

**FINDING THE BEST FIT: AN EXPLORATION OF
CONTRACEPTIVE DECISION-MAKING IN A SAMPLE OF
FEMALE STUDENTS AT THE UNIVERSITY OF KWAZULU-
NATAL**

By

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DECLARATION OF PLAGIARISM

I declare that this dissertation is my original research. All citations, references and borrowed ideas have been duly acknowledged. No part of this work has been submitted anywhere else in application for any qualification.

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DEDICATION

To my Dad and Mom for their support - financially, endless prayers and for believing in me;

to my siblings, I love you all.

ABSTRACT

The discourse around contraceptive use has attracted researcher's attention in recent times, due to the alarming rate of unwanted pregnancies and STIs including HIV/AIDS. In 2013, it was recorded that more than 99 000 schoolgirls fell pregnant at the rate of about 271 for every day of that year. These concerns emphasise the need for drastic improvement in sexual education and access to contraceptives such as condoms. Hence, this study attempts to examine how young women decide on contraception, focusing on the factors that influence the process. A grounded theory approach was used to explore the influences of contraceptive decision-making in a sample of seven (7) female students at the University KwaZulu Natal, Howard College campus. Data was collected through in-depth interviews and was analysed using Pidgeon and Henwood's (1997) approach to grounded theory analysis. The aim was to gain insight on the factors influencing contraceptive decision-making by female university students. The research identified an interplay of various factors that influence respondents' choice of contraceptives. The factors include knowledge levels, partners' role, social networking, health care workers (HCWs) and perceived side effects of contraceptives. This qualitative study showed that individual autonomous decision-making played a minor role in the decision-making process. The study highlights the need to empower young females to make informed decisions regarding the use of contraceptives.

Keywords: Contraceptive, decision-making, unwanted pregnancies, health care workers

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All things whatsoever ye shall ask in prayer, believing, ye shall receive. (Matthew 21: 22).

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	-Acquired Immunodeficiency Virus
CPR	-Contraceptive Prevalence Rate
DoH	-Department of Health
GT	-Grounded Theory
HCW	-Health Care Workers
HIV	-Human Immunodeficiency Syndrome
IUD	-Intrauterine Devices
SA	-South Africa
SADHS	-South African Department of Health Survey
SES	-Social Economic Status
STD	-Sexual Transmitted Disease
STIs	- Sexual Transmitted Infections
UNO	-United Nations Organization
WC	-Western Cape
WHO	-World Health Organization
UNFPA	- United Nations Population Fund

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CHAPTER ONE

INTRODUCTION

1.1 Preamble

The high rate of occurrence of unintended pregnancies among young adults in South Africa attracts public health interest (Seutlwadi, Peltzer, Mchunu, & Tutshana, 2012). The use of contraceptives is promoted as an effective approach in reducing the high prevalence of unintended pregnancies in South Africa. In a nationwide survey by Seutlwadi et al. (2012), it was reported that among women presently using contraception, 6.3% choose to use oral contraceptive pills, 5.2% adopt uterine contraceptive devices, 25% use injectable contraceptives, 57.6% use male condoms, 5.9% use female condoms (feminidom), and out of these figures 8.9% use dual techniques. Other methods used include the rhythm technique, withdrawal method, and emergency contraception. In recent times, sexual behaviour of young adult South Africans has taken on a worrying trend. Factors such as previous pregnancy, which used to serve as forecasters to contraceptive use are no longer relevant. In fact, being a carrier of the HIV virus or having unprotected sexual relationships with multiple partners have not facilitated the use of contraceptives (Seutlwadi et al., 2012).

A number of studies have been conducted on contraceptive decision-making in South Africa (MacPhail, Pettifor, Pascoe, & Rees, 2007; Peer, Morojele, & London, 2013; Wood & Jewkes, 2006) and outside South Africa (Noone, 2004; Yee & Simon, 2010; Yee & Simon, 2014). Furthermore, some studies were conducted on attitudes towards contraception in South Africa (Hoque & Ghuman, 2012; Oni, Prinsloo, Nortje, & Joubert, 2005; Patel & Kooverjee, 2009)

and outside South Africa (WHO & UNICEF, 2014; Williamson, Parkes, Wight, Petticrew, & Hart, 2009). At this juncture, it is imperative to note that there is a need for qualitative research that is focused on determining factors that influence contraceptive use among female university students (Hoque & Ghuman, 2012). These authors investigated South African female university students' knowledge, practices, and attitudes towards contraceptives. This study indicated that while students' knowledge and practices of contraception are moderately low, they generally have positive attitudes towards the use of contraceptives. The majority of the students considered in their study were unmarried and were between the ages of 20 and 25 years. The study also revealed that more than half of the students (about 53.2%) had been sexually active while about 35.8% had never used any form of contraception. These findings suggest that university students may be at risk of contracting sexually transmitted diseases (STIs) and having unplanned pregnancies which may lead to back street abortions, and in some cases, infertility. In terms of awareness, this study also found that 49.8% of the respondents were aware of contraceptives. This figure is lower than that of a previous study on university students in the same region which claims about 56.5% rate of awareness (Roberts, Moodley, & Esterhuizen, 2004). A significant number of students (55.2%) knew about contraceptives from friends while a few others were informed on contraceptive procedures by Health Care Workers (HCWs). These findings align with other studies conducted in South Africa (Myer, Mlobeli, Cooper, Smit, & Morroni, 2007) which concluded that the role of peers is crucial towards increasing the level of contraceptives awareness. The study revealed a lack of knowledge or inadequate knowledge about contraceptives among the respondents. More than two-thirds (69.6%) were unaware that prescription notes are not required in order to access contraceptives and 29.7% were uninformed on the safe and reliable use of contraceptive. The use of contraceptives among the sexually active students was moderately low (21.2%) compared to

28% in another South African study (Kistnasamy, Reddy, & Jordaan, 2009). Hogue and Ghuman (2012) also described a minimal level of awareness and practices pertaining to the use of contraceptives in their sample of female university students.

Furthermore, there is very little knowledge available on the influence a partner plays in an individual's decision to use contraceptives. The same is true of the influence of family members and peers. It remains to be determined what roles information received from partners, family and peers play in contraceptive decisions (Yee & Simon, 2010). Therefore, this study will apply a qualitative methodology to gain some insights on the factors that influence contraceptive decision-making in a sample of female students at the University of KwaZulu-Natal, Durban, South Africa.

For academic purpose, an understanding of contributions of these factors may facilitate better approaches that increase awareness and encourage young students to use contraceptives. This study seeks to achieve this goal by the application of the Grounded Theory (GT) approach to analysing the students' accounts of their contraceptive decision-making.

1.2 Background to the Study

Globally, it is estimated that sixteen million girls, aged between 15-19, give birth yearly (WHO, 2012). Complications from pregnancy and childbirth are some of the leading causes of mortality (Patton et al., 2009).

In 2015, 64 % of women of reproductive age worldwide were using some form of contraception. However, the rate was lower in the least developed countries (40%) and much lower in Africa (33 %). In the same year, the rate was much higher in other regions - 59 % in Oceania and 75 % in North America (UN, 2015).

In the major geographic areas there are substantial differences by region. A high increase in the Contraceptive Prevalence Rate (CPR) in 2015 was noted in North Africa and Southern Africa (53 % and 64 %, respectively) as well as in Central Africa (23 %) and West Africa (17 %). Contraceptive use has been growing recently in East Africa and now stands at 40%. Eastern Asia had the highest contraceptive prevalence rate of about (82 %) with China on about (84 %). In the other regions of Asia, the average contraceptive prevalence rate was in a range between 57% and 64%. In real terms, regional disparities are smaller in Latin America and the Caribbean, although the level of contraceptive use was lower in the Caribbean of about (62 %) than it was in Central America which is (71 %) and South America (75 %). Within Europe, prevalence in the year 2015 was lowest in Southern Europe of about (65 %) and highest in Northern Europe of about (77 %). In Oceania, the level of contraceptive use in Australia and New Zealand was typical of levels in regions of Europe, whereas the level was much lower, 39 %, in Melanesia, Micronesia and Polynesia (UN, 2015).

In Africa, countries with CPR of about 50 % or more are mainly islands (Cape Verde and Mauritius), or located in the north of the continent along the Mediterranean coast (Algeria, Egypt, Morocco and Tunisia) and in Southern Africa (Botswana, Lesotho, Namibia, Swaziland and South Africa). In South Africa, CPR is highest among sexually active young females in the 15-19 age group (68.7 %) and lowest in the 45-49 age group (57.2 %). The literature suggests

that use of contraceptives may be influenced by attitudes of Health Care Workers (HCWs), levels of awareness, fear of side effects, poor access and availability, religious factors, cultural factors and partners. These factors may play a role in an individual's choice and use of contraceptives.

1.3 Problem Statement

The rate of unplanned pregnancies among students globally is quite alarming. An estimated 205 million pregnancies occur each year globally while a third are unintended and a fifth results in induced abortion (Oluwole & Skaal, 2016). Most abortions are as a result of unintended pregnancies and it has been observed that young women have the highest risks of suffering serious complications from unsafe abortions. These complications often result in cervical or vaginal insertions, sepsis, haemorrhage, bowel or uterine perforation, tetanus, pelvic infection, abscesses, chronic pelvic inflammatory disease and secondary infertility (Oluwole & Skaal, 2016).

Studies have shown that South African female university students' knowledge, practices, and attitudes towards contraceptives were relatively low (Hoque & Ghuman, 2012; Smit et al., 2001; Tamire & Enqueselassie, 2007). This invariably is a factor to be considered in contraceptive decision-making. Lack of adequate knowledge about contraceptives may possibly represent a key factor in unplanned pregnancies leading to unsafe induced abortion among students in South Africa. Unplanned pregnancies are the result of various factors including knowledge about how to use contraceptives, access to contraceptives, side effects, partner's influence, religious factors etc. (Okanlawon, Reeves, & Agbaje, 2010). Little attention has been paid to contraceptive decision making process among female students in South Africa.

Therefore the aim of this study is to explore female students' description of their contraceptive decision-making process. The findings of this study could inform the development and implementation of interventions or programmes that will help improve the knowledge of contraceptive use among female students. The findings of the study will also contribute to the existing literature on contraceptive use among female students in South Africa.

1.4 Research Question

How do female university students describe their individual contraceptive decision-making process?

1.5 Aim and Objective

The study aims' to explore female students' accounts of the influences on their contraceptive decision-making processes.

The main objective of the study is to gain a better understanding of multiple influences on contraceptive decision-making at the individual, interpersonal, community and societal level.

1.6 Type of Study and Method

A qualitative research is adopted for this study using Grounded Theory approach which involves the collection of data through open-ended interviews. Grounded Theory is an inductive, qualitative method and is useful in generating themes when seeking the perspective of the individuals experiencing the phenomenon (Noone, 2004; Glaser & Strauss, 1967; Strauss & Cobin, 1998). In this study, female students were asked questions pertaining to multiple influences of contraceptive decision-making. Their perspectives were sought and used to generate common themes in contraceptive decision-making.

1.7 Significance of the Study

The study was undertaken to gain a better understanding of multiple influences of contraceptive decision-making among female students. Lack of knowledge or inadequate knowledge of contraceptives could in a way lead to unsafe sex which may result in STDs and unintended pregnancies which could lead to unsafe abortion.

Pregnancies among students are associated with maternal, fetal and neonatal adverse outcomes. (Chen, Wen, Fleming, Demissie, Rhoads, & Walker, 2007) Female students who drop out of school and become parents are unlikely to have economic and social means to cater for their children (Hunt, 2008). Knowledge on contraceptive decision-making is a major factor in the incidence of unplanned pregnancy and reproductive health in general. Active efforts to promote sexuality education and decision-making on contraceptives should be intensified among South African University students. Incidentally, a number of female students do not take preventive measures such as contraceptive use (Cooper, Harries, Myer, Orner, & Bracken, 2007). It has been suggested that there may be a link between factors that influence decision-making and actual contraceptive use. The phenomenon warrants researchers in health promotion to examine the problem and offer useful recommendations. Essentially, this study attempts to gain a better understanding of multiple influences of contraceptive decision-making among female students.

Findings in this research will help stimulate further research in this area which could ultimately inform intervention and awareness programmes on contraceptive use. Female students may then be empowered in making better decisions on contraception while also ensuring its appropriate usage to prevent unplanned pregnancies and STDs.

1.8 Definition of Terms

Contraceptives: These are medical devices or medications that are used to prevent pregnancy or protect an individual from contracting sexually transmitted infections.

Usage of contraceptive: This refers to the use of different types of contraceptives to avoid conception or prevent sexually transmitted diseases.

Knowledge of contraceptives: This is referred to as the state of awareness of contraceptive methods, any specific types and the source of contraceptives.

Factors influencing decision-making on contraceptives: These are factors such as knowledge and awareness of contraceptives, availability and access to contraceptives, side effects, religion, culture, etc. that influence decision-making on contraceptives.

1.9 Outline of Study

This dissertation is made up of five chapters that describe the different stages of the research endeavour:

Chapter One: Introduction

The introduction chapter provides a summary of what this research is about. It briefly provides the relevant background information to the study, outline of the problem statement, the purpose and objectives of the study, the type of methods used and the significance of the research.

Chapter Two: Literature review

Pertinent literature is reviewed in this research. The empirical review contains an account of past research on factors that influence contraceptive decision-making; which includes partner's

influence, the role of HCW; Knowledge, awareness, access etc. The chapter also includes interrogation of the socio-ecological framework that informs this research.

Chapter Three: Research methodology

This chapter describes the methodological outline, which espouses the research method for this study. It covers the research approach; sampling method; data gathering strategy; the fieldwork process, including ethical issues, and the analysis undertaken.

Chapter Four: Findings and discussion

Findings that emerged from the interviews are carefully delineated in this chapter. The findings are presented accurately in a clear narrative form. The influences are also discussed in relation to the research questions and the related literature.

Chapter Five: Conclusions and recommendations

This chapter contains the concluding statements of the research based on the findings. It also presents recommendations and limitations of the study.

CHAPTER TWO

LITERATURE REVIEW

This chapter includes an empirical review of relevant literature and will cover research on contraceptive knowledge and factors influencing contraceptive decision-making. The second part of this chapter contains the theoretical framework of the study, more specifically, Bronfenbrenner's ecological theory.

2.1 Empirical review

There are a number of factors that are said to influence contraceptive decision-making (DoH, 2012). These factors include attitudes of individuals and Health Care Workers (HCWs), levels of awareness and knowledge, fear of side effects, poor access and availability, religious factors, cultural factors such as the importance of fertility, partner's influence and so on. Knowledge or lack of knowledge on contraceptives appears to be the main factor. DoH (2012) shows that almost all women in South Africa know about contraceptives, but most of them have limited knowledge of the range of contraceptive methods available. This influences their ability to make informed choices about methods suitable for them as individuals. Also, this can impact negatively on their usage of a particular contraceptive method.

The section below covers research on the main factors that are said to influence contraceptive decision-making.

2.1.1 Knowledge

Hoque and Ghuman (2010) investigated knowledge, practices, and attitudes of female university students in South Africa towards the use of contraceptives. The findings of this study show that students' knowledge and practices of the use of contraceptives were significantly low but they had positive attitudes concerning contraceptives in general. The majority of the students were not married and between the ages of 20 and 25 years. More than half (53.2%) stated that they were sexually active and of this group about 35.8% had not previously used any form of contraception. These findings indicate that these university students were at risk of unplanned pregnancy. In total, about 49.8% of the participating respondents' conveyed they had heard about contraceptives. This figure is lower than that (56.5%) obtained in a prior study of university students in the very same region (Roberts et al., 2004). A sizeable number of them had heard about contraceptives from their friends or peer group (55.2%) and a few were informed of contraceptive use from Health Care Workers. These findings are in line with other South African studies that dwell on hearing about contraceptives from friends (Myer et al., 2007; Roberts et al., 2004). These findings suggest that peer education methods might be helpful in increasing contraceptive awareness. Additionally, the study reveals an inadequate knowledge about contraceptives among the respondents. More than two-thirds (69.6%) had no idea that a prescription is not mandatory in obtaining contraceptives from pharmacists, and about 29.7% did not know the right time boundaries for its efficiency.

Little is known about the dynamics in the influence of partners, family and peers in an individual's contraceptive decision-making process. The DoH (2012) report indicates that South African women with a higher level of education are more likely to use contraception. Levels of education have a strong influence on contraceptive decision-making. For instance,

current contraceptive prevalence among sexually active women with post-high school qualifications is twice as high (75%) than among women with no education (DoH, 2012). Although we know that partners, family, and friends are a source of information to young women, there is little literature on how this information is received from partners, family and peers and how this affects contraception decisions (Yee & Simon, 2010).

Considering racial groups, black women had the minimum Contraceptive Prevalence Rate (CPR) of about 62.2 % and white women, a maximum of about 80.9 % (DoH, 2012). This inequity in CPR is due to South Africa's history of racial bigotry, alongside gross imbalances in access to education, economic prospects and health services (Cooper, Morroni, Orner, Moodley, Harries, Cullingworth, & Hoffman, 2004) and is reflected in similar experiences of subjugated or marginalized racial groups elsewhere (Saxena, Copas, Mercer, Johnson, Fenton, Eren, . . . Wellings, 2006).

Related studies have shown the level of awareness and knowledge of contraception methods to be closely associated with the individual's level of education, status and place of residence. This suggests that people with higher levels of education, or who are married or living in urban areas are more likely to have better knowledge of contraception than single, less educated people living in rural areas (Esiet, Esiet, Philliber, & Philliber, 2009; Myer et al., 2007; Omo-Aghoja et al., 2009). Studies in sub-Saharan Africa have revealed an increasing awareness of contraception methods among young people; although this awareness may not involve detailed understanding about the way contraceptives function. Oyedeji and Cassimjee (2006) in a study conducted among students at the University KwaZulu Natal, showed that only 45% of males and 30% of females were aware of at least one contraception method available to men. However, they argued that students are ready to be responsible for contraceptive use if given

sufficient and correct information about its existence and its functionality. These findings were replicated in a study conducted among university students in Ghana, which revealed the male and female condoms as the only contraceptives known by 88.9% of the respondents, while 11.1% were aware of other modern methods such as the IUD, pills, Spermicides etc. (Appiah-Agyekum & Kayi, 2013).

International studies (WHO, 2012) have shown that low contraceptive use is usually the result of inadequate knowledge or social stigma. It is only after the first pregnancy that young female adults seem to become enlightened about contraceptive use and appear to opt for hormonal methods of birth control. Health service providers in South Africa tend to offer hormonal techniques to young mothers and young female adults in long-term relationships (Breheny & Stephens, 2004). Women 20 years and younger in South Africa have complained of difficulty in obtaining contraceptives arising from inadequate knowledge of availability (Williamson et al., 2009). Additionally research indicates that a larger number of women choose to use hormonal techniques of contraception rather than barrier methods and that young women make contraceptive trade-offs in which condom use declines as relationship length increases (Raine, Minnis, & Padian, 2003). In summary, it appears that knowledge of contraception is a key factor in the use of contraceptive decision-making. Education is a factor that determines knowledge of contraception as educated people are more informed about contraception methods choices as opposed to their less educated counterparts (Lopez-del Burgo et al., 2012).

2.1.2 Religion

Wyatt et al. (2000), report that the degree to which religious beliefs influence sexual behaviours has been largely overlooked in research on women's sexual decision-making by earlier research

such as Inazu & Fox (1980) and Zelnik & Kantner (1980). However, Nyamaruze (2015) researched the role of religion in young Christian men's perspective of condom use. Findings from his research make it clear that there is a conservative attitude towards contraceptive use by religious leaders, who are usually influential figures in the African communities. Even though Nyamaruze's (2015) research focused exclusively on young men, we can expect that his findings about the influence of religion on men also applies to young women. What religion shuns, the community shuns and the individual knows little about it, and what religion welcomes, the community welcomes and the individuals knows much about it. The effects of the conservatism borne out of the attitudes of religion and religious leaders are made manifest in the studies about knowledge of young women on contraceptives.

2.1.3 The role of health care workers

Wood and Jewkes (2006) reported that the attitude of nursing staff in clinics can influence contraceptive decision-making. Mantell et al. (2011) noted that the poor input of health workers or health service providers in South Africa in the dissemination of contraception information is worrisome. More reliable information should originate from health workers at the family planning programs or clinics but the family planning clinics are neither young women nor adolescent-friendly. The main reason for this unfriendliness is entrenched in the cultural beliefs of African societies where many still regard family planning services as the reservation of married people (Abiodun & Balogun, 2009; Otoide, 2001; Okpani & Okpani, 2000; Oye-Adeniran et al., 2004). In South Africa, DoH (2012) reported that there is evidence to show that young women, in particular, may be discouraged from using contraceptives by judgemental health providers. In addition, deliberations on sex and contraception with young adults is still considered unsuitable in some societies, even among health workers (Carr & Khan, 2004;

Osaikhuwuomwan & Osemwenkha, 2013). Therefore, there appears to be a need for youth-friendly reproductive health services to encourage sexually active young adults to increase their contraceptive use.

Research on contraception in South Africa points to a number of barriers to effective use. Historically, contraception services were established within a political framework of population control, with the emphasis on contraception which required minimal user involvement, for example, injectable contraceptives which remained the most frequently used method (Burgard, 2004; Chimere-Dan, 1996). In the 1998 report of Demographic and Health Survey (DoH, 1999) it was reported that 64.5% of black African women initiated contraceptive use with injectables and 23.4% with oral contraceptives, while among white women 5.0% initiated with injectables and 65.3% with oral contraceptives. There are two injectable contraceptives frequently used in public clinics, delivered by two or three monthly injections, constantly mentioned by their brand names Nur-Isterate and Depo-Provera respectively. Researchers have pointed to the wide-ranging social, economic and educational inequalities in the country in elucidating racial differences in patterns of contraceptive use (Burgard, 2004; Kaufman, Clark, Manzini, & May, 2004). Other factors include the negative experiences of many South African adolescents in attempting to access contraception (Chimere-Dan, 1996; Dickson-Tetteh, Pettifor, & Moleko, 2001; Mfono, 1998).

2.1.4 Fear of side effects

According to the DoH (2012), many women present at contraception services programs do not get adequate information and counselling on the anticipated side effects of injectable contraception methods in South Africa. The side effects of contraception are stated to be the

most common purpose for the withdrawal of contraceptive use. Literature reveals that young adults would not use contraceptives because of the perceived side effects including health risks on individuals. (Abiodun & Balogun, 2009; Mnyanda, 2013; Omo-Aghoja et al., 2009). Other studies show that while there are people who do not use contraceptives due to lack of knowledge, there are others who are aware of their existence and importance but will rather not use them, because of the fear of side effects. (Butawa, Tukur, Idris, Adiri, & Taylor, 2010; Cleland, Ndugwa, & Zulu, 2011; Curtis, Evens, & Sambisa, 2011; Ndifon, Ogaji, & Etuk, 2006; Osakinle, Babatunde, & Alade, 2013).

2.1.5 Social network and partner's issues

Yee and Simon (2010) reported that experiences and opinions of the social network influence contraception decision-making in the US. The social network including friends, family members, and media sources is a key source of information for many women. In their study, women described their social networks as highly influential in gathering contraception information and in their decision-making. Mothers and family members with the first-hand experience were sometimes considered more valuable resources than physicians. Physicians were felt to be reputable sources of facts but inadequate sources of personal experience. Rumours, myths and vicarious experiences supplied by the social network had a direct impact on contraception decisions for a number of women. Many women rejected an effective contraception method available to them mainly because of a myth relayed through her social network. The prominent myths and misconceptions were largely focused on issues of safety, efficacy, and side effects of methods. Scepticism about method efficacy, often with stories of failed contraception use, and fear of side effects, were pervasive. On the more encouraging side, however, some women chose a method specifically because of the positive experience of their friends and family. Beyond the interpersonal social network, media sources such as the

internet and television provide important contraception information that either sparked further discussions or supplemented information received verbally.

Peer et al. (2013) observed that the contraceptive prevalence rate in South Africa for sexually active women is relatively low and family planning programme should concentration on increasing men's approval of contraception, improving and encouraging partner communication around reproductive health, family planning issues, and strengthening women's self-confidence in their reproductive and contraceptive decision-making, and particularly their self-esteem and there should be a greater emphasis on nulliparous women.

MacPhail et al. (2007) found that the association between deliberating the use of condom with partners and actual use of condom indicates the importance of participation of male partners in women's contraceptive decision-making. The role of gender inequalities and multiple forms of coercion in undermining women's capacity for making autonomous decisions about controlling their fertility necessitates the use of contraceptive methods such as the injections that are easy to conceal (Varga, 2003; Wood & Jewkes, 2006). These issues also play a role in the importance attached to displaying fertility early (Preston-Whyte, 1999; Richter, 1996).

Cultural morals, principles, and communication between partners affect contraceptive use among women. South Africa predominantly operates in a paternalistic culture, especially in the rural areas, thus women feel pushed or burdened to prove their fertility (UNO, 1996). Effective communication between partners is known to increase the probability of using contraception (Sayem & Begum, 2008), as well as self-esteem among women (McNair, Carter, & Williams, 1998).

Previous research amid young people in South Africa confirms that the issue of trust turns out to be a significant factor in contraceptive decision-making in long term relationships, leading to a drop in condom use (MacPhail & Campbell, 2001). Amongst women in long time steady relationships, there appears to be the rather limited use of contraception methods that offer protection from sexually transmitted infections and HIV infection. Family planning programmes for young female adults should be directed at encouraging young female adults to think of prevention of pregnancy and sexual transmitted diseases. Particular emphasis should be placed on empowering and encouraging young female adults in steady relationships to maintain their use of STIs and HIV preventing methods. (Garrido, Castro, Fernández, & Álvarez, 2006).

Other researchers have also highlighted that inadequate contraception discussions between partners is associated with irregular use (Davies, DiClemente, Wingood, Person, Dix, Harrington, . . . Oh, 2006). There is a need for further research on the interplay of factors that influence contraceptive use among female university students (Hoque & Ghuman, 2012). From the foregoing review of relevant literature, it appears that there exists a variety of factors that influence contraceptive decision-making. These factors include attitudes of users and Health Care Workers (HCWs), levels of awareness and knowledge, fear of side effects, poor access and availability, religious factors, cultural factors such as the importance of fertility, partner's influence and so on. However, it is important to note that more quantitative surveys have been done to examine the factors that influence contraceptive decision-making. In order to obtain a more in-depth understanding of the topic, the aforementioned factors will be explored in this research through a qualitative approach. Hence, this study will apply a qualitative methodology to elucidate a better understanding of individual attitudes, vicarious knowledge, and other social network factors that influence use of contraceptive decision-making among female students of the University of KwaZulu-Natal.

2.2 Theoretical Framework

The study adopts Ecological system model to explain contraception decision-making among female students of the University of KwaZulu-Natal. The ecological system theory was developed by Urie Bronfenbrenner (1979). This model cuts across individual, interpersonal, community and society. The ecological environment is perceived to have nested structures namely; the microsystem, the mesosystem, the exosystem, the macro-system, and recently the chronosystem was added to it. The ecological systems theory is based on the proposition that human development occurs through complex reciprocal interactions between the individual and the immediate environment. The assumption in this theory is that a person is an active player who exerts influence on the environment and the environment compels the person in return, to adapt to its conditions and restrictions. Consequently, the environment is a nested structure (system) in which an individual is in constant interaction with. Moreover, the environment impacts on an individual both in the positive and negative way (Wilder et al., 2009).

Bronfenbrenner's Bioecological Model of Human Development

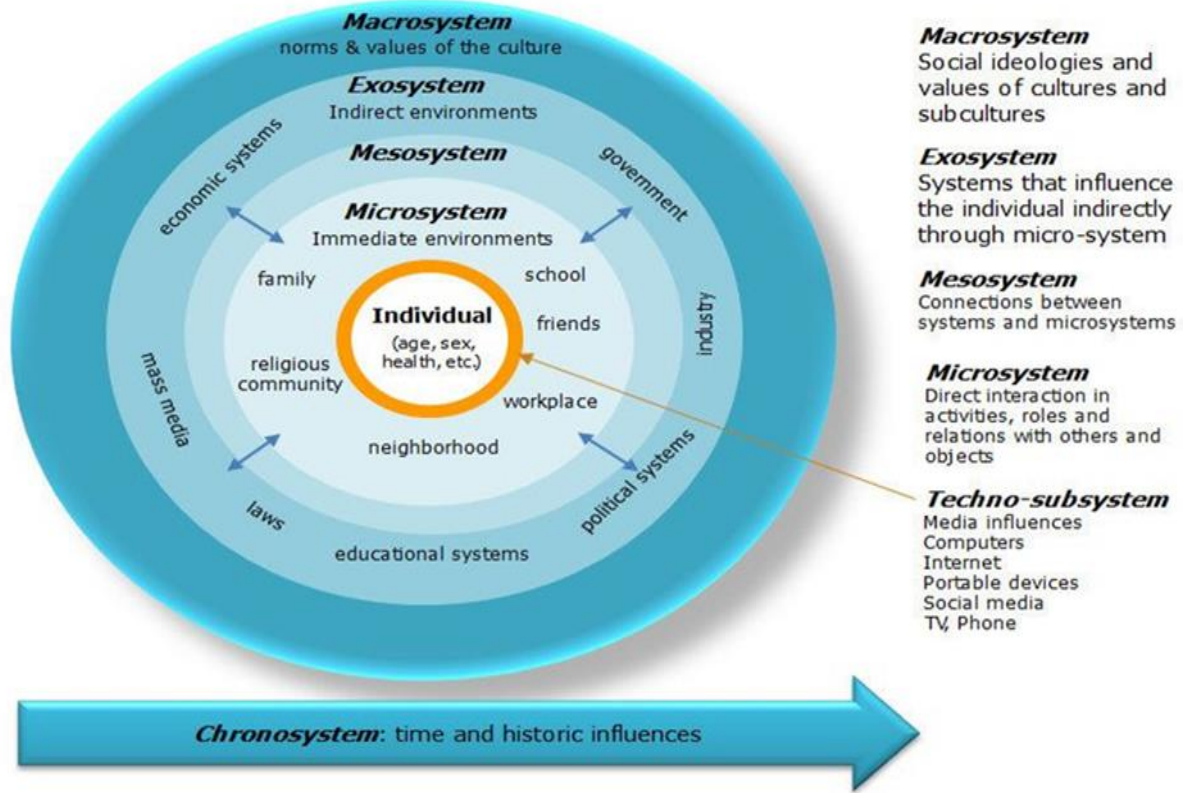


Figure 1: Bronfenbrenner's Ecological System Model

The ecological system model provides a framework for explaining the relationships between an individual's context within a community and the wider society (Kail & Cavanaugh, 2010). For the purpose of this study, the theory expounds on the individual level, that, an individual's attitude could be responsible for contraceptive decision-making. Individuals can develop attitudes about contraceptive based on the perceived stigma attached to it and this can well influence their decisions on contraceptive use. At the interpersonal level, partners could influence usage of contraceptives. Furthermore, institutions and groups such as family, school, religious institutions, and peers that directly impact an individual's development could significantly influence contraceptive decision-making. The stigma attached to contraceptive use

among younger women such as students in family settings can influence decision-making on contraception. At the community level, the stigma attached to contraceptive use, abortions, and unwanted pregnancy could influence decision-making on the use of contraceptives. Finally, at the societal level, culture, social policies, societal awareness, and myths could influence decisions made on contraceptive use. Societal and cultural stigma can significantly influence an individual's decision-making on contraceptive use. For instance, in societies where the people are predominantly Catholics, contraceptive use carries a kind of societal stigma and this can well influence decision-making on contraception.

The high rate of unintended pregnancies and HIV/AIDS infections in South Africa, particularly among the youth population, remains a public health concern as young people still engage in unprotected sex. The South African Department of Health revealed that many young South African women give birth by the age of 19. In response to this, the use of contraceptives, especially condoms have been promoted. Seutlwadi, Peltzer and Mchunu (2012) found out that communicating with a partner about condom use, education and being employed are significantly associated with contraceptive decision-making in South Africa.

According to the ecological theory, as presented by Bronfenbrenner, the microsystem refers to the direct influence an individual can encounter in certain contexts or environments such as associations with family, schools, work networks etc. (McLeroy, Bibeau, Steckler, & Glanz, 1988). The second level of influence (the mesosystem) refers to the relationship with the environment in which an individual is embedded. For instance, the interaction between the church, work, school etc. The ecosystem is the third level of influence and consists of the aspects that influence an individual who is embedded in the larger social system. For example, the impact of public hospitals on an individual's decision-making on contraceptive use. The

fourth level of influence is the macro system and this refers to ideas, viewpoints, and the principles that shape an individual within a society or environment that influence the other levels. For example, the stigma attached to contraceptive use can influence an individual's decision on whether to use it or not. Similarly, cultural norms and beliefs may also influence the individual's decision. This demonstrates how cultural inclination relates to how individuals respond to issues of life and health. The chronosystem encompasses change or consistency intensely not only in the characteristics of an individual but also of the environment in which the individual lives. For example, changes over the life course in family structure, socio-economic status, employment, or place of residence.

Bronfenbrenner's ecological model is borrowed and expanded by McLeroy et al. (1988) who divides the environment into five levels of analysis or stages. According to McLeroy et al. (1988), these levels of analysis include the intrapersonal, interpersonal, institutional, community and public policy. They are discussed in the following

Intrapersonal: The intrapersonal level of the model includes qualities an individual can possess such as knowledge, self-concept, self-efficacy, behaviour, attitude etc. McLeroy et al. (1988) posit that the individual with their intrapersonal qualities (including attitudes, beliefs, and knowledge) exists but go on to argue that every individual is located in a wider environment. They assert that intrapersonal qualities do have a role to play and can contribute to how the individual makes a decision on contraceptive use. For instance, if an individual has a strong self-efficacy they might make a decision on contraceptive use in order to prevent pregnancy or STDs more easily than someone who has a poor sense of self-efficacy or negative self-concept. It is important to note, however, that the development of these interpersonal qualities cannot be separated from the wider social environment. There is a dynamic relationship between the

intrapersonal and the environment. For example, if an individual has a poor sense of self-efficacy this may be due to the fact that they are located in a wider environment of poverty and or discrimination, rather than a simply weakness of the individual themselves.

Interpersonal: The second level of analysis refers to an interpersonal process which McLeRoy et al. (1988) argue includes associations with close individuals in which an individual is embedded such as family, friends, or neighbours. These relationships are considered to be important because they provide important social support that plays a significant role in shaping an individual within a defined environment. For example, social support of peer influence from friends can influence an individual's decision-making on contraceptives in a positive way. Albeit interpersonal factors play a significant role, health interventions that focus on interpersonal processes have typically focused on changing individuals through social influences, rather than on changing norms or social groups to which individuals belong. It has been suggested that most programmes that include health promotion tend to disregard that structure and function of social relationships. In other words, these programmes tend to focus on social influence rather than the source of the influence or the social groups to which individuals belong. McLeroy et al. (1988) argue that from an *ecological perspective*, interventions should be designed to alter the environment of present social relationships in which an individual has been embedded and that which impact on health-related behaviours. The authors further argued that while the aim of those strategies is to bring about changes in individuals, the main goal will be to work on the societal rules that might influence individuals to change behaviours in order to promote their physical and emotional wellbeing. For instance, an individual's family may influence decision-making on contraceptive use.

Institutional: The third level of analysis as pointed out by McLeroy et al. (1988) included institutional and organisational factors which are defined as rules that direct the social interactions and behaviours of groups of individuals. For instance, it has been found that organisations such as schools and work settings have a significant impact on the health behaviours of an individual. Moreover, the authors argue that organisations have the power to influence and support people within the organisation through their health concerns. For example, in universities, students who get support through students' assistance programme will make informed decisions regarding contraceptive use and experience better health than their counterparts who do not. It is argued that organisations can play a significant role in influencing good health, since people in societies spend an extensive amount of time within these organisations. Furthermore, organisations can act as good facilitators in health promotion to support behaviour change among individuals, for example, incentives can be awarded to regulate change in behaviour as well as “changes in rules and regulations” within the organisation can maintain or sustain behaviour. The authors maintain that organisations can be a significant platform to contrast or alter maladaptive behaviours in an individual.

Community: The fourth level of analysis is the level of community and refers to “relationship among organisations, institutions, and informal networks within defined boundaries” (McLeroy et al., 1988). The authors note that community can have three different meanings. First, community refers to “mediating structures or face-to-face primary groups to which individuals belong. This meaning, therefore, includes families, peer networks and neighbourhoods. Secondly, “community can be thought of as the relationship among organisations and groups within a defined area”. For instance, relationships between government health providers and schools in a particular political or geographical area. Thirdly, “community is defined in geographical and political terms”. The authors refer to “power structures” that influence the

allocation of resources including funding and materials. This meaning of community highlights that health promotion issues may have political and economic ramifications. The authors point out that those groups that experience the most ill-health are likely to be those who have the least access to the power structure in a community. For instance, an individual from an advantaged urban milieu may have greater access to contraceptives than an individual from a disadvantaged rural area.

Public policy: The last level of analysis in the *ecological model* is public policy. McLeroy et al. (1988) argue that “one of the defining characteristics of public health is the use of regulatory policies, procedures, and laws to protect the health of the community. They maintain that policies can have a positive impact in addressing health concerns in populations. For example, policies that state that human beings should not be denied health services can facilitate and improve the health of a population and enable access to health care that will improve their health conditions. They also highlight the significant association between the role of policy and community because a community can act as a mediator or contributor in policy development process to achieve change in health.

In South Africa, the policy framework for the provision and use of contraception has been developed to address the major identified reproductive health challenges. All sections of the policy framework are in line with international agreements, national legislation and policies. The policy embraces the new definitions of sexual and reproductive health, and the comprehensive reproductive health care paradigm. They focus on the rights of patients and the needs of providers.

2.3 Conclusion

The literature revealed that contraceptive decision-making is influenced by knowledge, social network, health care workers, fear of side effects and partners. The literature review shows the number of studies that have identified the factors influencing contraceptive decision-making. However, few literatures consider side effects as an influence on decision-making.

This chapter also presented a review of Bronfenbrenner's Ecological System model emphasizes the interrelationships between the environment and the individual. Bronfenbrenner (1979), as noted in the chapter, divided the environment into five levels of analysis which one may explore to determine influences on the individual. He referred to these levels as the microsystem, mesosystem, exosystem, macro system and chronosystem levels of influence. This theory is used to explain how these levels can influence an individual's decision-making on contraceptive use.

CHAPTER THREE

METHODOLOGY

The purpose of this study is to explore the factors influencing contraceptive decision-making among female students at the University of KwaZulu-Natal, Durban, South Africa. Therefore, this chapter details the research approach, sample and sampling strategy, instruments, procedures and analysis.

3.1 Research approach

Grounded Theory (GT) approach which was originally developed by Barney Strauss and Anselm Strauss in 1967 is adopted in this study. In 1990, Strauss and Corbin conveyed a more linear approach to the recommended methodology. Although GT has its antecedent in Sociology, it has found application in other areas such as medical studies by Charmaz (1990) and Psychology by Henwood and Pidgeon (1995). More recently, Kathy Charmaz, influenced by the work of Glaser and Strauss, introduced an evolved version of GT known as Constructivist grounded theory.

Charmaz described that she answered Glaser and Strauss' invitation in *The Discovery of Grounded Theory* (1967) to employ GT flexibly in the researcher's own style (Charmaz, 2006). She accepted this proposal by taking the original tenets of GT and translating them into contemporary research paradigms which have evolved significantly since the conception of GT four decades ago (Charmaz, 2006). In particular, she focused on interpreting GT within a constructivist paradigm thereby fashioning a third variation of the GT methodology.

According to Creswell (2009), grounded theory is a qualitative approach in which the researcher infers a general, theoretical process, activity or collaboration grounded in the perspectives of respondents in a study. It involves using multiple stages of data collection and the refinement of different categories of information (Charmaz, 2006). This approach has two primary characteristics: the constant comparison of data with emerging categories and theoretical sampling of different groups to discover the similarities and differences of information (Creswell, 2009).

In this study, data was collected using Pigeon and Henwood's (2003) four categories in conducting any GT. The categories are data preparation, initial analysis, core analysis and outcomes. The data preparation was done through getting the participant to talk about their experiences with contraceptive use. The data preparation process included audio recording the verbal discussion and field notes. This was followed by the initial analysis which is an indexing system where reoccurring concepts are identified and labelled. At the core analysis stage, new themes and incoming data were integrated with previous codes. The final category is that of outcomes, where key concepts, relationships and models existing between concepts were finally settled. However, due to the sample size used, the outcomes stage is not applicable. The researcher focused on local reflection in analysing data because this study is not intended to produce a theory. According to Pigeon and Henwood (1997), the goal of this type of analysis is to attempt a theoretical comparison between the emerging analysis and existing theoretical accounts of the problem domain.

3.2 Sampling and sample size in GT

Sampling is a process of carefully selecting units that participate in a research study (Neuman, 2006). Theoretical sampling is an important aspect of GT and it involves the collection of additional data in light of groups that have emerged from prior stages of data analysis. It also comprises of checking emerging concepts against reality by sampling incidents that may challenge or elaborate its developing claims. While the prior stages of GT require extreme openness and flexibility in order to recognise a wide range of predominantly descriptive groups, theoretical sampling is concerned with the modification and in the end, the saturation of existing and increasingly analytic categories.

A sample size of seven (7) respondents at University of KwaZulu-Natal, Howard College campus participated in the study. These are female students who had used or are currently using contraceptives at the time of this study. A self-selection method was adopted for the collection of the data. Self-selection requires a publicity or call for participants before the constitution of the respondents. Therefore, individuals who constitute the sample in the study are willing participants whose experience is of relevance to the study. A sample is self-selected when the inclusion or exclusion of sampling units is determined by whether the units themselves agree or decline to participate in the sample, either obviously or discreetly (Porter & Bear, 2014).

To this end, posters (see Appendix 3) were placed in strategic places on the campus, and handbills were shared to invite qualified participants. The criteria for participation were made explicit and included: the participant must be a female student, be sexually active and must have been on contraceptives. The target population for this study were the female students of

University of KwaZulu-Natal, from the age of 20 years and above as stated in the poster used to recruit participants.

3.3 Location of the study

This study was carried out at the Howard College campus of the University of KwaZulu-Natal, Durban, South Africa. The University of KwaZulu-Natal was formed on 1 January 2004 by the merger of University of Durban-Westville and the University of Natal, Durban. The merger brings together the rich histories of both universities. The University of KwaZulu-Natal has a total population of 37,850: 24,897 undergraduate students and 3,807 postgraduate students (UKZN, 2016). The University has five campuses namely, Pietermaritzburg campus, Howard College campus, Westville campus, Nelson Mandela Medical School and Edgewood campus. However, for the purpose of this study, the Howard College campus situated in Durban was used as the study location.

3.4 Data collection

There are a number of data collection methods available to researchers for qualitative investigations. Common methods include in-depth interviews (IDIs), focus group discussions (FGDs) and observation methods. For the purpose of this study, an in-depth semi-structured interview was used. Charmaz (2006) stressed the importance of the interview in grounded theory. This was substantiated by Guion, Diehl, and McDonald (2001) that in-depth interviews are most appropriate for situations in which open-ended questions that elicit the depth of information are required from relatively few respondents. Duffy, Ferguson, and Watson (2004), highlighted that in semi-structured interviewing, the interviewer requires more focused information and asks specific questions; the researcher opens the discussion, listens and uses

prompts to guide the respondent(s). In GT, data is usually collected primarily using interviews (Khan, 2014).

3.5 The interview

The interview technique is one of the most commonly used methods in social research (Gill, Stewart, Treasure, & Chadwick, 2008). According to Charmaz (2006), the use of semi-structured in-depth interviews in GT allows for the creation of categories of the data and analysis of the relationships between categories whilst attending to the live experience of participants. The researcher chose a semi-structured interview as the research instrument based on its effectiveness in producing quality data. The guidelines provided by Bryman (2012) on designing an interview schedule were adopted in formulating an interview schedule for the research. An interview schedule is central to the research process as it articulates a general framework of important issues to be addressed in the course of the interview. Charmaz (2014) further states that the interviewer may follow the outline, but should also be able to follow topical trajectories in the conversation that may be deemed appropriate to the subject at hand.

Questions were arranged to flow in a logical and meaningful order. The interview schedule (see Appendix 1) had three layers of questions which are presented in the following.

The first layer of questioning: This dwelt on *awareness of contraception*; the respondents were probed about their knowledge and use of contraceptives.

The second layer of questioning: This had to do with *factors that influence decision-making on contraception*. This was explored by probing respondents' experience while using

contraceptives (effectiveness, side effects). The role of peers, parents, family members and their partners were also probed

The third layer of questioning: This dwelt on *external factors that determine contraceptive use decision-making*. This was examined by probing respondents' service providers' influence, availability of contraceptives and the influence of the media in respect to their decision to use contraceptives.

3.6 Interview protocols

The protocols observed for the interview process in this study include ethical considerations and interview procedure. Details are highlighted in the following.

3.6.1 Ethical considerations

Ethical clearance with full approval was obtained from the University ethics' committee (see Appendix 5) after submitting the gate-keepers' letter collected from UKZN registrar. A gatekeeper is a person or institution that has the authority to either, officially or unofficially, grant access to research participants. (Neuman, 2006).

Efforts were made to ensure that ethical guidelines were observed. The aim of the study was explained to the participants prior to the commencement of each interview session. Confidentiality was ensured verbally by the researcher and in the informed consent form (see Appendix 2). Permission was granted by the respondents to audio-record the interviews. The participants' right to confidentiality, self-determination and freedom to withdraw at any time from the study were verbally explained. Finally, the respondents were guaranteed of their

anonymity and confidentiality by not being required to reveal their names and personal addresses.

3.6.2 Interview procedure

The interviews were led by the researcher while an audio recording of each session was taken with the consent of the participants. The first interview was conducted using a semi-structured interview outline, which had three layers. The questions covered participants' awareness and knowledge of contraceptive use; the factors influencing decision-making regarding contraceptive use at the inter and intra-personal levels, and the external determinants of contraceptive decision-making. The first participating respondent was interviewed face-to-face. Sessions held lasted between 20 and 35 minutes. Various probes were used to elicit views from the participant. For an example, an exploratory probe was used to understand the role of partner's influence in decision-making regarding contraceptives use. The findings from the first interview were transcribed and analysed. Patterns which were established were pursued with the next participant. This was done in an iterative way (Polkinghorne, 2005). After the interviews were conducted, the qualitative analysis and interpretation of the narrative data were performed with reference to the main research questions of the study and in line with the objectives of the study.

3.7 Data Analysis

The continuous cycle of collecting and analysing data is a crucial feature of grounded theory research (Charmaz, 2014). Thus, while the data collection and analysis sections are presented separately, it should be noted that these processes overlap with each other. It should be noted

that in grounded theory, data collection and analysis happens simultaneously from the beginning of the study.

This strategy of constant comparison involves taking one piece of data (one interview or one theme) and comparing it with all others that may be similar or different in order to develop conceptualizations of the possible relations between various pieces of data. Constant comparison analysis is well suited to grounded theory because this design is specifically used to study those human phenomena for which the researcher assumes that fundamental social processes explain something of human behaviour and experience. This constant comparative analysis guided the analysis of the data collected in this study until core concepts were saturated (Glaser & Strauss, 1967). The codes were then compared and categorized to see which ones best explain the phenomenon studied.

Pigeon and Henwood (2003) highlight four core stages in conducting any GT with qualitative data. These steps include data preparation, initial analysis, core analysis and outcome. In the data preparation stage, data are collected, collated and stored. In the initial analysis stage, the collated data are stored, while in the core analysis stage, new and incoming data are mapped through category integration with the coded ones. Lastly, in the outcome stage, key concepts, definitions, relationships and models existing between concepts are finally settled. This research aims to only reach the core analysis stage. This is because the concepts that would be identified from the coded data are not in any way conclusive since the pool of data is in the first place relatively small and does not intend to produce a theory.

Data Preparation: In order to isolate the concepts and themes which the research will work with from the data, one interview was conducted. Together with my supervisor, we analysed the contents highlighting the issues that needed to be examined in the next interview. This enabled

the preparation of concepts, themes and questions to be used in subsequent interviews following the guide of the semi-structure interview outline (Appendix 1). Subsequently, two more interviews were conducted using the concepts, themes and questions inferred from the first interview. Together with the first interview, they were transcribed and rewritten in a manner that allows for proper scientific data processing. The first set of data was coded based on relevance to the topic being studied. In line with (Charmaz, 2006), some general and specific codes were identified during the process of coding. In short, the first stage of data collection involves collecting a set of data, analysing and coding it, and the outcomes from this informed the subsequent set of data collection activity; which data to gather, from where to collect and which aspects need special attention.

Initial analysis: An indexing system for the data retrieved from the three conducted interviews began shortly afterwards. Tentative concepts that reoccurred from the interviews were firstly identified and labelled. The concepts identified from the first interview during interaction with my supervisor served as a guideline for the easy recognition of concepts and themes in the other two. As more concepts beyond those identified with my supervisor began to surface, the need for more interviews began to materialize. However, two categories evolved during data analysis, namely, “women’s knowledge of contraceptives” and “the process of contraceptive decision-making in ‘finding the best fit’ (Dickson et al., 2003). These categories were eventually linked to form one. Every single perception that was discovered was treated as the basic unit of analysis. Initial concepts and groups were treated as provisional, and only became part of the research by being present in the subsequent data (Bryant & Charmaz, 2010). Therefore, a significant aspect of the activity is a constant comparison of the concepts and categories as they emerge with the previously discovered ones for progressive refinement.

Core analysis: Since the process of coding can be interrupted at any point by the collection of more data if necessary, four more interviews were conducted to ascertain the prevalence of the new identified concepts. Using the same indexing system used for the first three interviews, the four new interviews went into the same process as the first three interviews.

Memo writing, which involves noting observations one has about a category or property and the relationships that exist between categories is important (Dickson et al., 2000). Glaser (1978) makes the point that the occurrence of ideas whilst working with emergent categories requires constant writing of memos since they will capture the different aspects of the propositions that emerge from the data. Thus, the indexing system became refined. The seven participants were categorized into two major groups based on their background, namely, the conservative and the progressive. Also, among the concepts identified from the interviews, some key concepts were brought out as the content of the indexing system. These include, knowledge (with 'background' as a major factor), partner's influence, social media, the role of health care workers(HCWs) and the fear of side effects. At this point, all the categories had been saturated, meaning that from the data sets that the researcher had collected, no new information could be extracted.

To make sense of the data collected, the grounded theory approach to analysis was used to analyse the data. After coding, during the middle stage of analysis, the focus was on central categories and their definitions to suggest new interpretations (Pidgeon & Henwood, 1997). Later stages of analysis are also likely to involve attempts to integrate the emerging categories by creating links between them. The researcher focused on local reflection in analysing data. According to Pigeon and Henwood (1997), the goal of this type of analysis is to attempt a

theoretical comparison between the emerging analysis and existing theoretical accounts of the problem domain.

3.7.1 Trustworthiness of the data

In most cases, a study is subjected to quality analysis after completion as a strategy to ensure the integrity of the research process and findings (Johnson & Christensen, 2010). Quantitative studies use the term reliability and validity to ensure the study's trustworthiness. (Bowen, 2009) defined trustworthiness as the conceptual soundness wherefrom the value of qualitative research may be evaluated. In qualitative studies, there exists no consensus on the terminology used for reliability and validity. According to Golafshani (2003) in qualitative research, reliability and validity are conceptualized as trustworthiness, rigor, and quality. The grounded theory approach proposes that "the research should be evaluated by the very constructs that were used to generate it" (Lazenbatt & Elliott, 2005).

Johnson and Christensen (2010) propose that instead of focusing on the appropriate terminology for reliability and validity in qualitative research, researchers need to focus on the research methods to ensure the quality of the study. This implies that researchers in grounded theory have to identify the basic components of grounded theory and understand how these research methods impact on the quality of the research. As previously mentioned, the continuous cycle of collecting and analysing data is integral to grounded theory research. The process of data analysis begins as soon as the data is collected and is followed by the comparison of one set of data with another. Comparison of data leads to the formation of categories.

Through selective coding, the researcher analysed the collected data and determined whether the developed categories remained the same when the data is reviewed for the developed categories. As new data was collected, the researcher continued to review the categories. This process guarantees that the formulated categories represent the collected data (Charmaz, 2014). As a result of the back and forth relationship between data collection and analysis, the researcher can check if initial findings remain constant after further data is collected. The constant cycle of comparative analysis and data collection essentially ensures that the researcher generates research findings that represent accurately the phenomena under study (Elliot & Lazenbatt, 2004).

3.8 Conclusion

This chapter outlined the methodology used in the study. A qualitative research approach was adopted for this study. Specifically, the study utilised a grounded theory approach with the data collection method of semi-structure interviews. The chapter also described the size and nature of the sample, the data collection methods used, the procedure used in carrying out the study and data analysis method. Finally, the chapter explained how credibility was achieved. The following chapter will discuss the findings of the study.

CHAPTER FOUR

FINDINGS AND DISCUSSION

This chapter presents an analysis and discussion of the findings of this study in relation to the relevant literature. The findings of this study are dynamic and multifaceted in nature. The core focus of the study is an *exploration of decision-making in contraceptive use* among female university students. This exploration has resulted in an account of how different factors influence the decision-making process. It was found that the females of this sample usually chose and adopted a method that, besides controlling their fertility levels, ensured that their choices did not affect their health. In line with current literature, this study identified five major sets of influencers namely knowledge, partner's influence, social network, health care workers (HCWs), and the fear of side effects of contraceptive use.

4.1 Social demographic profile of respondents

Seven respondents were interviewed for this qualitative study. The ages of the respondents ranged from 21 to 28 years. All seven respondents were female Zulu-speaking students of the University of KwaZulu-Natal from different departments at the Howard campus. Some of them had children, and they all had experiences on the use of contraceptive. For reasons of confidentiality and anonymity, the respondents will henceforth be referred to as respondent 1, respondent 2, respondent 7, based on the order in which the interviews were conducted.

4.2 Factors influencing contraceptive decision-making

The factors, which emerged from this research, that influence contraceptive use, include the influence of religion on knowledge, partners' influence, social network, health care workers (HCWs) and fear of side effects. These are discussed in the following:

4.2.1 Religious background and knowledge

Lack of adequate knowledge of contraceptive use is the major influencing factor bearing on the decision-making process of contraceptive use by university female students (Williamson et al., 2009). Lack of adequate knowledge is in the first place, determined largely by the background of the individual (Wyatt et al., 2000). The influence of the type of upbringing and home environment that the students were exposed was evident in their accounts of their decision-making. As an example, religion emerged as an influencing factor in this study.

While growing up in terms of my religion as a Christian, there are some topics that were not brought up in the house, such as relationships, and sex. It was seen as forbidden to talk about it, being in a relationship was seen as a distraction (Respondent 1).

I lived in a family where religious beliefs ultimately guided our moral activities...lived a routine life; house, school then house... (Respondent 2).

I was born into a Christian home where Christian values were upheld...topics such as boyfriends and sex were forbidden... (Respondent 3).

My parents were Christians and we were brought up in a Christian way. My mum taught us to be good Christians...coming from a conservative background, my mother hardly or does not bring up topics like that (Respondent 4).

My mum was not all that responsible...so I was put in the care of my grandmother...she encouraged us all to go to church, she believed in God and she instilled that belief into each and every one of us...but I talked about sex with my friends... (Respondent 5).

I grew up at my grandma's house...I would say she acted as both my father and mother...she was Christian...dating was not allowed because we were too young but you know youthful exuberance, we always find a way (Respondent 6).

For most South Africans culture and religion are interdependent (Macleod & Durrheim, 2002). One cannot be separated from the other; but the kind of relationship that exists between them may at times present a conflict situation While the Zulu culture embraces an upbringing of young people in a sexually welcoming environment (Delius & Glaser, 2002), religious beliefs sometimes conflict with this aspect of culture of openness to sex education (Mashau, 2011). This creates a conservatism towards sex education. Only one of the respondents displayed a tendency that negates this position and said the following:

There was open communication between the immediate family members...I could discuss anything with my parents, especially my mama...my mum was liberal and open to a lot of things (Respondent 7).

As indicated above, respondent 7 displayed tendencies that negate the above trend in that her religious upbringing was not seen as an obstacle in her sex education. Despite her religious background, she was able to have an open conversation with her mother about sex and contraceptives. However, hers was a progressive background as opposed to the more conservative ones displayed by the other six respondents.

Wyatt et al. (2000) report that the degree to which religious beliefs influence sexual behaviours has been largely overlooked in research on women's sexual decision-making. The responses of these respondents show that religion plays an important role in shaping the background of the individual, and the individual's background in turn determines what they know. In this case, findings show that the background of the university female students determines their knowledge about contraception.

The respondents with conservative background exhibited limited if not zero knowledge of the use of contraceptives, while the respondent with a liberal background exhibited adequate knowledge.

Not really, what I used to hear was only when my aunt was shouting to my big sisters...now that you have a boyfriend you must go and take a pill or injection
(Respondent 1).

I learned some intimate stuffs from being a boarder...my knowledge of contraceptives came from eavesdropping on my seniors (Respondent 2).

I can recall, the first time I heard about contraceptives was through my aunts...the second was from my friends (Respondent 3).

I wouldn't say I had any knowledge of the use of contraceptives, coming from a conservative background, my mother does not bring up topics like that (Respondent 4).

I got to know about condoms from my school during health education class and through some of my friends who were already having sex at that time (Respondent 5).

More information came from classmates and information from the internet (Respondent 6).

These responses tend to support the findings of Hoque and Ghuman (2012) which state that there is relatively low knowledge of the use of contraceptives among female university students. They also continue the tradition already established by earlier South African studies such as Myer et al. (2007) and Roberts et al. (2004) that female university students hear about contraceptives from friends. On the other hand, respondent 7 was an exception to this trend. As anticipated, respondent 7 was well informed about contraceptives.

I would say I have adequate knowledge...I was informed by my mama (Respondent 7).

4.2.2 Partner's Influence

Findings from this study revealed that partners influence the decisions on contraceptive use. Williamson et al. (2009) report that partners often manipulate, force, threaten, and use violence to get young women not to use contraception. Varga (2003) and Wood and Jewkes (2006) also

report that the role of gender inequalities in terms of power, roles, decision-making, and negotiation for contraceptive use undermine directly or indirectly young women's capacity for making autonomous decisions about controlling their fertility.

Partners' role is perceived to be the main factor that influenced most participants' use of contraceptives. Male partners seem to give preference to condoms, and this can be argued to be mainly for protection against sexually transmitted infections and not so much against preventing pregnancies. Varga (2003) and Wood et al. (2006) reported that because of gender inequality females rely on the suggestions of their partner. Another study by MacPhail et al. (2007) also discovered that partners were more involved in the decision of females on contraceptive usage than anticipated. On occasions when such involvement is lacking from the partner, Sayem and Begun (2008) explain that this might be as a result of lack of communication. Respondents 2, 5, 6 and 7 had the following to say:

...before then, I and my partner were using condoms, sometimes we get carried away and not use it which made me scared (Respondent 2).

My first influence was my initial boyfriend that introduced me to the use of condom (Respondent 5).

I think condom use was his idea...he influenced the use of condom and I implemented the use of pills, because sometimes we get carried away and we don't use condoms (Respondent 6).

You know I said I have been using condoms, when we started doing flesh to flesh, he was reluctant to use them again, so my boyfriend suggested the emergency pills (Respondent 7).

Another noticeable trend with regard to the role of the partner was that a failure to use contraceptives was linked to their getting comfortable with the partner (Raine et al., 2003; MacPhail & Campbell, 2001). When they get 'comfortable' with their respective partners or as the relationship becomes more stable, there is always a reluctance to continue using contraceptives.

Well it... just what it is we got comfortable with ourselves, we were not cautious enough cos we thought we were secured just loving and trusting each other (Respondent 2).

Perhaps the assumption in these cases was that should a pregnancy ensue, the expectation from the females was that their partners would provide the necessary support.

4.2.3 Social Network

Concerning the influence of the media, respondents 1, 2, 3 and 4 reported that they gained most of their knowledge about contraceptives from the media.

Yes.....I think on TV probably videos like soul city...but you will hear them so you can see that and it is on TV they are educating us and you are shying away but I think there was some form of education definitely... (Respondent 1).

Hmm..... a little I guess, if I can recall the awareness came from one old TV advert but didn't understand it until I grew older and I couldn't ask anyone (Respondent 2).

In a way I will say there were few external factors, like the media, the TV programs on awareness, family planning, prevention of diseases, STI's and HIV. Radio jingles and on campus, we had periodic programs and campaigns, organized by school and some external bodies I guess...My major external factor, was the internet, I always go online because it gave an adequate information about all the contraceptives in use, the methods, usage etc. (Respondent 3).

Whatever I hear from my friends, I went back to Google it. I believe so much in the internet, because a lot of research has been done. It always serves as a guide to me almost every time (Respondent 4).

The accounts of these four respondents makes clear the impact which the social media has on the decision-making process of the respondents. The synergized impact of partners and the social media highlights the prevalence of the interpersonal level of the bio-ecological theory upon which the study is built. As argued by McLeroy et al. (1988), the kind of relationships which the interpersonal level is indicative of, provides important social support that shapes the individual within a defined environment and the accounts discussed above demonstrate the significance of this interpersonal relationships. The findings of this study support that of Yee and Simons (2010) who found that the media greatly influences the decision on contraceptive usage.

4.2.4 Health care workers

The role of healthcare workers in the decision-making process of contraceptive use cannot be underestimated (Wood & Jewkes, 2006). HCWs have traditionally been negatively portrayed in

the literature. Findings from the interviews, however, revealed that health workers such as doctors and nurses positively influence the use of contraceptives.

For me the nurse was like a mother figure, her interaction was so timely then, she told me about the different types without leaving anyone out. I remember having mixed feelings before going to see a doctor or a nurse, how would people look at you when you get to the clinic to ask for contraceptives (Respondent 1).

I would agree that the nurse had the major role in deciding which way to go and the combination of myself and my partner...Seeing a gynaecologist, gave me a clearer picture to so many questions that were unanswered.... I understood how contraceptive works (Respondent 2).

However, these respondents' accounts do not agree with that of (Mantell et al., 2011) who noted that the poor contribution of health workers in South Africa to the dissemination of information on the use contraceptives is worrisome and that family planning clinics are neither young women nor adolescent-friendly. All respondents' accounts show that health care workers they encountered were friendly to young women and gave them helpful information that helped them in their decision to use contraceptives. Respondent 2, who despite having had prior knowledge of contraceptives from seniors in school and the media, only made a decision after interacting with health care workers.

It was found that some respondents started using contraceptives only after their first birth and it was during this time they got to meet health care workers who educated and enlightened them about the use of contraceptives (DoH, 2012).

Well the usage was immediately after I gave birth...After the knowledge from the nurses also the decision-making I decided well they advised me and I decided because I can't have another baby (Respondent 1).

It was noticed those who had been pregnant before seemed to prefer utilizing hormonal techniques and were less inclined to report utilizing condoms.

When available, advice from HCWs appeared to be most influential in their decision-making. In terms of the ecological model, the role of HCWs combines two levels because of its impact on the shaping and defining of the individual's decision-making of contraceptive use. The identified levels are the combination of the institutional level and the community level. At the institutional level, health care facilities do not only exert influence through HCWs, but they also exert influence by providing the incentives upon which decisions on contraceptive use are made. They provide the advice and the contraceptives themselves. A community can be considered as groups emerging out of the relationship between associations and gatherings inside a characterized territory (McLeroy et al., 1988). According to these health providers they can be seen as representing the community, as well as the institutional level in terms of their roles as ambassadors of the health department.

4.2.5 Fear of side effects

Findings from the study showed that the fear of side effects of contraceptives influenced usage by the respondents. Some of these side effects alluded to by respondents include obesity, excessive blood flow and menstrual cramps. These perceptions and experiences of side effects also influenced the type of contraceptive method chosen. A 25 year- old respondent gave an account of how side effects influenced her choice of contraceptive:

I remember that day, the doctor was so patient to put me through the types of contraceptives, the benefits and side effects of each one, that some may cause spotting, headaches, nausea feelings, after several mins of consultation I picked IUD...Firstly, because I have had friends that are using other methods like Depo-Provera, patch that has made the obese, caused heavy flow and I sure didn't want that for myself, that's why I pick the IUD method. Although he also said pregnancy could occur during the use of IUD and this may cause ectopic pregnancy. Secondly, I hate swallowing pills... because I know I suck at taking routine medications (Respondent 2).

I was particular interested in the side effects because of my nature of reacting to things (Respondent 3).

Contrary to this trend, respondent 1 reported that she experienced no side effects in her use of contraceptive and as such, side effects were not a major concern for her.

I don't think I had any side effect except am not sure if I could link it to that or the breastfeeding but you know that I was quite thin at that time but I didn't see it as a side effect but just now looking at the photograph could it be that but other than that for me I don't think there were any side effect...No dear! The media has no impact on me at all and the nurses were no for me, although I knew there were several health talks on campus but I never went for a single one (Respondent 1).

Raine et al. (2003) observed that most of the women in their study preferred to use hormonal techniques of contraception rather than barrier techniques. Most of the respondents in the present study examine the method's side effects and weighed these side effects against the dangers of unplanned pregnancies. Positive experiences from the previous use of a specific

method increased the chances of it being reconsidered again in the future. On the other hand, negative experiences that resulted from utilizing a particular method facilitated its elimination from existing options. According to respondent 2, characteristics or attributes associated with a specific method played a core role during the selection process. These characteristics or attributes included the method's interference with sexuality, effectiveness of a particular method and side effects associated with the method.

According to the DoH (2012), many women attending contraceptive services in South Africa do not obtain sufficient information and counselling on the expected side effects of injectable contraceptive methods. Side effects are reported to be the most common reason for the discontinued use of contraception. This is indicative of a need for better counselling of women on the expected side effects of the method of contraception they intend to use, especially when they first start to use a particular contraception method.

It has shown in this study that the respondents rely on the external source like social media, partner and most importantly the HCWs for required information.

The need to make a decision on choosing a contraception method or changing to another and the need for acquiring more information about the methods encouraged the participants to conduct a comparison on the methods and select an option that has fewer side effects. The existing knowledge about the techniques developed in earlier phases influenced their choice of contraception methods. Generally, most participants examined chances of failure for a particular method, exposure to risk of pregnancy, possible complications, effects of future pregnancies, and side effects before making a decision on which method is the preferable one. In conclusion, in terms of the ecological model of this study, while the intrapersonal level appears not to have been addressed, it was observed that each participant engaged in the

process in different ways, pointing to individual variations in their decision-making; the other levels are present and they explain the relationship between the five influencers which this study has identified. Figure 3 shows the dynamics of the respondents' influence of contraceptive decision-making below:

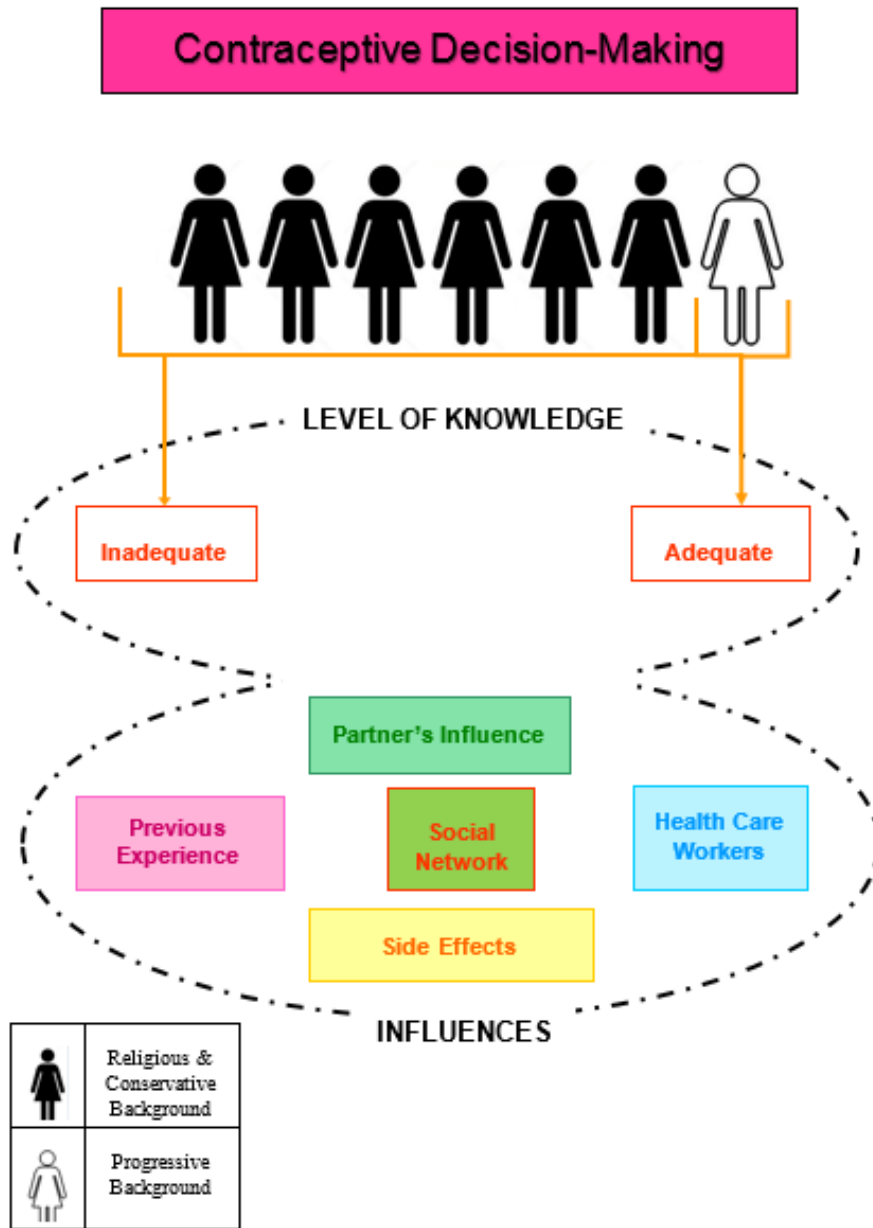


Figure 3: The dynamics of respondents on influence of decision-making of contraceptive use.

Source: Author

4.3 Conclusion

The respondents presented diverse opinions that captured all the different angles of the topic. In general, even though they regard contraceptives as important and necessary to prevent unwanted pregnancies, there were factors that inhibited them from getting knowledge about contraceptives use so as to make informed decisions on the type to adopt. These factors influence their diverse opinions, particularly, that their decision on the usage of contraceptives was hugely affected by the media and the HCWs. The largely conservative African culture is inherently not compatible with talks about sex and contraception to young adults.(Macleod & Durrheim, 2002). As such, teenagers grow into puberty and know next to nothing on issues of such importance. Eavesdropping on elderly ones talking among themselves becomes the option for many teenagers and this is not a good source of sex education. This inadequate foreknowledge is then expressed among young women when they are in the company of peer groups at the universities. Very few of them go to the HCWs for advice on the different types of contraceptives that are available and this is a result of the conservative African culture which makes university women see HCWs as extensions of their parents. The HCWs are often seen as been unapproachable and unfriendly. Also, HCWs were commonly described by adolescents as rude, short-tempered and arrogant.(Wood & Jewkes, 2006)

Previous research reveal that it is only after the women fall pregnant that they seek formal health education on contraceptives so as not to unexpectedly fall pregnant again (DoH, 2012).

The HCWs then give them proper formal education on contraceptives and they are now equipped to make informed decision to safeguard their future. The interview with these women shows the difference between those from conservative homes who have been denied proper sex education on contraceptives and one from a liberal home who have had this sort of education. While the former group rely on a range of sources for their information, the latter made informed decisions on the usage of contraceptives. However, all of them seemed to worry about the side effects of contraceptives.

In conclusion, the decision on the usage of contraceptives among university women appear to be largely influenced by external factors.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

It is arguable that the major impetus for the invention of contraceptives is the attempt to reduce incessant reproduction and give women the right to decide when to reproduce and how many times they desire to reproduce. Using contraceptives as prophylactics came much later only as a by-product. However, there are many factors inhibiting women from using contraceptives. This is more prominent among female university students. These female students are at a very crucial period in their life, such that the decisions they make during this period will affect their future. This study examines the factors influencing the decision-making process of female university students in University of KwaZulu-Natal, Durban, South Africa, on the choice and

usage of contraceptives. The study adopted an ecological system model to explain contraceptive decision-making among the study sample.

The ecological systems theory is based on the proposition that human development takes place through complex reciprocal interactions between the individual and the immediate environment. It assumes that a person is an active player, exerting influence on the environment and the environment compels the person to adapt to its conditions and restrictions. The ecological system theory corroborates the findings of the DoH (2012), which identifies the following factors as the influencers on contraceptive decision-making; knowledge, social network and partner's influence, HCWs, and fear of side effects. The study then explores each of these factors to determine their degree of influence on female students of the University of KwaZulu-Natal on contraceptive decision-making.

The study discovered that knowledge about contraceptives appears to be the main factor influencing decision-making because most female students have limited knowledge of the range of contraceptives available to them. The factor highlights the importance of education and concludes that educated people are more informed about contraceptive choices as opposed to their less educated counterparts. However, since the sample of this study are university students, emphasis shifted away from education and rests more on awareness. More appropriately therefore, the study reaffirms the primal place of this factor and demonstrates how the other factors are dependent on it. Nevertheless, HCWs were shown to have as much influence on contraceptive decision-making as knowledge and awareness, some respondents confirmed the reluctance of most female students in conversing with HCWs on issues about contraceptives with many consequently relying on second hand sources. Information gained

from HCWs were attested to by some respondents to be very useful and informative. The study shows that HCWs' information is very enlightening on the side effects of contraceptives. Almost all of the respondents confirmed that knowing or not knowing the side effects of the available contraceptives has a big influence on them. Since there is no better place to get acquainted with contraceptives' side effects than with HCWs, the role of HCWs becomes more prominent.

We live in a society ruled by technology and as such we are susceptible to the influences of the media. It is true that most of what the respondents know are sourced from the media; including knowledge about contraceptive use. Thus, whichever type of contraceptives that is media friendly at the moment easily becomes the choice of the female student. The influence of the media does not stop there, but further serves as a catalyst in the partner-pressure issue. This study shows that the issue of the partner relates more to the development of mutual trust between both parties. Respondents explain that once the trust between partners matures, they gradually lose sense of the importance of contraceptives.

5.1 Conclusion

A quick statistical survey of fertility cum reproduction rate in South Africa will expose the high and seemingly increasing rate of unintended pregnancies. This is more prevalent among young female students especially those in tertiary institutions far removed from the watchful eyes of parents and relatives. However, there is need for more emphases on contraceptive use because having unintended pregnancy prunes the growth and development of female students in more ways than one and as such, they are expected to take contraceptives seriously. Consequently, the fact that they do not take contraceptives seriously and the rate of unplanned pregnancies is precisely the impetus for this research.

The study discovered that there is little autonomy in the decision-making process by female students in the choice and usage of contraceptives. The choice and usage of contraceptives by female students is heavily influenced by such factors as knowledge, awareness and access to contraceptives, social network and partner's issues, HCWs, and side effects. The discovery by this study is not just the seeming lack of autonomy in the decision-making of female students on contraceptives use; this is because the ecological model adopted by the study already presupposes an interdependence between the individual and the environment, such that even after the female students have been subjected to the powerful forces of the influencers identified by the study, most of the times, the decision as to which type of contraceptives to use is still not exclusively made by the female students.

There is generally inadequate knowledge about contraceptives among female students, hence, they do not make informed decisions. Based on the study's findings, the following recommendations are made:

5.2 Recommendations

The study observed that female students' autonomous decisions on contraceptive use is mainly hampered by inadequate knowledge, lack of awareness and lack of access to contraceptives. The study therefore, recommends that awareness and enlightenment programmes are provided through which female students may gain adequate knowledge, information and access to contraceptives. Since the family is a microcosm of the society, the recommendation is to plan programmes that will be educative and informative, so that it can be implemented firstly within the family setting. Thus, parents should take out time to educate their daughters on the importance of contraceptives.

Once the female student has been made aware of contraceptives from home, she would be less ruled by the influence of the media and be willing and open to visit HCWs to discuss the pros and cons of contraceptives and particularly, about the different types available in order to make informed decisions on which type of contraceptives to use. Institutions should then take up the mantle and continue from where the family stops. High schools should incorporate into their curriculum sex education and make contraceptives awareness an important aspect of that module. Perhaps, things would turn around if the female students are individually equipped with the appropriate knowledge of contraceptives right from their respective homes, this knowledge is complemented during their high school days, discussions among them are enriched and those with outdated knowledge are updated, informed decisions are made on the usage and choice of contraceptives and the rate of unintended pregnancy drops.

Organised programmes by governmental bodies and NGOs alike need to emphasize to young women, the need to be in control of their decision regarding contraceptives use. Young women should be empowered to become knowledgeable and autonomous in their choices of contraceptive options. The influence of the interpersonal and societal factors must be transformed by these programmes so that young women will be able to see the need for intrapersonal and autonomous decision-making process of contraceptive use.

5.3 Limitations

The study's main limitation is the sampling of respondents from one university. Thus, the findings, conclusions and recommendations that emerged from the study cannot be generalised. Additional research involving a larger, representative sample of female students from different universities in the KwaZulu-Natal province will be crucial to fully understand the factors

influencing the decision-making of female students on contraceptive use. In addition, the study explored a sex related issue which is a sensitive topic, thus, social desirability can also be a limitation. In researching sensitive topics, respondents have a tendency of reporting behaviours and opinions that are deemed socially acceptable. While the researcher acknowledges the magnitude of this limitation, efforts were made to assure respondents of their anonymity and confidentiality of information provided by them.

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APPENDIX

APPENDIX 1: Semi Structured Interview Guide

Understanding the influence of decision-making of contraceptives use among female students.

The following demographic data will be collected

- Age
- Marital Status
- Level of study
- Religion

First layer of questioning

Awareness of contraceptives will be examined by probing the following:

- Knowledge of contraceptives
- Use of contraceptives

Second layer of questioning (asked after first layer has been exhausted)

Factors that influence decision-making on contraceptives will be explored by probing the following:

- Experience in terms of contraceptive use (effectiveness, side effects, if any)
- Peer influence
- Parental/family influence
- Partners' influence

Third layer of questioning (asked after second layer has been exhausted)

External factors that determine contraceptive decision-making will be examined by probing the following:

- Service provider's influence
- Availability of contraceptives
- Media

APPENDIX 2: Informed Consent Document

Dear [participant],

Thank you for agreeing to participate in my study! It is part of the requirements for a Master's degree in the Health Promotion, Discipline of Psychology, UKZN. My topic is: **FINDING THE BEST FIT: AN EXPLORATION OF CONTRACEPTIVE DECISION-MAKING IN A SAMPLE OF FEMALE STUDENTS AT THE UNIVERSITY OF KWAZULU-NATAL.**

All you will be required to do is share your perspectives around contraceptive decision-making. All information gathered will remain strictly confidential, and I will use a pseudonym when referring to you. When the research is complete, all the data will be disposed of. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

Participants have the right to withdraw without any negative consequences. Similarly, choosing to withdraw at any point during the research will not leave you disadvantaged in any way. You will not be expected to justify or explain your reasons for withdrawal.

If you give consent to participate in this study by sharing your perspectives and experiences, please sign this form to show that you have read the contents.

I..... (Full name) on (Date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I hereby consent to have this interview recorded..... or

I do not consent to have this interview recorded.....

If you have any questions, please feel free to contact me:

Enitan Oyedeji

success2000ng@yahoo.com

+27 721773004

Alternatively, contact my supervisor

Mrs Cynthia Patel

Department: School of Psychology

Howard College, MTB

UKZN. Tel: 031 260 7619

patelc@ukzn.ac.za

Or

HSSREC Research Office

University of KwaZulu-Natal

Govan Mbeki Building

Private bag X54001

Durban

4000

Tel: 031 260 8350

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Thank you for your time!

APPENDIX 3: Recruitment Poster

PARTICIPANTS NEEDED FOR RESEARCH ON *CONTRACEPTIVE DECISION- MAKING*



We are looking for volunteers to take part in a study entitled

FINDING THE BEST FIT: AN EXPLORATION OF CONTRACEPTIVE DECISION- MAKING IN A SAMPLE OF FEMALE STUDENTS AT THE UNIVERSITY OF KWAZULU-NATAL

If you are willing to participate you will be interviewed on the influences of decision



making on contraceptive use etc.

Your participation would involve three (3) sessions;
each session will be about fifteen (15) minutes long.

In appreciation for your time, you will receive

[light refreshments].

For more information about this study, or to volunteer for this study,

please contact:

Oyedeji Enitan

School of Applied Human Science

Masters in Health Promotion

084-221-2169

Success2000ng@yahoo.com

**This study has been reviewed by, and received ethics clearance
by the UKZN Research Ethics Board.**



Call Enitan Oyedeji
0842212169

Or

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APPENDIX 4: Gatekeeper's Letter



10 November 2014

Miss Enitan Oyedeji
School of Applied Human Science
College of Humanities
Howard College Campus
UKZN
Email: 214582134@stu.ukzn.ac.za

Dear Miss Oyedeji

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"Finding the best fit: An exploration of contraceptive decision making in a sample of female students at the University of KwaZulu-Natal".

It is noted that you will be constituting your sample by placing posters on the student notice boards on the Howard College Campus inviting students to participate in a semi-structured interview.

You are not authorized to contact staff and/or students using Microsoft Outlook address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR MC BALOYI
REGISTRAR

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Website: www.ukzn.ac.za



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

APPENDIX 5: Ethical Clearance