark on involving social media, working closely with religious leaders, parents and schools to enhance the positive impact on sexual behaviour described by the participants.

Future studies should examine health care providers' views on teenage contraceptive use, the quality of contraceptive services, the perceptions of parents on teenage contraceptive use in order for the health system to be able to provide good contraceptive services to teenagers in need.

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ANNEXURES

ANNEXURE A

Request to the manager of ‘100% young’ for permission to conduct a research study on the ‘100% young’ peer education training programme

Mr Nguidjoe Nyam Adalbert
Manager of the Programme 100%
Young peer education training programme

13 May 2014

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Mr Nguidjoe

My name is Ngo Ibom Salome Clemence and I am a Human sciences student at the University of South Africa (UNISA). The research I wish to conduct for my master's dissertation involves peer educators perceptions of the 100% young peer education training programme. This project will be conducted under the supervision of Professor Lizeth Roets (UNISA).

I am hereby seeking your consent to approach teenagers in Douala municipality who underwent the training to participate in this project. I have provided you with a copy of my dissertation proposal which includes copies of the measure and consent and assent forms to be used in the research process as well as a copy of the approval letter which I received form the UNISA Research ethics Committee.

Upon completion of the study I undertake to provide the programme with a bound copy of the full research report; if you require any further information, please do not hesitate to contact me

Telephone : 0739472150
Email :salomeclemence@gmail.com

Thank you for your time and consideration in this matter.

Yours sincerely

Ngo Ibom Salome Clemence.

ANNEXURE B

Letter of authorisation to conduct the research study on ‘100% young’ peer education programme

LETTER OF AUTHORIZATION TO CONDUCT

RESEARCH ON 100% YOUNG PEER EDUCATION TRAINING PROGRAM

Office of Research -Human sciences

100% young peer education training program

Bonadjo Douala Cameroon

BP 148

Subject: letter of Authorization to conduct Research at 100% young peer education training program

Dear Mr/Ms.

This letter will serve as authorization for the researcher (student) Ngo Ibom Salome Clemence to conduct the research project entitled "Peer educators perception of the 100% young peer education training program".

The 100% young peer education training program acknowledges that it has reviewed the protocol presented by the researcher. The program accepts and authorizes the research project to proceed.

If we have any concerns or require additional information, we will contact the researcher.

Sincerely,

..... 06/11/14

M. Nguidjoe Nyam Adalbert

Manager of 100% young peer education training program

ANNEXURE C

Information leaflet to participants

INFORMATION LEAFLET TO PARTICIPANTS

100% Young peer education training programme information

Definition

100% young programme is a health promotion training in which teenagers are trained to promote health – enhancing change among their peers. It is the teaching or sharing of health information, values and behavior in educating others teens who live in Douala Municipality and belong to the same backgrounds or have the same life experiences.

Rather than health professionals educating teenagers about sexuality, the idea behind 100% young programme is that ordinary teenagers (peer educators) are in the best position to encourage healthy behavior to each other.

Areas of application

100% young programme is a peer education programme; generally peer education programme has become very popular in HIV prevention among groups including young people, sex workers, men who have unprotected sex with men or people who use intravenous drugs. 100% young is associated with efforts to prevent unwanted pregnancies as well as sexuality transmitted diseases among teenagers by promoting healthy behavior, helping to create and reinforce social norms that support safer behaviors and also the programme serve as an accessible and approachable health education resource both inside and outside school.

The process

100% young programme is initiated by the programme de marketing social au Cameroon (PMSC), an affiliated of Population Services International (PSI). The programme recruited teenager who are trained in relevant health information and communication skills to become peers educators. Armed with these skills the peer educators are expected to then engage their peers in conversations about the issue of sexuality, contraception, self-respect, relationship, condom use, decision-making, family

planning, as well as planned parenthood; seeking to promote health-enhancing knowledge and skills.

The intention is that familiar people, giving locally relevant and meaningful suggestions, in appropriate local language and taking account of the local context, will be most likely to be able to promote health – enhancing behavior change.

ANNEXURE D

Informed consent form

INFORMED CONSENT FORM

I …… (First and last name) understand that I am being asked to participate in a research study at Douala municipality. This research study will describe the perception of peer educators, living in Douala, who underwent the 100% young peer education training programme, and the effect it have in my own sexual behavior.

I understand that I will be personally interviewed by the researcher for approximately 30 to 60 minutes. The interview will be tape-recorded and take place in a private office at the Douala municipality Hall on a time and date mutually agreed upon. No identifying information will be included when the interview is transcribed. All the information given by me will be kept confidential by the researcher. I understand that I will receive no remuneration for participating in the study. There are no known risks associated with the study.

I realize that the knowledge gained from this study may help either me or other peers in the future. I realise that my participation in this study is entirely voluntary, and that I may withdraw from the study at any time if I wish to. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary manner and will not be disadvantaged in any way. Information obtained may be used in nursing publications or presentations.

The study has been explained to me. I have read and understand this consent form, all of my questions have been answered, and I agree to participate. If I am a minor, my parent or guardian will sign the form on my behalf. I understand that I will be given a copy of this signed consent form. If I need any information regarding this study and my participation I can contact the Higher Degree Committee Office at UNISA +27(0) 124292226 or the researcher at 0739472150.

Signature of participants……Date……..

ANNEXURE E

Ethical clearance certificate

ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/174/2013

Date: 17 April 2013 Student No: 4627-076-0

Project Title: Peer educators perception of the 100% young peer education training program.

Researcher: Ngo Ibom Salome Clemence

Degree: Masters in Public Health Code: MPCHS94

Supervisor: Prof L Roets
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

UNIVERSITEIT VAN SUID-AFRIKA
PRETORIA
UNIVERSITY OF SOUTH AFRICA

Prof MM Modiba
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE F

Parents’ permission letter

PARENTS' PERMISSION LETTER

(Minor participants 13-17 years old)

Dear parents

Your son/daughter ---------- (first and last name) has been asked to participate in a research study at Douala municipality. This research study will describe the perception of peer educators , living in Douala, who underwent the 100% young peer education training program, and the effect it have in their own sexual behavior.

He/she will be personally interviewed by the researcher for approximately 30 to 60 minutes. The interview will be tape-recorded and take place in a private office at the Douala municipality Hall on a time and date mutually agreed upon. No identifying information will be included when the interview is transcribed. All the information given by the participants will be kept confidential by the researcher. He/she will receive no remuneration for participating in the study. There are no known risks associated with the study.

The knowledge gained from this study may help them or peer in the future. Their participation in this study is entirely voluntary, and they may withdraw from the study at any time if the wish to. The study will be explained to them and all questions answered. We would like to have your consent before we ask your son/daughter to participate.

Please sign the attached form and return it as soon as possible. If at any time you have any question about the study or his/her participation, feel free to call The Higher Degree Committee Office at UNISA+27(0) 124292226 or the researcher at 0739472150

Thank you.

The researcher signature……Date…….....

ANNEXURE G

Parents’ permission slip

PARENTS' PERMISSION SLIP

I,…… (Parents' name and surname), gave permission for my son/daughter …… (Name and surname) to participate in the research study **"PEER EDUCATORS PERSCEPTION OF THE 100% YOUNG PEER EDUCATION TRAINING PROGRAMME** at Douala municipality. I understand that he/she will be interview about his/her experience about the programme he/she underwent, answering two questions:

-please describe how you perceived the peer education training programme you underwent?
-please describe how this training affects your own sexual behavior?

I understand that I will receive a copy of this permit at any time he/she wants to.
I understand that his/her participation is voluntary and that he/she can decide to discontinue his/her participation at any time; and if I have any question about his/her participation I will call The Higher Degree Committee Office at UNISA+27(0) 1242921226 or the researcher at 0739472150.

Parents' signature……Date……..

ANNEXURE H

The children assent

*

THE CHILDREN ASSENT

We are doing a research study about “PEER EDUCATORS PERSCEPTION OF THE 100% YOUNG PEER EDUCATION TRAINING PROGRAMME”. A research study is a way to learn more about people.

If you decide that you want to be part of this study, you will be asked to describe how you perceived the peer education training programme you underwent and how this training affects your own sexual behavior. You will be personally interviewed by the researcher for approximately 30 to 60 minutes.

You can ask questions about this study at any time. If you decide at any time not to finish, you can ask the researcher to stop.

The questions we ask are only about what you think. There is no right or wrong answer because this is not a test.

If you sign this paper it means that you have read this and that you want to be in the study. If you don’t want to be in the study, don’t sign this paper. Being in the study is up to you and no one will be upset if you don’t sign this paper or if you change your mind later.

When we are finished with this study we will write a report about what was learned. This report will not include your name or that you were in the study. Your parents know about the study too.

If you decide you want to be in this study, please sign your name.

I……. want to be in this research study.

……. …….

Sign your name here **Date**

ANNEXURE I

Grand tour questions

GRAND TOUR QUESTIONS

- Please describe how you perceived the peer education training that you underwent?

- Please describe how, if relevant, this training affected your own sexual behaviour?

ANNEXURE H

Letter from the editor

LETTER FROM THE EDITOR

14 Carlisle St

Mount Croix

Port Elizabeth

6001

22 January 2016

082 723 5408

TO WHOM IT MAY CONCERN

EDITING OF REPORT: Salome Clemence

This serves to confirm that I edited Ms Clemence's Master's in Public Health dissertation.

Yours faithfully

Ms L. Kemp

B. A. (Hons English); MBA (Cum Laude)