Contraceptive Myths: A qualitative study investigating contraceptive myths amongst Black female students at the University of KwaZulu-Natal.

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Declaration

I declare that this dissertation is solely the result of my own work. It is being submitted in partial fulfilment of the requirements for the Degree of Masters of Social Sciences, Educational Psychology, in the School of Psychology, University of KwaZulu-Natal, Pietermaritzburg. It has not been submitted for any previous applications or degrees in this or any other higher learning institutions.

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Abstract

This qualitative study investigated the contraceptive myths held by black female students of the University of KwaZulu-Natal aged 18–27 years. Data for this study was collected through a focus group discussion and individual interviews. Majority of students who participated in this study indicated that they did not use condoms. Most participants appeared to have the knowledge of contraception and of risky sexual behaviours. The results also revealed that students are aware of the common myths and misconceptions about contraceptives, however, most of them perceived these myths to be true. Some of these myths included infertility and vaginal wetness as a result of using hormonal contraceptives. Participants also reported that their partners also influence their contraceptive use because of the myths they hold about contraceptive usage.

Contents

Acronyms

AIDS…….....Acquired Immune Deficiency Syndrome
BTC……...Behind the Counter
DHS……..... Demographic and Health Surveys
DOH……. Department of Health
EC……. Emergency Contraception
ECP……...……Emergency Contraception Pill
HIV……. Human Immunodeficiency Virus
IUC…… Intrauterine Contraception
IUD……Intrauterine Device
LAM…….……Lactation Amenorrhoea Method
LARC……...…… Long Acting Reversible Contraceptives
LNG IUS……....Levonogestrel intrauterine system
MAP……. Morning after pill
OTC...……...……Over the Counter
SA……South Africa
SADHS……. South African Demographic and Health Surveys
STI……. Sexually Transmitted Infection
TOP……Termination of Pregnancy
UKZN……University of KwaZulu-Natal
USA……...…United States of America
WHO…… World Health Organization

Definitions

Contraceptive: A device or method or drug serving to prevent pregnancy, HIV and STIs (DOH, 2012).

Contraceptive methods: Methods that prevent pregnancy, HIV and STIs which include condoms, pills, injection, IUDs (Phelps, Murphy & Godfrey, 2011).

Contraceptive prevalence rate: It looks at the proportion of females who are currently on, at least, one contraception, or whose sexual partner is also using any form of contraception, regardless of the contraception method used (DOH, 2012).

Dual Methods: Condom and non-barrier contraception (Grady, Billy & Klepinger, 2012).

Emergency contraception: A levonogestrel pill for preventing unplanned pregnancy resulting from unprotected sexual intercourse that can be orally taken within 72 hours after unprotected intercourse. (Phelps, Murphy & Godfrey, 2011).

Misconceptions: A misconception is a logically unjustified concept and it is at variance to that of an expert and it can hinder learning (Kawulich, Garner & Wagner, 2009).

Myth: A widely held but false belief or idea (Gotesky, 2009).

Imithi: Concoctions of medicinal mixtures by traditional healers (Wood & Jewkes, 2006).

Isangoma: A diviner or traditional healer (Truter, 2007)

Sexual Risky Behaviours: Activities that put one in the risk of contracting HIV, STIs and unwanted pregnancy (Hoque, 2011).

Chapter 1: Introduction

This introductory chapter will start by providing a background to the study and the research problem. This will be followed by the aims and the rationale of the study, the objectives, the research questions, and the delimitation of the study.

Background to the Study

Contraceptives play a key role in women's family planning and sexual life. Such measures could help in preventing unwanted pregnancies, Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs). In South Africa, various contraception methods are available for use by women and teenagers who are sexually active. Despite contraceptives being freely available for use, multiple myths and misconceptions have been linked to the non-use or dislike by women of varying ages (Russo, Miller & Gold, 2013). This dislike of contraceptives leads to poor use and contributes to high levels of unplanned pregnancies, HIV and STIs, which are highest amongst the black population (Hoque, 2011).

There are many different contraceptives available in South Africa. For example, there are barrier, behavioural and hormonal methods. Each method of contraception has its own myth and misconception associated with it. Often times, barrier methods are associated with lack of pleasure and discomfort, whereas hormonal methods are often associated with myths of infertility, weight-gain, hair-loss and many other myths and misconceptions (Russo et al., 2013). In a study that was conducted by Wood and Jewkes (2006), they found that young women were misguided by misinformation, misconceptions and myths about contraceptives. The study further explained that the contraceptive information these young women had was diverse and came from different sources, which included nurses, friends and schools (Wood & Jewkes, 2006).

Research Problem

Often times, when women do not have the correct information about contraceptives, they are more reluctant to use those methods (Russo et al., 2013). Eram (2017) argued that misconceptions and negative myths about contraception are a barrier to contraceptive use.

These myths often spread in informal interactions and lead to these beliefs. Eram (2017) further posited that poor use of contraception is a result of lack of knowledge and education, religious beliefs, and fear of side effects. The reality is that contraception has been made available and easily accessible in South Africa, however, women still engage in unprotected sex. This is associated with many health risks (Hoque, 2011) such as HIV, STIs, and unwanted pregnancies, which lead to abortions that are often performed illegally. Furthermore, high numbers of unwanted youth pregnancies are also often accompanied by high HIV infection rates, especially amongst university students (Hoque, 2011). All these problems are highest amongst the black population (Hoque, 2011). Thirty-five percent of all unplanned pregnancies take place before the age of 20 (Seutlwadi, Peltzer & Mchunu, 2012) which is the age of many university-going students. Also, according to the Department of Health (2012), STIs and HIV are highest amongst females aged 18–24 years. This often results in early child-rearing and an increase in university drop-out rates (Gama, 2008; Nibabe & Mgutshini, 2014). Hoque (2011) averred that some of these problems are caused by the fact that there are no programs designed to educate, promote and encourage safe sexual behaviours in many South African universities to address the myths and misconceptions about contraception.

Aims and Rationale

The study aimed to investigate myths and misconceptions held by black female students at the University of KwaZulu-Natal (Pietermaritzburg campus) and how these myths affect the effective use of contraceptives. Despite the increased accessibility and availability of different contraceptive methods, young South African women still experience early unplanned pregnancies and HIV and AIDS infections (Nibabe & Mgutshini, 2014; Russo et al., 2013; Teal & Romer, 2013). This study sought to explore black university (UKZN, Pietermaritzburg campus) students' understanding of contraceptive myths which might account for these statistics. The study also investigated the sources of myths that students might have about contraceptives.

Objectives of the Study

Following were the objectives of the study:

- To explore what myths and misconceptions black female students at UKZN hold about contraceptives.
- To explore origins of the contraceptive myths and misconceptions held by black female students (UKZN, Pietermaritzburg campus).
- To explore the possible role that these contraceptive myths have on the sexual behaviour of black female UKZN students.

Research Questions

- What myths and misconceptions are held by black female UKZN students regarding contraceptives?
- Where do the contraceptive myths and misconceptions held by black female UKZN students originate from?
- How do the contraceptive myths held by black female UKZN university students affect their sexual behaviour?

Delimitation of the Study

This study investigated contraceptive myths and misconceptions held by black female students at the University of KwaZulu-Natal, in the Pietermaritzburg Campus. In its scope, this study is thus limited to this campus. The study findings cannot be generalised to other settings and demographics.

Conclusion

This chapter presented a background into the study. The study aims and rationale were discussed. Objectives and relevant research questions for this study were also advanced in the course of this chapter. The next chapter presents literature review that was used and consulted for this study.

Chapter 2: Literature Review

Introduction

This chapter is a review of literature on sexual behaviours of university students, contraceptive use and contraceptive myths. It will also look at knowledge and attitudes of contraception within the South African context. It further considers the myths about contraceptives. There is also a critical discussion of social constructionism theory and its usefulness in understanding contraceptive myths and their effect on the sexual behaviours of black female university students at UKZN. Factors that can promote contraceptive use amongst women are also discussed.

Contraception Use and University Students

Tertiary education denotes a shift towards independence from home (Dominguez & Shields, 2008; Hoque, 2011; Nibabe & Mgutshini, 2014). The high levels of sexual activity and multiple sexual partners put university students at risk of STIs, unwanted pregnancies and HIV infections (Civic, 2011). Similarly, the consumption of alcohol and other drugs leads to careless and risky sexual behaviour, which increases the high levels of unplanned pregnancies and HIV infections (Civic, 2011). Contemporary research suggests that HIV, STIs and pregnancy rates are the highest and increasing amongst the youth of 15–24 years (Laher, Todd, Stibich, Phofa, Behane, Mohapi & Gray, 2009; van Staden & Badenhorst, 2009; Wood & Jewkes, 2006) and these ages are generally similar to the age group of many students in universities. Van Staden and Badenhorst (2009) argued that students worry more about pregnancy than contracting sexually transmitted diseases after they have engaged in unprotected sex. Research by Civic (2011) indicated that the regular use of contraceptives, especially male and female condoms, for sexual contact is extremely useful at dropping the spread and transmission of HIV and STDs. Interestingly, there has been a great increase in the use of contraception, however, a considerable percentage of sexually active undergraduate students still do not use contraceptives consistently; especially condoms (Civic, 2011).

Poor use or non-use of contraceptives can lead to many detrimental consequences for female students.

University Drop-out

The first consequence of not using contraceptives by university students is the likelihood of having to drop out of university. Some students come from very disadvantaged backgrounds. Some even come from child-headed homes. As a result, when students fall pregnant through poor use of contraception, they are forced to drop out so that they are able to take care of their children (Gama, 2008). Nibabe and Mgutshini (2014) argue that unwanted pregnancies jeopardise students' educational progress and future career prospects. Furthermore, Cornelissen's study that was conducted in 2005 avowed that "the negative impact of HIV/AIDS will result in students never reaching senior levels in the economic work sector; thus directly affecting efforts directed at addressing structural problems, including high levels of unemployment, skills shortages and high levels of income inequality" (as cited in van Staden & Badenhorst, 2009, p. 20).

Unplanned Pregnancy

The second consequence is pregnancy and early child-rearing. When students become parents at a very young age, their goals and dreams are delayed. This not only affects the student but the economy as well. Russo et al. (2013) argue that pregnancy has adverse effects on a young woman's SES, education, psychological and physical health. Also, these pregnancies, since they are mostly unplanned, lead to termination either legally or illegally (Nibabe & Mgutshini, 2014).

HIV and STIs Infections Rates Increase

The third consequence is health. Most studies indicate that when the youth fail to use contraceptives they expose themselves to many infections (Nibabe & Mgutshini, 2014; Russo et al., 2013; Teal & Romer, 2013; Wood & Jewkes, 2006). HIV/AIDS is also a result of unprotected sex that could, in addition, result from not using contraceptives. Sexually Transmitted Infections are also reportedly high at the time of HIV diagnosis (Protogerou, Flisher & Wild, 2014).

Termination of Pregnancy (TOP) and its Effects

The fourth consequence is having to terminate unplanned pregnancies and the effects thereof. As students engage in poor use of contraceptives, they end up falling pregnant. These pregnancies are often unplanned (Sebola, 2014). This results in termination of pregnancy which is sometimes performed illegally (Fergusson, Horwood & Ridder, 2006; Sebola, 2014). This does not only lead to emotional problems but health problems as well. TOP results in a lot of psychological distress due to traumatic experience that girls are often subjected to when having abortions (Fergusson, Horwood & Ridder, 2006). The prevalence of TOP has increased (Sebola, 2014), which means that frequency of births has decreased. This is also a clear indication that the failure of contraceptive use among young women leads to unwanted and unplanned pregnancies resulting in TOP.

Contraceptive Prevalence in the South African Context

Research (Nibabe & Mgutshini, 2014; Russo et al., 2013; Teal & Romer, 2013; Westley & Glasier, 2010) indicates that many young South Africans involve themselves in risky sexual behaviours, which include early onset of unprotected sexual activities, often concurrent partners and poor use of condoms or any contraceptive method (Wood & Jewkes, 2006). The availability of contraceptives in South Africa has increased, however, early child-bearing and unplanned pregnancy levels are increasing (Nibabe & Mgutshini, 2014; Russo et al., 2013; Teal & Romer, 2013; Westley & Glasier, 2010). According to research by Wood and Jewkes (2006) 35% of women in South Africa experience pregnancy before the age of 20. About 75% of these reported pregnancies in South Africa are unintentional. The reported HIV prevalence in South Africa is 17.9% and people living with it are estimated to be 5.575 million (DOH, 2012). The World Contraceptive Use (2011) statistics report proposed that injectable contraception is the most commonly used method of contraceptive by females in South Africa, followed by male condoms. This seems to suggest that many people are preventing pregnancy but not HIV and STIs. Another study conducted by Laher et al. (2009) on HIV positive women and their utilisation of contraceptives found that these women preferred to use condoms because they had no known side effects, yet their partners would resist using them. This means that preference does not determine use.

Typology, Uses and Availability of Contraceptives in South Africa

The Nature of Contraception

The different kinds of contraceptive methods that are available in South Africa include the following: hormonal, barrier, behavioural, and natural methods.

Modern Methods of Contraception

According to Ronald and Burkman (2007), contraceptives can be classified in two ways: the barrier methods and the hormonal methods. However, there are also behavioural and tubal methods. Hormonal methods, more than any other method, are often associated with a number of myths and misconceptions. Nonetheless, fewer myths and misconceptions are associated with the use of barrier methods. Having knowledge of different methods and how they work has been proven to affect contraceptive choices and use.

Barrier Methods

Barrier methods can be described as methods that prevent sperm from entering the vagina. These are methods associated with myths of limiting pleasure (Black et al., 2015). Most people report that they do not experience the same feeling when wearing a condom. Some also report issues of erection loss when they put on the condom (Black et al., 2015). For both male and female condoms and other barrier methods such as vaginal cap, there are always reports that they slip out (Black et al., 2015). Black et al. (2015) argue that another common myth about barrier methods is that there is a belief that they all protect users from STIs.

There are many different barrier methods which can be used by both females and males or by females only and males only. These include: spermicides, diaphragm, the vaginal cap and the sponge, female and male condoms (Ronald & Burkman, 2007). The diaphragm is implanted inside the vagina with an aim of preventing semen from coming into contact with the egg (Ronald & Burkman, 2007). It acts as a spermicidal barrier inside the cervical opening (Phelps et al., 2011). Similarly to the diaphragm, spermicides are gels, creams, or suppositories that kill semen. They are also inserted inside the woman's vagina before intercourse takes place and during intercourse they discharge chemicals that destroy sperm (Ronald & Burkman, 2007).

On the other hand, the vaginal sponge and cap are used to block semen from making contact with the egg (Ronald & Burkman, 2007). The vaginal cap – also known as cervical cap – is a bowl-shaped device. It functions in two ways: as a physical barrier of semen and a spermicidal barrier. The sponge works as a spermicide and it is circular in shape (Phelps et al., 2011). It can only be used once.

Male sterilisation – also known as a vasectomy – is a permanent method of family planning and has been used for years (Phelps et al., 2011). They prevent the release of sperm when a male ejaculates. Female sterilisation is a ligation blocking process during which the fallopian tubes are blocked with clips (Phelps et al., 2011). It is one of the most effective methods of family planning.

A condom is a thin cover made out of latex and natural animal membranes and worn before intercourse. It is used to prevent body fluids secreted during sexual intercourse from entering the cervix or vagina and coming into contact with the egg (Phelps, Murphy & Godfrey, 2011; Ronald & Burkman, 2007). They also reduce the risks of contracting HIV and STIs. Condoms are only used for each act of sexual intercourse (Phelps et al., 2011). The female condom, on the other hand, is a sheath that has a silicone-based lubricant, both inside and out, with a closed flexible ring (Phelps et al., 2011). Similar to male condoms, a sheath prevents semen from entering the cervix. As with male condoms, female condoms are only used once. The biggest myth around both male and female condoms is that they limit sexual pleasure and make noises.

Hormonal Methods

Hormonal methods of contraceptives can be described as chemicals that attack the sperm's body by killing it, reducing mobility and disrupting its activity (Ronald & Burkman, 2007). The most common myth around hormonal methods is that of weight gain (Outlook on Reproductive Health, 2015; Black et al., 2015). Fertility loss and delays are also associated with hormonal contraceptives (Black et al., 2015; Outlook on Reproductive Health, 2015). Black et al. (2015) argue that some women believe that certain kinds of hormonal contraceptives are ineffective.

There are also different methods of hormonal contraception. There are oral contraceptives like the pill that can be taken at the exact same time every day (Ronald & Burkman, 2007). These pills thicken the cervical mucus. There is also an emergency contraceptive pill (ECP) that is taken when one has had unprotected sexual activity, or there was a contraceptive failure or sexual assault or lack of knowledge about contraceptives (Nibabe & Mgutshini, 2014). This is otherwise known as the morning after pill (MAP). These pills can also be obtained over the counter in pharmacies. The MAP can also be used within 72 hours after unprotected sexual intercourse and it interferes with fertilisation and implantation of the foetus (Fasanu, Adekanie, Adeniji & Akindele, 2014; Phelps et al., 2011).

There are also injectable contraceptives that are taken daily at the same time (Ronald & Burkman, 2007). This form of contraceptive is administered either every second or third month depending on the decision an individual has made (Ronald & Burkman, 2007). Furthermore, hormonal contraceptives include implantable long-term progestins, like the patch which can last up to a week. It is placed on a woman's body, for example on the abdomen, upper outer arm, or buttocks.

Tubal and Implantable Methods

Tubal methods can be defined as permanent medical procedures used to prevent pregnancy whereas implantable methods can be defined as long-acting reversible methods that are inserted into a woman's body for a certain period of time (Ronald & Burkman, 2007). The common myth around tubal methods is that there will be menstrual disturbances after tubal ligation or implantation (Black et al., 2015). There is also a myth that they are not reversible (Black et al., 2015). With a vasectomy, it is suspected of causing prostate cancer and sexual dysfunction (Black et al., 2015).

There are also tubal contraceptives. In males it is called a vasectomy where the tubes are closed to prevent semen from entering the vagina, and in females the fallopian tubes are tied in order to prevent the semen from reaching the egg (Ronald & Burkman, 2007). There is also intrauterine contraception (IUC), also known as an intrauterine device (IUD). It is a long-acting reversible contraception that is implanted inside the vagina (Phelps et al., 2011). It is a small T-shaped device which, similar to the IUD, is an implantable rod.

There is also an implant worn underneath the skin. It can be worn either in the arm or in the thigh (Ronald & Burkman, 2007). The implant is a long-acting, reversible contraceptive method. It is a single rod the size of a matchstick and it can last up to three years. In addition to the aforementioned, a ring that produces spermicides can also be inserted inside the vagina (Ronald & Burkman, 2007). The vaginal ring is transparent in colour and it is aimed at inhibiting ovulation (Phelps et al., 2011). It is usually one size that fits most women.

Behavioural and Natural Methods of Contraceptives

The common myth around natural family planning is that it is the most effective and safest method to use. The home-grown methods of contraceptives have always been there and people are still using them, albeit not as widely as before (Ronald & Burkman, 2007). The first method is coitus interuptus, which is widely known as the withdrawal method (Ronald & Burkman, 2007). In this behavioural method, a man is expected to remove his penis just before ejaculation and it is still widely used by many couples. However, this method is very challenging and it cannot be safely trusted since it is a demanding and difficult method requiring a man to exercise self-control (Ronald & Burkman, 2007).

Another method is that of liquids that women believe can flush out semen from the vagina, known as a postcoital douche (Ronald & Burkman, 2007). It includes several womanly hygiene products, plain water and vinegar that are believed to clean out the semen from their vagina (Ronald & Burkman, 2007). According to Ronald and Burkman (2007), this method can be least trusted and it is very ineffective. In a study conducted by Wood and Jewkes (2006), women were also reported to be using some mixtures for family planning purposes.

Another method is that of concoctions or *imithi*. Black women also use traditional medicines from traditional healers (Wood & Jewkes, 2006). In their study, Wood and Jewkes (2006) discovered that young girls still use mixtures and traditional remedies as indigenous ways of birth control from their *sangomas* and traditional healers. Traditional remedies were considered to be popular and trusted by many young South African women and they view these mixtures safe for use (Wood & Jewkes, 2006).

Another method of contraception, known as lactation amenorrhea, is considered effective but this only occurs during breastfeeding. It is believed that women exhibit low levels of fertility during this period due to breastfeeding (Ronald & Burkman, 2007). Apart from this, there is also another method that looks at ovulation. This method is known as the rhythm or natural method where sex is often considered safe after menstruation because there is a release of an unfertilised egg in the form of blood (Ronald & Burkman, 2007).

Another method is fertility awareness also known as rhythm method. This method calculates the fertile days of a woman's menstrual calendar/cycle (Phelps et al., 2011). This method allows for the calculation of the menstrual cycle or paying attention to changes in the body, such as the presence of mucus and an increase in basal body temperature (Phelps et al., 2011). The couple often abstains from having sexual intercourse in the days where fertility might be high.

However, there has not been any research to prove if these methods are effective and are safe to be used by young women of reproductive age. The present study seeks to fill this gap by examining contraceptive myths: A qualitative study investigating contraceptive myths amongst Black female students at the University of KwaZulu-Natal.

Factors Promoting the Use of Contraception

There are many factors that can promote contraceptive use. These are: dissemination of knowledge, reproductive health information, women empowerment, training and re-educating health-care workers and increased availability and accessibility (DOH, 2012).

Most common contraceptive myths result from incorrect information. Students often lack fundamental reproductive health information. Increasing the knowledge of contraception in students will help overcome the myths they hold. Indongo (2008) stated that students need correct and accurate information on the concerns and consequences of unsafe sexual activities, in addition to being educated on developmental body changes, for example, menstruation and conception.

Training health-care workers, parents and educators is also important in promoting contraceptive use and dispelling the myths. Studies reveal that health-care workers, parents and teachers are often reluctant or unable to provide complete, effective, accurate, age appropriate reproductive health information to young women (Indongo, 2008; Wood & Jewkes, 2006). This is often caused by their uneasiness in conversing about sex and contraceptives or the false belief that providing the information will encourage young people to start engaging in sexual activity (Indongo, 2008; Karim, Magnani, Morgan & Bond, 2003). Consequently, most young girls find themselves in sexual relationships with no knowledge or very limited knowledge of the consequences, knowledge gleaned from friends or from the media. Indongo (2008) argued that there is substantial evidence that extending the variety of available contraceptive methods increases the use of contraception.

Many women find it difficult to discuss their sexual matters with key important adults, such as parents, with whom they can converse about their reproductive health issues and body developmental changes. Some students go to the extent of dating older men who make them feel inferior. This requires a more focused approach to empower young women. Most women indicate that it is usually their partners who decide on condom use (Protogerou et al., 2015). Russo et al. (2013) posited that counselling women is very important. They argue that women who are in abusive relationships or in relationships where they cannot negotiate, need to be counselled on LARC because their partners will not know that they are protecting themselves. Being assertive in a relationship is also very important. Students need skills to enable them to negotiate their sexual relationships (Indongo, 2008).

Increasing accessibility to and availability of contraceptives can also promote contraceptive use. Wood and Jewkes (2006) believe that these two factors play a major role (Wood and Jewkes, 2006). The provision of a variety of contraceptives allows individuals the opportunity to use a contraceptive method that aligns with their unique needs. Indongo (2008) argues that there is a correlation of high contraceptive use in places where access to a variety of methods is consistently high. Taking this into consideration, it may be useful to make more contraceptives readily available to university students to increase usage.

Availability of Contraceptives

Most research conducted indicates that there is high availability of contraceptives in South Africa (Nibabe & Mgutshini, 2014; Russo et al., 2013; Wood & Jewkes, 2006). There are both modern hormonal and barrier methods. Implants have been recently added to the list of available contraceptives in South Africa. There has also been an increase in the availability of contraception for lesbians, gays, bisexuals, transgender and intersexed people (LGBTI). All these methods are available in clinics, hospitals, and organisations such as Gays and Lesbians Network, Marie Stopes, and many others. They are all free of charge. It has also been noticed that the injectable contraceptive, the pill and the male condom are the most widely used methods of contraception in South Africa (World Contraceptive Use, 2011).

Contraception Knowledge and Education in the Youth Population

There is a lack of sufficient knowledge of contraceptives among university students. Previous studies indicate that young women appear to have very limited information about contraceptives (Teal & Romer, 2013; Wood & Jewkes, 2006). About 97% of sexually active South African women have some knowledge of at least one method of contraception (Seutlwadi, Peltzer & Mchunu, 2012).

An article by Teal and Romer (2013) reported that young adults have very limited information when it comes to long-acting reversible contraceptives (LARC). Some of these LARCs include the copper-T intrauterine device (IUD), the levonorgestrel intrauterine system (LNG-IUS) and the subdermal contraceptive implant (Teal & Romer, 2013). Furthermore, it has been found that despite knowing that condoms can prevent STIs and HIV transmission, there is still a low proportion of women reporting use of condoms (Laher et al., 2009). Also, most students have knowledge of contraceptives, but, knowledge of contraceptive methods has not been a determinant of consistent contraceptive use (Seutlwadi et al., 2012).

Contraceptive Myths and Misconceptions

Many previous studies conducted in South Africa indicate that there is widespread accessibility and availability of contraceptives, both in rural and urban areas, but that nonetheless, young women still fall pregnant and engage in unprotected sexual activity (Nibabe & Mgutshini,

2014; Russo et al., 2013; Teal & Romer, 2013; Westley & Glasier, 2010). Whenever the issue of contraceptives is presented, certain barriers to contraceptive use always emerge. Such barriers include attitude, knowledge, accessibility and availability. In addition to these barriers, myths and misconceptions often emerge preventing women from using contraceptives or having certain preferences over others (Russo et al., 2013). Black women hold different myths for short-term and long-term reversible contraceptives (Russo, et al., 2013). In addition, contraceptive myths have an influence on women when it comes to making contraceptive decisions. Below are some of the myths that women hold against contraceptives for both long-acting and short-acting contraceptives. As indicated earlier, some myths may look more like misconceptions. Also, myths are often accompanied by misconceptions.

There seems to be widespread knowledge of myths amongst young girls and less knowledge about the facts and truth about contraceptives and this is evidenced in a study by Wood and Jewkes, conducted in 2006. The study found that many young girls are misguided and have incorrect and vague medical information about contraceptives, which in turn affects the use of contraceptives based on these incorrect ideas (Wood & Jewkes, 2006).

In reporting the myths, misconceptions will also be reported as they are often intertwined. Below are the myths and misconceptions that have been reported in the literature.

***Myth*: *Loss of fertility* (*associated with Hormonal Methods*)**

In a study conducted by Shozi (2013), it was found that many university students started using contraceptives consistently once they had conceived their first child (Shozi, 2013). Literature (Gueye et al., 2015; PATH, 2015; Russo et al., 2013) suggested that some women believe that they will completely lose their fertility if they use contraceptives. They believe that contraceptives are responsible for infertility. Research conducted previously disproves this myth (Russo et al., 2013).

***Myth*: *Difficulties in conception* (*associated with Hormonal Methods*)**

Above and beyond loss of fertility, some women believe that using contraceptives makes it difficult to conceive when you want another baby (Russo et al., 2013; Shozi, 2013). The belief is that the womb will not be able to hold the baby. In a study conducted in the United States of

America, some students believed that some contraceptives, like intrauterine devices (IUDs) and hormonal contraceptives, cause difficulties in conception (Russo et al., 2013). The findings from the study conducted by Shozi (2013) revealed that students reported that hormonal contraceptives destroy fertility and they seemed to show more preference for condoms. This is a challenge as young women continue using less effective or ineffective contraceptives instead of the most effective ones because of the strong myths they have towards other contraceptives (PATH, 2015; Russo et al., 2013).

The fact is that after one has stopped using any form of contraception one's body returns to normal where hormones balance out again almost immediately (Marie Stopes, 2010). This is believed to take a little bit longer with injectable contraceptives (Marie Stopes, 2010; Gueye et al., 2015). Hormonal contraceptives like IUDs have been found to be effective even in women who have a history of ectopic pregnancies and nulliparous women (Phelps et al., 2011).

***Myth*: *Contraceptives cause the baby to drown in blood and ectopic pregnancies* (*associated with Hormonal Methods*)**

Some women believe that contraceptives are responsible for killing the baby once it has been conceived. This is because they have heard from friends that the injectable contraceptive stems menstrual blood flow resulting in no periods (Woods & Jewkes, 2006). Students from UKZN argued that the blood becomes blocked inside the womb causing the baby to drown in that blood (Shozi, 2013). Hormonal contraceptives are not responsible for an ectopic pregnancy (Russo et al., 2013). Russo et al. (2013) argue that if a woman develops an ectopic pregnancy while on contraceptives, chances are that that woman was prone to this type of pregnancy regardless of the contraceptive.

***Myth*: *Morning-after pill is abortion* (*associated with Hormonal Methods*)**

Women also believed that the morning after pill (MAP) is like an abortion pill (Fasanu, Adekanie, Adeniji & Akindele, 2014; Shozi, 2013). It was presumed that the MAP kills the baby because they believe that the sperm had already impregnated the egg and using a morning after pill is akin to abortion (Hamani et al., 2007; Shozi, 2013). This myth is a challenge because those who strongly believe in the immorality of abortion would rather be pregnant than live in the knowledge that they have aborted a baby by using the MAP (Hamani et al., 2007).

However, the emergency contraception impedes fertilisation of an egg, whereas abortion pills are used after fertilisation has taken place and are prescribed by professional practitioners who supervise the process.

***Myth*: *Contraceptives make women promiscuous* (*associated with Hormonal Methods*)**

In a study conducted by Gueye et al. (2015), they found that women associated contraceptives with promiscuity. This meant that after using contraceptives, women want to have sex more often.

***Myth*: *IUDs cause abortion* (*associated with Hormonal Methods*)**

IUDs are not commonly used in South Africa, especially amongs students; however, in a study conducted in the USA, it was found that much like the MAP, IUDs are also believed to cause abortions. Russo et al. (2013) argue that IUDs do not terminate pregnancy. They only prevent fertilisation. Also, the copper IUD does not harm the already formed foetus (Phelps et al., 2011). After using this method, there is a speedy return to fertility.

***Myth*: *Condoms cause diminished sexual enjoyment* (*associated with Barrier Methods*)**

Most women who have participated in contraception studies have reported that their partners say that condoms cause diminished sexual pleasure (Onyensoh, Govender & Tumbo, 2013). Research has found this to be false because condoms come in all forms of fits, textures, and thicknesses to enhance sensitivity (Marie Stopes, 2010).

***Myth*: *The pill is less effective* (*associated with Hormonal Methods*)**

The low frequent use of contraceptive pill is often associated with the myth that it is less reliable compared to other forms of contraception. The fact is that the pill is effective when it is taken correctly (Marie Stopes, 2010).

***Myth*: *Implants and IUDs cause cancer* (*associated with Hormonal Methods*)**

The nature of implants and IUDs requires one to insert them underneath the skin and in the vagina. Women perceive this as a health risk and that it might cause cancer. However, research

indicates that there is no causal relationship between these implants and cervical cancer (Russo et al., 2013). Research has found that women using the pill have a lower risk of having ovarian cancer than women who are not on contraceptives (Russo et al., 2013).

***Misconception*: *Contraceptives cause weight gain* (*associated with Hormonal Methods*)**

The most common justification for not using hormonal contraception is the misconception of weight gain. Most studies indicate that this is a common concern for most women (Russo et al., 2013; Shozi, 2013; Wood & Jewkes, 2006). Research indicates that weight gain is a side effect that is caused by circulating hormones and the experience of water retention in the body.

***Misconception*: *Contraceptives cause hair loss and skin conditions* (*associated with Hormonal Methods*)**

In a study conducted by Hamani et al. (2007) young women believed that continued use of contraceptives causes skin conditions and acne (Hamani et al., 2007). Research indicates that if one experiences such it is more likely evidence that the body is not responding well to the level of hormones (Marie Stopes, 2010).

***Misconception*: *Contraceptives cause menstrual irregularities* (*associated with Hormonal Methods*)**

In a study in South Africa conducted by Wood and Jewkes (2006), they found that most young girls complain about menstrual irregularities after they have started using contraceptives. Russo et al. (2013) argue that menstrual irregularities are the most common side effect that patients should be counselled about.

***Misconception*: *Implants and IUDs are painful* (*associated with Hormonal Methods*)**

Some women believe that after inserting implants or IUDs one experiences continuous pain caused by the presence of foreign objects in the body. Some women also show concerns of pain even during insertion (Russo et al., 2013).

Media and contraceptive myths

Knowledge remains to be an important obstacle in contraceptive use (Westley & Glasier, 2010). It seems that correct information is the only way to disprove myths.

Unfortunately, at present, the substantial misinformation that women have about pregnancy risks and contraception is being exacerbated by media coverage (Westley & Glasier, 2010). "Besides side effects, like nausea, heavy bleeding and cramps, regular use of emergency contraception may cause infertility and in some instances increase the risk of cancer," stated one BBC story on emergency contraceptive pills in Kenya (Westley & Glasier, 2010, p. 243).

Another example of how media can be misleading and promoting myths about contraceptives: "EC [emergency contraceptives] come with an increased risk for things like blood clots and hormone-related cancers, like many traditional forms of birth control," stated one of the mainstream newspapers in the USA (Westley & Glasier, 2010, p. 243). All these statements are incorrect but are regrettably widespread. This is very alarming for the student population that is widely exposed to the media and the internet.

The role of the media today cannot go unnoticed by public health and medical professionals. Health-care providers need to take active and positive measures to correct these myths and misconceptions among students. They need to be ever ready with facts about contraceptives (Westley & Glasier, 2010). More campaigns are required. There is also a need for accurate media coverage (Westley & Glasier, 2010). This is believed to play a huge and crucial role in dissemination of news about healthy behaviours, health risks and dissemination of information in general. Many studies have been conducted to prove the safety of contraceptives (Westley & Glasier, 2010).

Myths, gender dynamics in relationships and contraceptive non-use

It is also important to locate the myths and contraceptive non-use within the romantic relationships and the cultural settings in which they occur. Unequal distribution of power affects the sexual behaviours of parties involved (van Staden & Badenhorst, 2009). Furthermore, gender-based violence and inequalities are important in determining women's risk of contracting HIV (van Staden & Badenhorst, 2009). Van Staden and Badenhorst (2009)

argue that male and female roles are the result of the culture and society to which they belong and males are usually regarded as superior, with women being considered their subordinates.

"Not only does male dominance influence the sexual behaviour of female students and place them at risk, but cultural practices such as male students' view of perceived masculinity, condom use, myths and expectations based on financial status also increase male students' own risk for HIV infection" (van Staden & Badenhorst, 2009, p. 19). Women are also pressured to prove their fertility before getting married because there is a common held belief that men do not want to marry infertile women.

Male dominance plays a major role in perpetuating contraceptive myths. In a study that was conducted in Soweto on HIV positive women, women reported that their partners believe that contraceptives cause promiscuity because of vaginal wetness (Laher et al., 2009). This results in women not using safer methods because they fear their partners.

Religious beliefs and contraceptive myths

Contraceptive use has not only been hindered by whether they are available or not; there is an identified relationship between religion and contraception that has been documented (Olugbenga-Bello, Abodunrin & Adeomi, 2011; Romo, Berenson & Wu, 2004). Religion is recognised as a very important determinant of contraceptive usage (Olugbenga-Bello, Abodunrin & Adeomi, 2011). Similarly, moral beliefs affect contraceptive use (Romo et al., 2004). In a study conducted in Latino women, it was found that some women do not use contraceptives because they hold certain myths about them, such as, they believe that they cause abortion (Romo et al., 2004). Religious and moral beliefs inhibit the use of contraceptives in some women (Romo et al., 2004).

Barriers to the use of contraceptives

Apart from contraceptive myths and misconceptions in South Africa, there are many other factors that influence contraceptive use in women. The National Contraception and Fertility Planning Policy and Service Delivery Guidelines from the Department of Health (2012) list some of the factors that impede women from using contraceptives. Also, in studies conducted

by Akintade, Pengpid and Peltzer (2011) on undergraduate students in Gauteng, and Coetzee and Ngunyulu (2015), they pointed out some barriers to contraceptive use affecting students.

Students' socio-economic status has been found to be a barrier. This suggests that women in disadvantaged backgrounds still have poor or limited knowledge of contraceptives (DOH, 2012; Wood & Jewkes, 2006). Burgard (2004) argued that women in rural areas were only exposed to injectable contraceptives which limited their knowledge of the range of contraceptives available. Also, women's educational levels play a considerable role in the use of contraceptives. The DOH (2012) found that less educated women indicate poor use of contraceptives. Contraceptive statistics indicate that educated women who have some form of tertiary education, about 75% of these women use contraceptives compared to women who do not (DOH, 2012).

Another factor is that of family, partners and expectations on the issues of fertility. This comprises, for example, pressure on young women to validate their love for their partners by demonstrating their productiveness or fertility by childrearing, discussions around condoms and contraceptive use between partners, and familial expectations for women to have children (DOH, 2012; Protogerou et al., 2015; Russo et al., 2013; Wood & Jewkes, 2006). The burden to prevent conceiving babies in young African women influences the use of contraceptives (Wood & Jewkes, 2006). Family members such as mothers and aunts, for example, influence young women to use contraceptives.

Moreover, many students do not have sufficient information as to how conception takes place (Akintade, et al., 2011; Coetzee & Ngunyulu, 2015). There is also evidence in previous studies where women fall pregnant first and afterwards they realise they are not ready to have more babies; only then do they start using contraceptives. Furthermore, in one study, it was found that one reason for incorrect and ineffective use of Emergency Contraceptive Pills (ECPs) is the unclear interpretation of fertility, contraception and pregnancy risks, a problem prevalent in both developed and developing countries (Westley & Gracier, 2010). "In France, a survey of women seeking abortion indicated that more than half were unaware of their pregnancy risk at the time that they became pregnant or could not identify the specific act of intercourse that led to the pregnancy; only a minority of women used emergency contraceptive pills" (Westley & Gracier, 2010, p. 1). There is also poor knowledge of contraceptives. DOH (2012) stated that

women have some knowledge about family planning, however, they have very limited knowledge on the range of contraceptives available to them. In a study of South African students by Coetzee and Ngunyulu (2015), knowledge and awareness were also found to be problematic. Burgard (2004) argues that most African women know about injectable contraceptives because that is what they were exposed to, even during the apartheid era. Furthermore, women are aware of the various available methods, unfortunately, knowledge of how these methods work is often limited. In addition, there are often problems with services. Research indicates that service providers have a major role in encouraging or discouraging contraceptive use amongst sexually active women (Wood & Jewkes, 2006). Nevertheless, this is not the only issue; the settings from which students originate also affect their contraceptive use. Majority of students come from poorly-resourced areas where contraceptive availability is limited. That is why Prata (2009, p. 3093) indicated that "Family planning programmes in resource-poor settings are usually fragile, show signs of poor performance and are both dependent on international funding and constrained by existing policies or lack thereof. However, it is exactly in those settings where family planning programmes are most needed if countries aim to reduce inequalities in health, reduce maternal and child mortality rates, alleviate poverty and foster economic development".

Less conversant of health-care providers is another problem. Health-care providers do not provide young women with information about different contraceptives and their attendant disadvantages and advantages. A study conducted by Wood and Jewkes (2006) found that even health-care providers provide youth with very vague to no information at all about contraceptives. Furthermore, health facilities, particularly community clinics, are often viewed by young women as user-unfriendly as most of them lack significant confidentiality and privacy (Indongo, 2008). Russo et al. (2013) argued that most of the problems faced in contraception can be addressed by proper counselling of patients.

Another problem is that of perceived intimacy. Civic (2011) and Protogerou et al. (2014) found that if one has been dating long-term, there is usually a decrease in contraceptive use because of the perceived intimacy and trust that has developed. Also, women feel that discussing condom use with their sexual partners may be construed as a lack of trust in them (Protogerou et al., 2014). Another factor contributing to contraceptive non-use, especially condom use, is the perception that one is at low risk of HIV/STD (Civic, 2011). According to van Staden and

Badenhorst (2009), condom and contraceptive non-use are also dependent on how males perceive the relationship (male dominance). Van Staden and Badenhorst (2009) reported that males have two groups of partners: those with long-term faithful women partners, and casual sexual partners. Regularly, men prefer not to use condoms or any other form of contraception with their long-term partners, but when engaging in sexual activity with their casual partners they would use contraceptives.

Accessibility of contraceptives can at times be stressful for young women. Accessibility of contraceptives has been increased, with women being able to access contraceptives from clinics, hospitals and even shops; however, there are still problems in accessing contraceptives. Sometimes they would want to use certain kinds only to find that they are not available. Also, women complain about the embarrassment and judgement they experience when accessing contraceptives (Civic, 2011).

Yet another concern with contraceptive use for sexually active students, is poor compliance with contraceptives (Hamani, Sciaki-Tamir, Deri-Hasid, Miller-Pogrund, Milwidsky & Haimov-Kochman, 2007). Poor compliance may be a result of myths about contraceptives and personal fears and perceptions (Hamani et al., 2007). Hamani et al. (2007) suggested that misconceptions and incorrect beliefs may prevent its wide use among youth and lead to discontinuation and increased risk of unwanted pregnancies.

The Theoretical Framework: Social Constructionism

Social constructionism theory is the theory that has been chosen for this study. Social constructionism focuses on the reality being socially constructed (Berger & Luckman, 1991; Galbin, 2014). This theory emphasises that much of human life is the way it is because of social and interpersonal interactions (Galbin, 2014).

Social constructionism theory suggests that all realities are socially constructed and these realities are founded through the use of language (Galbin, 2014; Stam, 2001). This knowledge that is constructed is sustained through interaction and social processes. In this study, this could be expressed in the interactions that young women have about contraceptives whereby they share and pass on information, oftentimes incorrect information, about contraceptives. The

social constructionism theory has less focus on individual processes in constructing realities; rather, it is interested in social interactions (Andrews, 2012). The assumption of this theory is important in this study as it is in agreement with the literature which states that women mostly learn about contraceptives from their friends and those around them (Eram, 2017; Woods and Jewkes, 2006).

Galbin (2014, p. 83) argues that "social constructionism involves challenging most of our common sense knowledge of ourselves and the world we live in. This means that it does not just offer a new analysis of topics such as 'personality' or 'attitudes' which can simply be slotted into our existing framework of understanding". Often social constructionism is referred to as a tag representing a chain of positions in society (Galbin, 2014). The theory also postulates that the mind of an individual signifies the reflection of reality (Galbin, 2014). The constructionist sees the world through the lens of historical interaction and communication between groups of people.

There is a fair amount of literature looking at gender constructions and these cannot be ignored when discussing the use of contraception because gender roles are socially constructed. Maharaj (2001, p. 254) averred that "numerous studies report that culturally defined gender roles, which reinforce male dominance and female submissiveness, influence sexual and reproductive decision-making and significantly limit communication between partners on sexual matters". This is another way of looking at sexual behaviour as promoted by gender roles. Also, the importance of fertility in women is promoted by the use of myths to instil fear in young women.

It is also important to look at what the reality and knowledge of contraceptives are in South Africa. The reality is that contraception has been made available for people, but still women experience unplanned pregnancies, HIV and STIs. All these could result from the knowledge they have about contraception, which may be correct based on social interactions regarding contraception. Looking at the knowledge of contraception, it is clearly flawed as women continue engaging in unsafe sexual practices based on the unfounded beliefs about contraception.

Meaning and power are the main focus of this theory (Galbin, 2014). According to social constructionism theory, meaning is believed to be constructed through the use of cultural frames of social, linguistic, discursive and symbolic practices (Cojocaru & Bragaru, 2012 in Galbin, 2014). Galbin (2014, p. 84) argued that "persons and groups interacting together in a social system form, over time, concepts or mental representations of each other's actions. These concepts eventually become habituated into reciprocal roles played by the actors in relation to each other". Gender roles and how they are constructed is a good example of the reciprocal roles. Men often have the advantage of masculinity and power over women (Chikovore, 2004), which affects the effectiveness of contraceptive use. This reciprocal role extends to friends. Wood and Jewkes (2006) stated that women find out about contraceptives from their friends and the information they receive is often incorrect, which indicates that have habituated it and they share it with friends as being correct information.

Furthermore, in relationships, women feel that they have a duty to keep their men and boyfriends happy. Women report that when their male partners talk negatively about contraceptives, for example, a case where contraceptives are seen to be promoting promiscuity, women tend to stop using them or hide them from their partners (Laher et al., 2009). These roles can be viewed as part of interactionism. Each member of society enters into a role and these roles become reciprocal interactions that are institutionalised. In the institutionalisation process, meaning is entrenched in society (Galbin, 2014). Knowledge and people's conception (and belief) of what reality is, becomes embedded in the institutional fabric of society (Berger & Luckman, 1996, pp. 75–77, in Galbin, 2014, p. 84). In all these processes, language plays a role in connecting people (Galbin, 2014). The social constructionism theory thus tends to focus on social interactions rather than individual persons (Galbin, 2014).

Viewing this problem of poor contraceptive use amongst university students using the social constructionist theory, one needs to look at the way female students position themselves in the discussions about the use of contraceptives. The social constructionism posits that individuals construct their own realities (Galbin, 2014). Young women are more concerned about falling pregnant than contracting HIV and STIs because they do not think they can contract HIV; this eventuality is relegated to other people who are not their peers. Van Staden and Badenhorst (2009) call this process 'othering'. This is the reality that they have created for themselves. In addition, examining the contraceptive myths through constructionist lenses shows that the

myths have become part of their reality. The correct and accurate information about contraceptives has been made available through credible internet resources and health-care clinics but still students believe that their myths are true. These strong beliefs about myths are achieved using language through shared understandings and meanings (Galbin, 2014; Stam, 2001). Research reveals that knowledge of contraceptives does not ensure the use of contraceptives. This proves what the constructionist theory states about realities. The realities that they have created make young women ignorant about risky behaviours.

As Berger and Luckmann (1991) argue, in society there are objective and subjective realities, with the former being formed in social interactions of people with the social world. Andrews (2012) argued that the social world ends up influencing people in what they term as 'routinisation' and 'habitualization'. In other words, the actions are repeated frequently and lead to patterns which get repeated without effort (Andrews, 2010). According to Andrews (2012), people become less innovative and creative as they are hesitant to start something new. In the topic of contraception, people become embedded in beliefs and myths about contraception, which makes these beliefs their source of knowledge. Subsequently, the knowledge one has, whether correct or incorrect, gets passed on from generation to generation and re-affirmed in social interactions. Burgard (2004) argues that black women were provided with no information about contraception during the apartheid era, which means that for generations the information they have been passing on to others is what they have created themselves in their interactions with each other.

Furthermore, the poor contraceptive use of young women is also influenced by male dominance. The society has constructed men as dominant and women as subordinate. This, for women, has become part of their daily lives. They live to be submissive and obedient to their men. These dynamics and meanings are also constructed by societies. In a study conducted by Deacon (2010), where the focus was on condom use or non-use, the study revealed that the discourses about sexual relationships offer the subjects a position through which they are able to make sense of their actions and lives (Deacon, 2010). The myths that young women have about contraceptives, also depended on the positions through which they have created. For example, in African communities, fertility has been created as something important and thus women tend to believe the positions of contraceptive information as being risky or threatening

to their fertility. Chikovore (2004) argues that when dealing with such matters, it is always important to consider the contexts in which they take place.

In conclusion, it is important to keep in mind that knowledge is concerned with the analysis of construction of reality and its significant role in society. This means that the knowledge students have, whether valid or invalid, is the one that will be used to construct reality. The question is, how do we deconstruct the misinformation and the myths they have about contraception?

Conclusion

The chapter outlined contraceptive use, knowledge and attitudes. In terms of use, this chapter noted that many students do not use condoms or make use of dual methods of contraception. University students also lack accurate and complete information which results in them developing myths about certain contraceptives. The social constructionism theory was also discussed as the theoretical framework for this study.

Chapter 3: Methodology

Introduction

This methodology chapter discusses the research design, the recruitment process for participants, sampling method used, data collection and processing methods used, and the data analysis method that was adopted in this study.

Research Design

This study was aimed at exploring the contraceptive myths held by black university students and their sexual behaviour. To this end, a qualitative research design was adopted in this study.

Qualitative research is primarily exploratory in nature and it is used in gaining essential underlying opinions and details about human subjects (Babbie & Mouton, 2005). It also has a great interest in studying human experiences (Babbie & Mouton, 2005). In qualitative studies, the researcher becomes the principal instrument of the research (Babbie & Mouton, 2005). One of the strengths of qualitative research is that it is able to provide explanations of how people see or view a given topic or phenomena (Mack, Woodsong, MacQueen, Guest & Namey, 2005). This research design further allows for the identification and exploration of imperceptible factors such as societal norms, ethnicity, gender roles, religion and socio-economic status and the roles that are not always apparent in research (Mack et al., 2005; Babbie & Mouton, 2005). It also allows for interpretation of complex realities.

The design that was adopted was an exploratory design. Exploratory research seeks to examine an area that has been under researched and the data gathered helps inform the direction of future research as it serves as preliminary data (Durrheim, 2008; Mack et al., 2005). The strengths of an exploratory design are that it uses a flexible, open and inductive approach in coming up with new insights (Durrheim, 2008).

The researcher chose to adopt this method because it was viewed as helpful in accessing the female students' experiences in relation to their contraceptive knowledge, myths and use. This study chose to employ this approach because it allowed the researcher to explore and

investigate the personal experiences, beliefs and opinions regarding the contraceptive myths held by female UKZN students.

Sampling

Purposive sampling was the sampling method used in this study because of its strengths. Purposive sampling is a non-probability sampling method that is also known as a subjective or judgemental method (Durrheim, 2008). This means that it is a deliberate method where the researcher looks for particular characteristics in participants. It allows for participants to be selected based on the researcher's desired characteristics and whether they will be able to answer the research question based on their knowledge and experiences (Durrheim, 2008). This method is selective and subjective in nature and it is one of the widely used methods in qualitative research (Durrheim, 2008). The researcher looks for individuals who are well-informed about the phenomenon being studied. In this study the researcher targeted participants who would be able to answer the research questions which were about contraceptive myths, their sources and effects on effective contraceptive use and sexual behaviour. This sampling method was done by putting up posters on university notice boards (see appendix 9). Very few female students responded to this sampling method and procedure so a different sampling method was adopted – snowball sampling.

Snowball sampling is yet another type of purposive sampling (Mack et al., 2005; Durrheim, 2008). This method allows for participants who have been contacted and identified for the study, to refer the researcher to other potential participants who have the characteristics that the researcher is looking for (Mack et al., 2005; Durrheim, 2008). This method was used in this study because the researcher could not access the target population due to the sensitivity of the topic and the stigma associated with sexual behaviour.

Participants

The overall sample was 14 female students from the University of KwaZulu-Natal (Pietermaritzburg campus). Seven participants participated in individual interviews (see Table 1.2 below) and nine participated in a focus group (see Table 1.3 below). Two of the seven participants from the individual interviews also participated in the focus group discussion. They

were chosen based on their interest and voluntarism. Participants were placed in the focus group or individual interviews based on their availability.

The participants of this study were selected from black female students of the University of KwaZulu-Natal, Pietermaritzburg campus, whose characteristics matched those the researcher was looking for. The eligibility criteria for recruitment of participants were that the participants should be registered students at the University of KwaZulu-Natal. They also needed to be 18 years of age or older. The researcher decided to use black female students of any level of study because she wanted to find out if the contraceptive myths exist amongst the students population of any level. She also wanted to find out if high levels of unplanned pregnancy and early child-rearing amongst the black female population in general are a result of contraceptive myths amongst black students because HIV infections and pregnancies are high amongst young black females (Civic, 2011; Laher et al., 2009; Wood & Jewkes, 2006; van Staden & Badenhorst, 2009). The participants were extracted from a university context which, according to the literature review, appears to expose students to HIV/STI because of high risky behaviours where students engage in a variety of sexual risks such as experimentation and non-condom use (Protogerou et al., 2014). Non-condom use by students is attributed to environmental factors such as drug and substance use, lack of direct and present parental supervision, beliefs of invincibility, living in the moment, and emotional and attachment factors, particularly feelings of intimacy, love and trust (Protogerou et al., 2014). Prata (2009) argues that correct knowledge and accessibility of contraceptive methods fundamentally relates to the use of contraceptive. This becomes a challenge for the student population because they are often provided with vague and unclear information (Wood & Jewkes, 2006) and the health-care service providers are usually not welcoming. It was therefore important for the researcher to use participants who were from this context, who are inhabitants of this context, and who have better understanding of it. It was also convenient to use participants who were 18 years and older for this study because they are old enough to consent to participation in research without assistance or permission from parents and guardians. Furthermore, there are very limited studies studying contraceptive myths in the general student population.

Table 1 Individual Interviews Demographics

Participant	Sexually Active?	Baby?	Under/postgraduate	Focus Group (FG)/ Individual Interviews(II)
P1	Yes	Yes	Undergraduate	II
P2	Yes	No	Undergraduate	II
P3	No	No	Undergraduate	II
P4	No	No	Postgraduate	II
P5	Yes	No	Undergraduate	FG/II
P6	Yes	No	Undergraduate	FG/II
P7	Yes	Yes	Postgraduate	II

Table 2 Focus Group Interviews Demographics

Participant	Sexually Active?	Baby?	Under/postgraduate	Focus Group (FG)/ Individual Interviews(II)
P1	Yes	Yes	Undergraduate	FG
P2	Yes	Yes	Undergraduate	FG
P3	Yes	No	Undergraduate	FG
P4	Yes	No	Undergraduate	FG
P5	Yes	No	Undergraduate	FG
P6	Yes	No	Undergraduate	FG/II
P7	Yes	No	Undergraduate	FG/II
P8	No	No	Undergraduate	FG
P9	No	No	Undergraduate	FG

Data Collection

Registered black UKZN female students between the ages of 18 and 27 who consented to participation qualified for this study. Being sexually active was not a requirement. The important requirement was that each participant had to be a female student at UKZN with some knowledge of contraceptives. This is because knowledge of contraceptives is a significant determinant of access to and use of proper contraception in a timely and effective way (Somba, Mbonile, Obure & Mahande, 2014). A focus group discussion and seven individual interviews were the methods used to collect data. The details of each method used will be discussed below:

Focus Group Discussions

A focus group was used in this study because Kelly (2008) argues that it allows the researcher to explore the discussion of beliefs, attitudes and opinions about the formal questions presented by the researcher. A focus group discussion was also important for this study because it is a useful method of collecting data in exploratory studies due to its flexibility and richness (Kelly, 2008). The formation of a focus group includes a small number of participants the researcher found to be relevant to the study and each participant is carefully chosen (Kelly, 2008). It is a good method of examining social interactions, perceptions, beliefs and shared representations of a phenomenon (Kelly, 2008). A focus group was used to explore what myths and misconceptions black UKZN female students have regarding contraceptives and how these myths affect their sexual behaviour.

The focus group discussion of this study was held at the Psychology Building, in a research laboratory at UKZN, on the Pietermaritzburg Campus. This venue was used because it ensured that no disruption would take place during the discussion and confidentiality was assured throughout. The building also allowed for the recording of the interviews with ease. Nine participants participated in the focus group discussion.

The researcher welcomed all participants and handed out the information sheet to each participant (see Appendix 1). After the participants had studied the information sheet, they were handed informed consent forms that the researcher requested them to read and sign (see Appendix 2a) if they agreed with its terms. They were also requested to sign a confidentiality

pledge (see Appendix 3) which would ensure that what was discussed remained confidential. The focus group discussion lasted approximately one hour and 30 minutes.

Individual Interviews

Individual interviews are an interactional exchange of words between the researcher and participants (Kelly, 2008). Kelly (2008) argues that interviews allow for collecting data on sensitive topics, experiences, personal histories and perspectives. The researcher chose to use individual interviews because they allow for detailed discussion of the person's experiences that the participant may have found difficult to discuss in a group context. The questions used in these interviews were compiled by the researcher based on literature and the issues of contraception in the South African context (see Appendix 8a & 8b).

At the beginning of each interview, the researcher gave participants an information sheet which contained the research aims, the research process and what was expected from participants (see Appendix 1). The researcher ensured participants that confidentiality would be retained throughout the process. Also, it was also clearly explained to participants that the study was voluntary and that they could withdraw at any time should they wish to do so. After participants had read their information sheet and understood all that was involved, they were asked to sign an informed consent form agreeing to participate in the study (see Appendix 2b) and to have the interview audio recorded. Participants were also asked to sign a consent form for audio-recording. The researcher then ensured participants that the data gathered would only be accessible to the researcher and the researcher's supervisor and would also be kept in a safe place inside the supervisor's office. The individual interviews were approximately 35 minutes long. The interviews were conducted in Library Discussion Rooms at the University of KwaZulu-Natal.

Data Processing

After data collection, the researcher had to format recorded data into a format that could be analysed (Braun & Clarke, 2006). This process meant that the researcher had to transcribe recorded data – which was spoken – into the written word (Braun & Clarke, 2006). Transcribing verbatim involves capturing sounds, words and non-verbal communication, such

as crying and laughing (Bailey, 2008). Verbatim transcription is a method of managing data and it is important in the analysis and interpretation of the verbal data (Bailey, 2008). It was used because the researcher wanted to extract a full and rich record of the interviews for analysis. The researcher used pseudonyms. In a further effort to protect the identity of participants, the researcher changed the name of places and people that appeared in the data.

Data Analysis

This study used thematic analysis to analyse data. Thematic analysis is a qualitative analytic method that involves descriptive and interpretive methods of explicit and implicit themes (Creswell, 1998). Explicit themes include those that are stated clearly and in detail, whereas implicit themes include those that are implied through discussions and behaviour (Creswell, 1998; Braun & Clarke, 2006). The descriptive method is used when a researcher is interested in describing a phenomenon, whereas an interpretive method is used when a researcher asks for a meaning to the phenomenon (Creswell, 1998). According to Braun and Clarke (2006), thematic analysis is a method used to identify, report patterns or themes, and analyse themes found in the data. Braun and Clarke (2006) argue that this method of analysis, compared to discourse analysis and other qualitative research methods, is the most flexible method as it employs several methods of analysis. It further allows for possible exploration of other issues/topics to study within the current dataset (Braun & Clarke, 2006). This method is based on grounded theory which looks at the generation of theory in a particular setting in relation to the phenomenon being researched (Addison, 1992). Braun and Clarke (2006) argue that a theme focuses on something very important about the data in relation to the topic being researched. It also characterises some form of patterned or repeated answers and responses within the dataset. Thematic analysis is made up of five steps, all of which were adopted in this research (Braun & Clarke, 2006). A step-by-step process of thematic analysis as described by Braun & Clarke (2006) was followed by the researcher.

The first step of analysis was familiarisation with the data collected by the researcher. Whilst the researcher was transcribing data from the audio-recording, familiarisation process was taking place as the researcher had to revisit and re-read data to extract initial ideas and note them down. Generating initial codes and reducing data was the second step. Data reduction is a process which is a form of analysis that sorts, focuses and organises and discards data for

analysis (Braun & Clarke, 2006; Cresswell, 1998). In this process, the researcher searched for related codes and grouped them all together by using highlighters of different colours. The researcher also kept a codebook. After reducing data, the third step was to identify themes. In this step the researcher looked at the themes already gathered to see if they matched the codes identified in the previous step. This step involved comparing and contrasting themes and identifying structure among them.

Connecting themes with the literature review was the fourth step. This step involved analysing themes. Each theme had to be given a meaning. The fifth step involved checking for congruency between themes and literature. The researcher had to carefully define each theme and the meaning each theme entailed. The last step required the researcher to produce results which included careful consideration of all themes and how they related to one another. This analytic phase then informed the findings of this study.

Adopting a thematic analysis approach for this study was compatible with the aims and rationale of this research. It permitted the researcher to investigate the knowledge that participants have about contraceptive myths and the effects these have on sexual behaviour.

Validity, Reliability and Rigour/ Generalisability

Validity is a term often used in quantitative research to check for the quality of research. In qualitative research it is referred to as credibility. Credibility looks at where the research findings reflect what is happening in a particular context (Krefting, 2010). Ensuring credibility is very significant as qualitative research is about human subjects, their views and opinions, and their experiences (Krefting, 2010). Credibility was increased through triangulation, which is mainly about data verification. Two methods of data collection were adopted in this study, being a focus group discussion and individual interviews. The researcher further ensured credibility by adopting reliable qualitative research methods which would render the findings credible. Thematic data analysis was used which is a qualitative data analysis method. The researcher also made use of other similar studies for checking congruencies and knowledge generated, which also helped to increase credibility. There was also a constant examination of diverging data to verify if it still answered the research questions.

Dependability refers to the reliability of the research study and is part of the positivist model (Durrheim & Painter, 2008). Dependability looks at the consistency of results if the study is repeated by different researchers on different occasions using the same sample (Durrheim & Painter, 2008). The researcher ensured *dependability* in that she used all standards of good qualitative research (Durrheim & Painter, 2008). The researcher also used the same questions for all participants (Durrheim & Painter, 2008). Dependability was ensured by using different data collection methods, i.e. individual interviews and a focus group discussion (Durrheim & Painter, 2008). The researcher also individually interviewed some of the participants who had participated in the focus group discussion to observe their behaviour when alone with the researcher. Sampling bias was further minimised by adopting purposive sampling.

Confirmability is also important in ensuring the quality of qualitative research. It is also known as neutrality or objectivity of research. It focuses on the accuracy and truth value of research (Golafshani, 2003). Its key emphasis is that research findings should limit researcher bias and be about participants, their experiences and views (Krefting, 2010). A detailed methodological description of all the steps and processes of research was put in place in order to guide the researcher. The use of triangulation in this study also increased credibility which in turn increased confirmability. The researcher had to constantly visit theories, literature and data to ensure that what was planned was what was adhered to in conducting this research.

Transferability looks at the applicability of research findings in other settings (Golafshani, 2003). Qualitative research often uses a small number of research participants, however, this does not necessarily mean that transferability is not attainable. Although this study consisted of a small number of participants, 14 in total, the study findings may still be transferable to other contexts such as other universities with black female students similar to the participants in this study.

Ethical Considerations

There have always been issues around ethics in research involving human subjects, in both the public and private sectors (Kroll, 1993; Wassenaar, 2008). Previously, there were no ethical principles safeguarding the wellbeing of human subjects and research was conducted according to the subjective judgment of researchers (Kroll, 1993). The value of research was considered

more important than the dignity, welfare and life of human subjects (Kroll, 1993; Wassenaar, 2008). The brutality that was committed by Nazi medical researchers on human subjects during World War II led to the formulation of the Nuremberg Code (Wassenaar, 2008). In this Code important emphasis was placed on informed consent in all research involving human participants in order to prevent further brutality and exploitation of research participants (Kroll, 1993; Wassenaar, 2008). There was then an emphasis that research should not take precedence over the dignity and welfare of participants (Wassenaar, 2008).

There are eight ethical principles that all researchers should adhere to when conducting research with human subjects. The ethical principles as highlighted by Emanuel, Wendler and Grady (2000) and Wassenaar (2008) were all followed in this research.

The first principle is collaborative partnership. This principle emphasises the importance of research being designed in collaboration with the community or population studied (Emanuel et al., 2000; Wassenaar, 2008). There must be a community need first before research is conducted and researchers need to be sensitive to the beliefs, culture, values and traditions of that community (Wassenaar, 2008). Furthermore, the research should benefit the community. In this study, the community is the female university student body. This research will add significant knowledge in understanding another possible cause of the problem.

The second principle is social value which stresses the importance of research addressing questions that are of social value (Emanuel et al., 2000; Wassenaar, 2008). Research should also benefit participants directly or indirectly (Wassenaar, 2008). This research was deemed to add social value to knowledge and health of students, female students in particular. It will also add to increased understanding of contraceptive myths and how they affect contraceptive use and sexual behaviour

The third principle is scientific validity. This principle states that the methods used in research should be justifiable, rigorous and feasible, leading to valid research answers (Emanuel et al., 2000; Wassenaar, 2008). This research followed qualitative research methods to answer the research questions. It is an exploratory study which made use of a focus group discussion and individual interviews to increase the credibility of results.

The fourth principle is fairness in selection of participants. There was fair selection of participants by using voluntarism and adhering to the qualitative selection methods. Purposive, convenience and snowball sampling methods were used because the topic was sensitive and it was difficult to locate participants. In addition, the researcher made use of participants who were all students at UKZN, Pietermaritzburg Campus.

The fifth principle is favourable risk/benefit ratio which looks at possible harms, risks and costs to participants caused by the research (Wassenaar, 2008). Potential risks to participants were not foreseen, however, the researcher had an agreement with the Child and Family Centre to refer participants there for counselling should they experience any emotional difficulties during the interviews (see Appendix 5).

The sixth principle is independent ethical review. This principle involves reviewing research for any potential harm to participants before the research is conducted. It involves looking at whether all the ethical guidelines were followed in the proposed research. Ethical clearance was obtained from UKZN's Ethics Committee and permission to conduct this research at UKZN PMB was obtained from the Registrar.

The seventh principle is informed consent. This involves giving participants appropriate information (Wassenaar, 2008). Participants need to be able to understand what is written in the consent form. They must volunteer to participate and understand that they can withdraw at any time from the research should they wish to (Kroll, 1993; Wassenaar, 2008). All participants were given Participant Information Sheets (see Appendix 1) explaining what the study involved, access to results and findings, storage of data, the nature of voluntary participation, and use of pseudonyms to protect their identities. The consent form was written in English. The researcher went through each point of the information sheet with the participants to ensure they understood that participation was voluntary. All participants were above 18 and they could consent to participate in the study. Written informed consent from each student was obtained for participation in the study and for audio-recording of focus group discussions and interview sessions. All participants were treated with respect. The researcher maximised confidentiality by giving participants a confidentiality pledge (see Appendix 3) stating that all focus group discussions would remain within the group and this pledge was signed by each participant.

The last principle is ongoing respect for participants. This principle involves respecting participants during the study, including their confidential information. It also involves giving feedback on the research findings to the research community or study participants. Participant information was treated with caution and stored in a safe place. Pseudonyms were used and the data was locked in the research supervisor's office. The researcher took the participants' contact details to inform them about the research findings once the study was complete.

Conclusion

This qualitative study adopted an exploratory design. Purposive and snowballing sampling methods were used. The study made use of a focus group discussion and individual interviews. The data was audio-recorded, transcribed and translated for analysis. This study employed thematic analysis. Validity, reliability and rigour was increased by adopting qualitative methodologies of conducting research. All ethical principles were adhered to by the researcher as explained in the literature (Wassenaar, 2008; Emanuel et al., 2000). The next chapter will present the findings from this study.

Chapter 4: Findings

Introduction

This chapter presents the findings from the study both from the interviews and focus group discussions. Participants were all female students enrolled at the University of KwaZulu-Natal. FG represents focus group participants whereas II represents individual interviews. **Table 3** below represents the summary of themes that will be discussed in detail in this chapter.

TABLE 3: TABLE OF FINDINGS

Themes	**Sub-themes**
Theme 1: Contraceptive Myths and Misconceptions	Myths associated with hormonal methods of contraception Myths associated with barrier methods of contraception
Theme 2: Sources and Knowledge of Contraceptive Information	Knowledge gained from schools Knowledge gained from the media Knowledge gained from parents Knowledge gained from friends
Theme 3: The Effect of Sources in Contraceptive Choices and Uses	Effects of contraceptive myths
Theme 4: Other Factors Affecting Contraceptive Use	Partners' role in contraceptive use Keeping partners happy Stigmas associated with contraceptive use Church and contraception Counselling messages between participants and nurses Enablers of contraceptive use Barriers to contraceptive use

Themes:

Theme 1: *Contraceptive Myths and Misconceptions*

Several myths and misconceptions were found to be associated with different types of contraception methods. Myths and misconceptions are presented below:

Myths associated with hormonal methods of contraception: Several study participants believed that the hormonal methods of contraception have multiple negative effects on their bodies. The quotations below capture this:

> *II-P2*: *Also that when you use injection*, *your body becomes loose and not tight and even down there*, *like in your vagina*, *it becomes loose in that your men doesn't enjoy you*.
>
> *FG-P5*: *They also say that you have a loose body*.
>
> *II-P7*: *My friend told me that you also leak…like you become too wet down there you know…the kind of wetness that is a turn off*.
>
> *FG-P5*: *It* (*contraceptive*) *makes you wet in your private part*.
>
> *II-P2*: *Oh ya one more it is this thing that you might not have children when you are using contraceptives*.
>
> *FG-P5*: *You may not have children again because it kills your fertility as it prevents you from conceiving*.

Participants also believed that hormonal contraceptives, such as implants, "moves" in your body and it is not effective. They also felt that by using contraceptives after sexual intercourse, one is killing the baby that is already formed. The following excerpts capture this:

FG-P1: *No some say it moves*, *it doesn't stay in one place*. *And as a result when you want to take it out after 3 years*, *you won't find it inside your skin*. *And it causes a damage*.

FG-P9: *Yes it moves and you never find it again*.

FG-P5: *People say that contraceptives are bad because they kill the baby that is already formed*. *They also say that you get fat*. *Uhm yes*.

The bodily changes, especially vaginal looseness and wetness, were reported to be disliked by men during sexual intercourse. One participant had this to say:

FG-P7: *You see*, *these men don't like it when you are too wet*. *It's like he is drowning in water down there*. *They like it tough and hard*.

Additionally, the results revealed that men are said to believe that the changes are due to contraceptive promiscuity. Consequently, the participants reported that their partners discourage them from using hormonal contraceptives. One participant had this to say:

II-P7: *My boyfriend hates contraceptives because of these things*. *So I end up hiding that I am using injectable because if I were to tell him he would just say I don't feel you there*.

Another one supported this:

FG-P5: *These souls they will tell you that you are gaining weight*, *you should stop using injectables but they won't even give you a cent to buy morning-after pills*.

There were some reported positive myths about hormonal contraceptives. A few reported that they know of something positive about myths and it was mostly associated with beautiful skin. Participant 3 said:

FG-P3: *My high school teacher said when you using the injection, it makes you glow and beautiful. But it is mostly the negatives*.

Another participant had this to say:

II-P7: *My sister told me that one of the nurses told her that contraceptive pills can cure skin diseases*.

Myths associated with barrier methods of contraception: They were also myths for barrier methods such as condoms. The barrier method myths were mostly reported by male partners to their girlfriends. Following extracts speak to these myths:

II-P5: *He also told me that condoms are painful. I will bleed uhm yes*.

FG-P4: *Yes I know that boys tell you that you will be hurt and you will start bleeding if you use condoms*.

FG-P5: *Yes and sometimes men believe that uhm you know…sex with a condom is boring. You don't enjoy*.

II-P7: *uhm, yes because again I heard that condoms are painful and they make you not enjoy sex. So I really do not know at the moment*.

FG-P6: *Yes and they say condoms just make the penis not to be straight*.

FG-P4: *Hahahaha some men say that condoms are made for people with small dicks and people who are loaded Hahahaha tight them*.

II-P5: *Uhm it was my boyfriend. He told me that you don't break someone's virginity wearing condom because they will be injured. Ya and he also told me that you never enjoy sex with a condom. And that you don't get pregnant on your first day which is true*.

What was interesting to note was that even after participants were told by their boyfriends that it is impossible to break someone's virginity with a condom, they believed this to be true. This is what one participant had to say:

> *II-P7*: *He said he cannot sleep with me using a condom on my first time because it will hurt and he was right*. *It is really impossible because on your first it is like you are opening the chins*.

Participants also believed their boyfriends when they told them that one does not fall pregnant on their first day. There were also some reports which suggested that when condoms are not used from the onset of the relationship, it will be difficult to use them later in the relationship.

> *FG-P7*: *Sometimes even with condoms*, *like from the beginning of the relationship you don't even use them because boys say you can't break someone's virginity with a condom*. *Hahahaha*.

> *II-P5*: *We never used condoms in our relationships because he told me that I won't enjoy and I won't fall pregnant on my first day*. *Since then it is skin to skin*.

Theme 2*: *Sources and Knowledge of Contraceptive Information

Sources of contraceptive information are associated with the participants' knowledge of contraception. This section will discuss the sources and knowledge of contraception:

Knowledge gained from schools: Participants indicated that schools were the predominant source of contraceptive knowledge. They reported that the information they received from school was vague and it was received during Life Orientation and Life Science periods. They felt that teachers were not confident enough to go into detail with topics related to sex. Other participants felt that the incorrect information they have about contraceptives was the result of vague information given to them by teachers. The following extracts capture what participants had to say:

FG-P1: *High school but still it wasn't clear enough. Teachers were just skimming through because they saw that the topic was awkward if you know what I mean.*

II-P3: *My teachers talked about them but just in passing because children would just love the topic so much and because teachers were more like mothers to us, they would teach us because they had to not because they wanted to.*

Knowledge gained from the media: Almost all participants reported that the media was the main source of contraceptive information. They reported that radio and television played an important role. They also felt that as although the media was their main source of information, they could not interact with it in order to address some of the questions they had. Some participants indicated that the information provided by the media was somehow adequate because the stories on television depict exactly some of the questions they have and they are informative. They also felt that ongoing campaigns also helped to educate them about contraceptives. Below is what some of the participants had to say:

FG-P4: *TVs* (*televisions*) *I think yes they are the sources…they give clear information even though sometimes it is not enough to answer our questions.*

FG-P5: *Yes media is the best because we watched Soul City and that show that play on Fridays…Intersexions.*

Knowledge gained from parents: Whilst most participants felt that parents were not good sources of contraceptive information, only a few reported that their parents discussed matters relating to relationships and sex with them. According to some participants, the contraceptive talk started after their first baby. Some participants felt that their parents do not provide them with correct information. They also felt that their parents threaten them that if they should fall pregnant they will be chased out of the house. Nearly all of those who reported that their parents spoke to them about contraceptives, reported that this conversation was initiated because a neighbour's daughter had fallen pregnant.

FG-P7: *Hahahaha for us it didn't start with the sex topic. It started with seeing that everyone in the community was having children so she just said, I don't care what you do or even if you prevent or what but I don't need babies here.*

Parents also felt that if their daughters continue having babies out of wedlock, they are decreasing their chances of getting married in the future because they believe that no man would want to marry someone who has more than one child. Participants felt that the contraceptive talk is usually initiated out of fear of embarrassment in the community because it is a shame for participants to have babies when they are not married. Furthermore, participants felt that if one has a boyfriend, he is seen as a potential husband who could pay *ilobolo* (*dowry*) and if the parents love that boyfriend, they would allow their daughter to fall pregnant to prove her fertility to the boyfriend, after which they would tell her to start using contraceptives:

FG-P7: *Again, parents keep quiet intentionally because they want you to get pregnant first then prevent. They want you to show people that you can conceive first. And in rural areas you have to prove your fertility.*

Knowledge gained from friends: When participants were talking about friends in relation to contraceptive use, they reported that "friends are not very good sources of contraceptive knowledge or information". They also reported that the topic is always difficult and tense. Friends were also reported to be judgmental especially if they know that you have never been sexually active before.

II-P7: *Where did I hear about contraceptives? … I think school yes JA it was school then my friends.*

II-P3: *It was my teachers, like in class and friends as well talk about them.*

Another participant described how judgmental friends can be:

FG-P7: *Sometimes it is better to talk with a friend whom you know that they are also getting it* (contraceptives) *instead of those who haven't because they will judge you and they will look at you in a very bad way*.

Knowledge of contraceptives: After participants had named their sources of contraceptive information, they were then asked about the knowledge they have. Participants appeared to have some knowledge of what contraceptives are and the different methods that are available.

II-P1: *Things you use to protect yourself from getting pregnant or getting HIV or STDs*.

FG-P9: *There is an injection and then there are pills that are used but I don't know their names*.

II-P2: *The condom you put it on the penis and uhm the female one you insert it down inside the vagina*. *The injection you have to go to the clinic for injection every 3 months*.

Theme 3*: *The Effect of Sources in Contraceptive Choices and Uses

When participants were asked if their sources of contraceptive information had any effect on their contraceptive use and choices, most of them felt that this is always the case. Participants reported that they would shun away from contraceptives that are believed to affect their looks. Furthermore, participants who were not yet sexually active reported that the information they already have will help them protect themselves once they become sexually active.

II-P3: *Based on the information they gave to me I would consider using contraceptives if I was sexual active*. *I will take what they are saying into consideration because if I want to be sexual active and don't want to get pregnant there should be something but it should be something without side effects*.

Other participants felt that through campaigns and television stories they learnt about the variety of contraceptives available to them. By knowing the different varieties and their uses, it also informed their choices.

FG-P8: *It helps because*; *they introduced a lot of variety of contraceptives to me so you choose which ones are more suitable for you*. *Also*, *you get to think about the importance of protecting yourself when you are having sexual intercourse*.

Theme 4*: *The Effects of Myths on Contraceptive Use

All participants believed that myths have negative effects on effective contraceptive use. An example of common effects noted by participants is communicated in the following extract:

II-P5: *It decreases the rate of use of contraceptives because people grow up having these misconceptions and believing that it is the truth so if you hear elderly people telling you that these things affects you*, *you definitely not gonna use it…you tell yourself that "I won't even start because I will be fat or whatever"*. *So it increase chances of not using contraceptives because you believe that these myths are the truth*.

Another participant, indicating that she does not even know which one she would recommend to a person who needs to make a contraceptive choice, said:

FG-P5: *Yes…she is right contraceptives cause skin problems*, *I really do not know which ones I would recommend because condoms again are a problem*. *Maybe I would say withdrawal*.

The researcher asked a participant which method she would use when she becomes sexually active. The response of this participant indicated that the myths do have an effect on contraceptive choices. Following is the participant's response indicating uncertainty:

II-P2: *Uhm I am not sure because they say that injection makes you gain weight*. *And uhm what's this thing that you insert on your arm oh implant yes*. *They say that it moves in your body and get disappeared and when you want to have children you fail to conceive because it kills eggs*.

Some also reported that their friends discourage them from using certain kinds of contraceptives because of what they have heard from other people or what they themselves have experienced.

> *FG-P7*: *Yes and some of them discourage…They just look at the problems they faced and they would be like*, *if you say you want to try injection…They would say "have you seen how fat so and so is" she is fat*. *You will be like that too*. *Try other methods girl*.

Other participants said:

> *II-P5*: *My friends are always saying negative things about contraceptives and I was the last one in our group to be sexually active*. *So they would just say whatever they have heard from their friends but I remember that uhm mostly it was that injection and pills are not good*.

> *II-P3*: *Even right I need to look at how people who are using contraceptives have changed in terms of their bodies and all*. *If I happen to see them gaining weight*, *I know that I shouldn't use the contraceptive they are using*.

Theme 5*: *Other Factors Affecting Contraceptive Use

Partners' role in contraceptive use: Most participants reported that their partners do not like using some contraceptives because of different beliefs about contraceptives. In the midst of having to deal with a partner who does not like a certain kind of contraceptive, participants complained about their partners not supporting them in taking precautions after sexual intercourse. They reported that after their boyfriends have satisfied their sexual needs, they are left alone to ensure they do not fall pregnant.

> *FG-P3*: *It's funny 'cause your boyfriend will say that the condom is not good but when it is time to buy the morning after pills you are all alone*.

FG-P3: *I was not using condoms in my relationship and I got pregnant because my boyfriend was against it and even now I don't. I am using injection*.

FG-P4: *Sometimes it is this thing of asking your boyfriend to wear a condom. Like really? Where do you start bringing that up in a relationship? No never. He will think that I know a lot*.

II-P1: *I know, it becomes very awkward to talk about condoms with your boyfriend and if you don't wanna fight with him, you just go for it and use morning after*.

FG-P1: *There is a lot of pressure from partners that prevent you from using contraceptives*.

FG-P3: *Also they always treat you badly and speak in a very bad way with you, calling you a barren because you are not conceiving. This ends up in you wanting to prove to him that you can conceive*.

Having "no support from their boyfriends" and also "their boyfriends wanting them to fall pregnant" caused some participants to use contraceptives discretely because their partners are against contraception.

FG-P5: *Sometimes you just have to make sure that he never finds out that you are using injection*.

Some participants' partners would encourage them to use hormonal contraceptives as a reason for them to have unprotected sex. Participant 4 had this to say:

FG-P4: *Yes and partners take a lot of advantage when you are using contraceptives* (*hormonal*)*…They want to sleep with you without a condom forgetting that there are diseases*.

Keeping partners happy: There was also a pressure to keep their partners 'happy' by sleeping with them without using contraceptives. This meant that participants had to risk their lives in order to gratify their partners out of fear of losing them. They also felt that this was their duty.

> *P1*: *Yes girls end up having unprotected sex just because they want to make their men happy*.

> *P7*: *True and you end up giving him without a condom just because you want to keep him happy and you want to make your relationship works*.

Contraceptive non-use: Some reported that the issue of condoms is not even considered from the start and as a result they never bring up condom-use in the relationship. Condom non-use was also associated with intimacy and trust that has developed over time. A few participants reported that if one has never caught their partners cheating that was enough to trust them. Also, knowing each other's status was also another reason for condom non-use. The following extracts talk about this:

> *FG-P3*: *Sometimes even with condoms like…from the beginning of the relationship you don't even use them…*

> *FG-P5*: *Sometimes you stop using condoms because you now trust the person and he has never cheated on you*.

> *II-P7*: *Sometimes it is that you both tested and found that you are negative*. *For me it was that I tested and I assumed that he is not positive because I tested negative and from there we started not using condoms*.

Stigmas associated with contraceptive use: There was some stigma associated with using contraceptives with many of the participants.

> *II-P3*: *People assume…Okay that maybe you are like that…maybe that you don't like to have a baby that is why you are preventing...that is one of them*. *It is like you love*

sex too much that you want to protect yourself. It is like you are relying on sex for survival.

FG-P5: *Yes a lot. When you are using contraceptives*, *people say that you sleep with anyone or you are like a slut*.

FG-P4: *When you come from a poor family*, *they also say you use contraceptives because you are selling your body to men. Like doing business with your body*.

Church and contraception: Those participants who were churchgoers reported that using contraceptives is a sin. Some of them reported that even from the days when they were growing up, contraceptive use was discouraged in their churches. They also felt that the nurses who work in clinics are also church members making it difficult for them to go to clinics.

FG-P7: *Yoh there is a lot*, *even at church they see you as a sinner. Someone who is just dirty*.

FG-P4: *But she can't because her mom is a Christian and she is strict and sex before marriage is a sin*.

Counselling messages between participants and nurses: Participants felt that they were not given enough contraceptive information by nurses. They reported that they were only told how the methods work. Side effects of contraceptives were not reported when they consulted with the nurses. One participant reported the following:

FG-P3: *Oh no never. I remember I went to clinic because I was scared I was gonna fall pregnant and the nurse just said we have pills and injection. Which one do you want to use? And I said I think pills and she said you should drink them every day at the same time cos if you don't you will fall pregnant*.

Enablers of contraceptive use: When participants were asked about what could make contraceptive use easier, they mentioned a number of things. The most common one was that "nurses and everyone working in hospitals needs to be friendly". They also felt that male nurses

over female nurses were much better in terms of treatment and gossiping about them. Participants also indicated that they needed "more information on contraceptive", "educational talks and campaigns", and also "normalising the talks about contraception". This is what they had to say:

> *FG-P4*: *I really agree with that because nurse's shame are bad*. *Male nurses are better*, *they don't talk…they just give you what you need*, *finish and klaar*.

> *II-P2*: *I think educating us about them or even teaching the society about them because they like talking when they see you using contraceptives*.

> *II-P7*: *I feel that the way people talk about contraceptives it is like uhm you are talking about something scary or something immoral that will kill people…Maybe changing the talk around it can help*, *making it uhm part of our daily like man*. *This thing of playing good people is not working*.

> *II-P7*: *The knowledge about them like uhm that-this do that…and their side effects like fact wise like from hearing from a medical practitioner and use them having all the knowledge you require in that way it could be easier for us to use contraceptives*.

Participants reported that they want contraceptives to be everywhere, especially in rural areas where they come from. They reported that if one needed to use contraceptives in rural areas, they had to go to clinics to get them from nurses or get condoms from the clinic toilets. Similarly, the emergency contraceptives were also problematic because they first had to get money for transport and then money to buy the contraceptives. Participants also reported that condoms are usually dropped off at tuck-shops but that happens occasionally and when it does, they get used up very quickly. Also, some tuck-shop owners do not want them there. One participant said:

> *FG-P6*: *Sometimes you even have to go clinics' toilets just to get condoms where they can just come up with other ways of making them available everywhere in rural areas*.

Barriers to contraceptive use: Several barriers to contraceptive use were reported by participants. They ranged from "nurses who are not welcoming" to "shame and embarrassment" that they have to endure when they are using contraceptives. The following is what participants said about difficulties they experience when using contraceptives:

> *FG-P3*: *For me I would say, the things that people say about contraceptives and even the way that people look at you when you are using them. Yes I think.*

> *II-P1*: *It is because people always have opinion of people using contraceptives and that affect them like that they are looking who's going to see them taking condoms, or even at the clinic the nurses scare you and they are too harsh with you.*

> *II-P5*: *Uhm and how can I forget nurses. Yoh those people can be rude to you when you go for your flu medication. Imagine when you go there for contraceptives they can even kill you. I also think that they also need to change.*

Condom distribution and placements were also identified as difficulties in contraceptive use. Participants felt that placing condoms in a private area could increase contraceptive use.

> *FG-P6*: *I also think the way they put condom and where they put them is not cool. Like imagine putting them at cafeteria, you go there and there's a whole lot of people there and taking them is scary and embarrassing because everyone is looking at you…they just know that you are going to get it.*

Summary of Findings

In terms of contraceptive knowledge, all participants had knowledge about the different methods that are available and they were able to name them. However, they appeared to have limited knowledge as to how other methods of contraception work. Their sources and origins of contraceptive information were mostly schools and the media. Friends and parents were amongst the least referred to sources for contraceptive information and the information they provided were mainly myths and misconceptions. Also, the most used form of contraception was reported to be emergency contraception, followed by injectable and the last one was

condoms. There was a lot of condom non-use. Participants reported that it was difficult for them to negotiate condom use because they feared that their partners would think they were promiscuous. Furthermore, some participants reported that there was no need to negotiate because from the very onset of a relationship, condoms were never used. Similarly, they reported that their partners told them that it is impossible to break someone's virginity using condoms. Condom non-use was also associated with knowing one's status and knowing that the person is honest in the relationship and it was also part of perceived intimacy. In addition, condoms were also not used because male partners felt that their manhood was threatened.

There were also a number of myths that were reported by participants. They reported that contraceptives cause weight gain and weight loss. They also affect skin and hair. Participants also reported that contraceptives cause vaginal wetness which leads to unenjoyable sex. Participants further reported that contraceptives cause infertility and some increase fertility. Regarding implants, it was reported that once inserted they moves around one's body and it is never discovered again. Condoms were associated with people who have small penises.

In addition, a number of difficulties were reported about contraceptive use. Participants reported that sometimes they need money to access contraceptives. They also reported that contraceptives are not as widely available as they would like them to be. When it came to enablers of contraceptive use, participants felt that proper education about contraceptives would help correct the myths they have. Furthermore, participants felt that nurses also need to change and be more welcoming and kinder to patients.

Chapter 5: Discussion

Introduction

In this discussion chapter, the main findings of this study are discussed in relation to the research questions and the relevant literature consulted.

What myths and misconceptions are held by black female UKZN students regarding contraceptives?

There was confusion about the awareness of myths and the knowledge of myths. For example, participants would say that contraceptives cause vaginal loosening and at the same time they would say that this is true. When students were asked about contraceptive myths and misconceptions, they were able to name them. What was interesting was hearing their firm belief that these myths were true and making reference to people they have seen exhibit health problems after the use of contraceptives. The social constructionism theory states that individuals in societies position themselves according to the norms and they construct their own realities (Galbin, 2014). This means they create their own realities from what they observe from others. Campbell (1964) in one of the four functions of myths argues that the myth authenticates and sustains sociological order which could be shared wrongs or rights on which society relies for its existence. This is further evidenced by the fact that some participants do not dispute the myths that their partners hold about contraceptives because of the gender roles and expectations; they tend to be submissive and understanding of their partners' needs. This could signify that they have been socialised in a way that these commonly-held myths are now deeply instilled in them.

Most of the myths and misconceptions participants reported, like weight gain or weight loss, skin conditions, hair loss, infertility, and contraceptives as abortive measures, are commonly cited nationally and globally and are found in much of the literature (Laher et al., 2009; Russo et al., 2013; Wood & Jewkes, 2006). However, two of the myths that they reported were interesting. First, that the implants move around the body and are never discovered. This is disconcerting because implants were only recently introduced in higher education institutions' clinics and already students have myths and misconceptions concerning them. The second myth

is that of vaginal loosening. There is no research that has proved that contraceptives cause vaginal loosening. Vaginal loosening, much like vaginal wetness, is a concern for women because of their association with promiscuity. Literature also indicates that birth deformities and the belief that one is killing the baby in the womb are some of the leading concerns for women (Gueye et al., 2015).

Where do the contraceptive myths and misconceptions held by black female UKZN students originate from?

These study findings indicate that the very first source of contraceptive information were teachers. However, students felt that the information they received was not enough because teachers were not comfortable discussing the topic.

Participants reported that the second source of contraceptive information was the media. Literature (Waynn, Foster & Trussells, 2009) indicates that the media and the internet could be good readily-available sources of contraceptive information; however, at the same time they can also spread false information about contraception. According to Waynn et al. (2009) internet resources have now become an increasingly significant instrument in the provision and dissemination of contraception and health information in the United States (US) and globally. Majority of our students reported they have never searched and researched correct information about contraceptives. This could signify a lack of willingness to seek correct information about contraceptives. Consequently, students should be provided with credible sites which they can surf for facts about contraception.

Friends and parents were also reported as sources of contraceptive information, but both parents and friends reportedly shared the same myths and misconceptions about contraceptives and what they have heard of it. In a study that was conducted by Wood & Jewkes (2006), it was also found that friends have a role to play when it comes to contraceptive information. In addition, studies indicate that parents are not good sources of contraceptive information and they either never or seldom engage with their children about these issues (Wood & Jewkes, 2006). In a study conducted by Biney (2011), it was indicated that parents' views on sexual matters can influence risky sexual behaviours in their children.

Furthermore, myths were perpetuated by poor counselling from health-care workers. Almost all students had some contraceptive myth which could have been addressed with proper counselling. Besides knowing that contraceptives prevent pregnancy, HIV, and STIs, they had no knowledge of the advantages and disadvantages of contraceptives.

All students had heard about contraceptives and almost all of them who were sexually active had used them before. Some participants did not know that EC only interferes with fertilisation and implantation of the foetus. Previous studies indicate that correct knowledge of emergency contraception was a predictor of contraceptive utilisation. Furthermore, despite utility, some participants believed that they are abortion pills. This is also in agreement with what Fasanu, Adekanie, Adeniji and Akindele (2014. p. 3) found in their Nigerian study that "even where women have heard about emergency contraception, myths and misconceptions still exist about what it is, how it works and how or where to get it".

It also appears that injectable contraception is considered to be the worst method amongst the student population. The belief that injectables cause weight gain is also disconcerting because injectables are one of the most effective methods of contraception. The period during which students are most sexually active, coincides with increased preoccupation with their body image. Weight gain was also a commonly-held myth amongst participants in this study. This study conforms with other studies that found that weight gain is often a concern for non-contraceptive use (Hamani et al., 2007). The fear of weight gain alone is an important consideration for students when making contraceptive choices. This could also be corrected through proper contraception counselling by health-care professionals.

Research indicates (Morroni et al., 2006) that there is an increasing prevalence of non-barrier contraceptive use in South Africa; however, students in this study indicated that they were using non-barrier contraceptives as they were worried about health-related risks such as infertility, and other reported myths.

All participants in this study believed in at least one myth about contraceptives.

How do contraceptive myths held by black female university students affect their sexual behaviour?

Nationally, there is growing acknowledgment of the significance of dual-method use (Morroni et al., 2006). Most students interviewed were not using dual methods, which is a source of great concern. According to the report by DOH (2012), there is still persistently high HIV and STI prevalence amongst the youth with women between the ages of 15 and 25 exhibiting the highest incidence HIV and STI infections. A recent study by Protogerou et al. (2014) indicates that there are low frequencies of dual–method use. The lack of dual–method use was also influenced by myths that there is no sexual pleasure when one is wearing a condom.

It is also expected that students in universities have more knowledge about things compared to lay people because of the high availability of information and widespread exposure to technology, the internet, and information. However, it appeared that the same contraceptive myths that the general population has were also shared by the student population and were instrumental in affecting their contraceptive choices. This was one of the most disconcerting findings; even students who were not yet sexually active, reported that their future choices of contraception would be based on what they have seen or have been told by people close to them.

Furthermore, even students who were already sexually active continuously engaged in risky behaviours because of fear of how contraceptives might affect their bodies. Even though there was knowledge of methods, students were still not making informed decisions. It shows that once again knowledge of methods will not necessarily influence good sexual practices and prevent diseases. This study corroborates a study by Biney (2011, p. 45) where it was found that even women who had heard of certain contraceptive methods, “some chose not to use a method, or used it inconsistently. A few reasons were stated for this occurrence; the most important being past experiences of harmful side effects, along with negative rumours about the harmful effects of contraception on women”.

Most participants were sexually active – only a few were not – but both groups of students had fears about contraceptive use. The fear of falling pregnant resulted in sexually active students tending more towards the use of emergency contraceptives as opposed to LARC. Myths also

prevented them from using long-term trusted methods for fear of the consequences (Russo et al., 2013). There was also fear that their parents would think that they were sexually active if they used contraceptives.

Furthermore, contraceptive myths had great influence, especially on hormonal contraceptives. Some students reported that they will not use injectable contraception because it causes the body to be loose and causes significant weight gain and vaginal wetness. Injectable contraception is one of the most effective methods of contraception. If students opt not to use it, they will instead opt for using less-effective methods.

In a study that was conducted by Romo et al. (2004), they found that there was low emergency contraception use and the question they had was: Is this poor use a result of poor factual knowledge? In other reports by the DOH (2012), they also found that the knowledge, awareness, and utilisation of emergency contraception was low. This was contrary to the findings of this study. Students who participated in this study had some knowledge and awareness of emergency contraception. Students indicated that they use emergency contraceptives more often, because they do not use condoms in their relationships. Others were also aware of them; however, they felt that they are abortive in nature. Study participants also knew that use of emergency contraception is possible up to a certain point, after which it may affect fertility. When students had exhausted their time limits at the Campus Clinic, they reported using their own money to buy them. They also knew they could access them at clinics and chemists.

The university setting denotes a period of freedom and sexual exploration for many female students. This is the time where many students happen to be more sexually active as they take up residence in cities where there is an absence of caregivers and parents (van Staden & Badenhorst, 2009). Some of them experiment sexually for the first time at university. This freedom could result in them contracting HIV and STIs. It appears that condom non-use is not only a personal issue, but there are many other systems at play. There is a belief that sex without a condom is not enjoyable. Literature states that the shift also denotes a place of exploration and this could also mean that condom non-use could also be part of experimenting.

Knowledge of contraception was found to be present amongst study participants, a finding which agreed with other studies. They knew the importance of condoms. Despite the safety and effectiveness of condoms, they are still infrequently used by women because of myths and misconceptions. A myth reported by students is that condoms are for men with small penises.

Also, myths stating that one cannot break a girl's virginity using condoms seemed not to be an issue for female students. Some of them believed that it was true because they did not fall pregnant when they engaged in sexual intercourse for the first time. It is worrying that the student population believes such myths and misconceptions. Literature clearly states that sometimes some of the reasons women fall for everything that men tell them is because of the age difference as sometimes women date older men. They would end up not using condoms because they are just vulnerable and have not had sex before and believe everything they hear.

Other Factors Affecting Contraceptive Use

Gender inequality has been proven to contribute to the risky behaviour that women engage in (van Staden & Badenhorst, 2009). According to van Staden and Badenhorst (2009), the cultural practices (obedience, submissiveness, sexual subordinates, and willingness) and stereotypes that men hold, put women in a position where they are more vulnerable to HIV, STIs, and pregnancy. From the findings, it appeared that men play an important role on whether women will or will not use contraception. It also appeared that men also influenced the method to be used based on their beliefs as men. Biney (2011, p. 45) argues that "acknowledging men's perceptions of contraception and abortion, in a region (sub-Saharan Africa) where men do have a degree of power over women's reproductive rights, could aid in understanding the decision-making processes that go into, what seems like, deliberate contraceptive non-use of some of the respondents, resulting in unintended pregnancies and induced abortions".

In addition, men have a tendency to prove their masculinity by engaging in risky behaviour (van Staden & Badenhorst, 2009). Society again has socialised women into believing that they should keep their men happy (van Staden & Badenhorst, 2009). Also, not supporting their female partners when they go to clinics could also be related to proving their masculinity.

Both African and Western cultures have taught women to not be open about their sexual concerns, interests, and preferences (van Staden & Badenhorst, 2009). Participants appeared to be aware of contraceptive myths that were reported to them by their boyfriends; however, none of them reported that they would challenge them.

Women felt that their partners did not like injectable contraceptives and thus they had to stop using them in order to please them. This finding correlates with other studies (van Staden & Badenhorst, 2009) where women compromise their values, beliefs, and even health just to be obedient to them. They also engage in risky behaviours because they fear rejection.

The university setting denotes a period of freedom and sexual exploration for many female students. This is the time where many students happen to be more sexually active as they take up residence in cities where there is an absence of caregivers and parents (van Staden & Badenhorst, 2009). Some of them experiment sexually for the first time at university. This freedom could result in them contracting HIV and STIs. It appears that condom non-use is not only a personal issue, but there are many other systems at play. There is a belief that sex without a condom is not enjoyable. Literature on HIV amongst university students states that the shift also denotes a place of exploration and this could also mean that condom non-use could also be part of experimenting (van Staden & Badenhorst, 2009).

Knowledge of contraception was found to be present amongst study participants, a finding which agreed with other studies (Shozi & Haffajee, 2017; Wood & Jewkes, 2006). They knew the importance of condoms. Despite the safety and effectiveness of condoms, they are still infrequently used by women because of myths and misconceptions. A myth reported by students is that condoms are for men with small penises.

Also myths stating that one cannot break a girl's virginity using condoms seemed not to be an issue for female students. Some of them believed that it was true because they did not fall pregnant when they had sexual intercourse for the first time. This finding is in line with a study conducted on teenagers which found that condom use in first-time sex was less likely to take place in those who had pledged to keep their virginity (Martino, Elliott, Collins, Kanouse & Berry, 2008). It is worrying that the student population believes such myth and misconceptions. Literature clearly states that sometimes some of the reasons women fall for everything that men

tell them is because of the age difference as women sometimes date older men. They would end up not using condoms because they are just vulnerable and have not had sex before and believe everything they hear.

Religious beliefs also contributed to contraceptive myths. The relationship between religion and family planning has been documented by previous studies and religion has been recognised as an important determinant of contraceptive usage. Most participants were Christians. Some of them strongly believed that using contraceptives was a sin and was immoral. This could be motivated also with the belief that sex before marriage in Christianity is a sin. Romo et al. (2004) found that when women believed that contraceptives are abortive in nature, their use decreased because of their religious beliefs.

Moreover, counselling, which plays a very important role in addressing contraceptive myths, appeared to have been lacking from the nurses. Almost all students had some contraceptive myth which could have been addressed with proper counselling. Besides knowing that contraceptives prevent pregnancy, HIV, and STIs, they have no knowledge of the advantages and disadvantages of contraceptives.

All students had heard about contraceptives and almost all of them who were sexually active had used them before. Some participants did not know that EC only interferes with fertilisation and implantation of the foetus. Previous studies indicate that correct knowledge of emergency contraception was a predictor of contraceptive utilisation. Furthermore, despite utility, some participants believed that they are abortion pills. This is also in agreement with what Fasanu, Adekanie, Adeniji and Akindele (2014. p. 3) found in their Nigerian study that "even where women have heard about emergency contraception, myths and misconceptions still exist about what it is, how it works and how or where to get it".

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use (Hamani et al., 2007). The fear of weight gain alone is an important consideration for students when making contraceptive choices. This could also be corrected through proper contraception counselling by health-care professionals.

Research indicates that there is an increasing prevalence of non-barrier contraceptive use in South Africa; however, students in this study indicated that they were using non-barrier contraceptives as they were worried about health-related risks, such as infertility, and other reported myths (Morroni, Tibazarwa & Myer, 2006).

All participants in this study believed in at least one myth about contraceptives.

Furthermore, there were other difficulties reported by students other than contraceptive myths. Students indicated that they did not like to go to clinics for contraception because of the nurses. They reported that nurses are judgmental and some of them knew their parents because they were community members. As a result, health-care workers were not so popular to students. This indicates lack of professionalism and inadequate family planning education by health-care workers with regard to students. This also exacerbates the problem of contraceptive non-use.

In addition, considering the availability of contraceptives, students further reported that the availability of contraceptives was especially higher on campus and that they were free; however, their limited use was a sign that more education was needed. In the rural areas from which they come, they reported that the availability was limited and they needed transport to access them. They also reported that although they were distributed in local tuck-shops, it was still not enough as the condoms usually get taken very quickly and some tuck-shop owners do not want them in their tuck-shops. This also indicates that distribution of condoms in rural areas, especially contraceptives, needs to be revisited.

Chapter 6: Conclusion

This chapter will consider the limitations of this study and suggestions for future research will also be made. This chapter will also make recommendations for students and universities in mitigating the problem of contraceptive myths and misconceptions in South Africa.

Conclusions about the Research Questions

This was a qualitative study investigating contraceptive myths and misconceptions held by black female students at the University of KwaZulu-Natal, Pietermaritzburg Campus, and how these myths affect the effective use of contraceptives. Knowledge about contraceptives was also explored. Participants identified the following myths regarding hormonal methods of contraceptives: infertility, hair loss, and vaginal wetness. Participants also identified lack of pleasure as a myth for barrier methods of contraceptives. The main sources of information regarding contraceptives was from schools and the media. The participants mentioned that parents and friends were not the best sources of information regarding contraceptives. Most importantly the participants in this study mentioned that contraceptive myths had a negative effect on contraceptive use and sources of contraceptive information influenced their contraceptive choices.

Recommendations for Future Research

There is a need to understand poor use of contraceptives amongst university students. From the current study it seems that more work and research needs to be conducted regarding the role that contraceptive myths and misconceptions play on contraceptive use with university students in South Africa. Furthermore, it may be useful for research to explore in more detail the role that families play in sex education for youth and how this influences decisions around sexual behaviours and contraceptive use later in life. This study focused primarily on female students and what emerged was the role that their male partners play in influencing contraceptive choices and use. Future studies could also focus on male youths and their sources of contraceptive information, the myths they hold about contraceptives, and how all this affects decision-making regarding the use of contraceptives.

Recommendations for Interventions

Recommendations for universities

The findings of this research indicate that more vigorous promotion of contraceptives on university campuses is required. Although students have some knowledge of contraceptives and how they work, this study exposed the quality of this information. It may be useful for this information to be tailored to both male and female students. This study found that contraceptive choices and use are influenced by partners and, as such, interventions and health promotion initiatives should address both groups. The role of nurses in influencing the use of contraceptives was also identified in this study. It would be useful for university campus clinics to be aware of the concerns regarding nurses that some students have had in the past as evidenced by the responses from study participants. This awareness can be accompanied by efforts to train nurses with sensitive methods to approach and work with students, especially when dealing with issues concerning sexual and reproductive health.

Some participants in this study seemed to be disempowered in relationships, especially when it came to contraceptive choices and use. Education and programmes on gender awareness, empowerment, and rights could be useful to address some of the issues that seem to stem from societal conceptions of gender roles and expectations.

Recommendations for participants

This study highlighted the importance of dissemination of appropriate education and reliable facts regarding different types of contraceptives. This dissemination of information should be tailored for both male and female students. From this study it became clear that with regards to contraceptive information, sources of information, preferences and use involves both male and female students.

Recommendations for government

Availability of contraceptives needs to be increased and more accessible in rural areas. More educational programmes and promotional efforts need to be instituted to make discussions on contraceptives a more normalised affair. This is likely to also assist in changing the discourse

around contraceptives from the current medical one to a more societal one. Currently, the two seem to work in opposition to one another.

Training of health-care workers is also important because they are often unwelcoming to students who go to clinics for contraceptives. Nurses are often experienced as judgmental and inhospitable by the students.

Twenty-four hour call centres and contraception support may also be useful in providing ongoing support and counselling regarding contraceptives. Some of these services are already partially available but can be extended and directed to this demographic.

In the curriculum of Life Orientation in schools, issues regarding contraceptives and myths around this topic can be addressed to ensure that students are given correct and reliable information.

Limitations of the Study

This study was conducted at the University of KwaZulu-Natal, Pietermaritzburg Campus. Participants were all isiZulu speaking. As a result, this study cannot be generalised to other universities in different geographic locations. Majority of females who are of university age are not registered at universities in this country. Failure to include this group has also meant that this study has missed out on the views and experiences of a large group of young females who are likely to be affected by some of these issues.

A second limitation of this study was that it did not explore the views of male students regarding their contraceptive myths. The importance of this demographic for a study of this nature has already been discussed.

A third limitation of this study was the difficulty in accessing up-to-date statistics about the use of contraceptives (and types) by young females in the KwaZulu-Natal province. This kind of information would have been very useful for this study as it would have allowed for a narrower focus on specific contraceptives and the myths associated with them.

Conclusion

The availability of contraceptives has been increased, however, students still engage in high risky behaviours and still hold myths about certain contraceptives. Many students who participated in this study engaged in unprotected sexual intercourse due to many factors, which include contraceptive myths and misconceptions, male dominance, and culture around sexual and reproductive health choices. This study highlighted the importance of involving as many actors as possible in educating/promoting and improving contraceptive, sexual, and reproductive health choices of young people in the KwaZulu-Natal province. Contraceptive myths and sources are socially constructed and go on to influence the use and choices of young women. Future studies should also explore the experiences and views of young men, nurses, and parents in order to develop holistic interventions for the sexual and reproductive health of young people.

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APPENDICES

Appendix 1: INFORMATION SHEET ABOUT THE RESEARCH PROJECT

Dear Student

This page aims to provide you will all the information you will like to know about this research. It will further explain your expected participation and role during the interview processes.

The Research

I am conducting a study looking at contraceptive myths with black female students from University of KwaZulu-Natal. This research is part of my Masters studies.

The Interview Process and Recording

About 45- 60 minutes will be used to interview you. In the interview, questions about contraceptive myths will be asked. There are no wrong or right answers because the study wants to know your knowledge and attitudes about the topic. All the processes including the focus group discussions and interviews will be recorded so that the researcher can accurately capture all that is said, and convert it into English is spoken in IsiZulu or if there is a need.

Confidentiality

All interviews and focus group discussions will be confidential and will respect the autonomy of participants. Your name will not be used during the discussions, only the fake names. This is done to ensure that no one will be able to know or decipher who said what during the interviews or focus groups. The personal details will not be linked to participants' responses.

Future studies

Information gathered in this study is likely to be kept and used for future research purposes. Confidentiality will still be retained in this case too.

Withdrawal

If you agree to participate, but then at a later time you feel that you would like to withdraw from the interview, or not participate any more, that is fine. You can say so and we will stop the interview. There will be no penalties from withdrawing at any time.

Should you wish to know more about the study please let us know by contacting my supervisor- Mr. Thabo Sekhesa on 033 2605370/ Sekhesa@ukzn.ac.za)

Appendix 2 a: Consent Form Focus group

Dear Participant

In this focus group I will ask you questions about contraceptives and contraceptive myths. I would like to find out what your beliefs are regarding certain contraceptives and how they influence your decisions regarding their use.

The focus group discussion will take about 45-60 minutes.

Participation in this study will be kept confidential. No identifying information will be used in this study code numbers will be used to refer to all participants.

I will ask you questions about contraceptive myths. In this way, I hope to find out what knowledge students have regarding the use of contraceptives

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees. Also, in this way confidentiality will still be maintained by use of pseudonyms.

If you agree to participate, but then at a later time you feel that you would like to withdraw from the interview, or not participate any more, that is fine. You can say so and we will stop the interview. There will not be any penalties for wishing to withdraw.

The benefit of the study is that you will get an opportunity to benefit from other people's experiences on contraceptives when you are given back the report.

There are no foreseen risks of the study except that people you may feel embarrassed discussing some of their experiences with other people.

If you have any questions, then please let us know. You can talk to us directly, or you can call or email my supervisor – Mr. Thabo Sekhesa (033 260 5370 Sekhesa@ukzn.ac.za).

…… …….

Signature of Participant **Date**

Appendix 2b: Informed Consent Form for Interviews

Dear Participant

For this study, as a researcher, I will ask you questions about contraceptives and contraceptive myths. I would like to find out what your beliefs are regarding certain contraceptives and how they make you make the decision you make about contraceptives and their use.

The interview will take about 45-60 minutes.

Participation in this study will be kept confidential. No identifying information will be used in this study and pseudonyms and code numbers will be used to refer to all participants.
I will ask you questions about contraceptive myths. In this way, I hope to find out what knowledge students have regarding the use of contraceptives.

The data collected from this study will be used in writing up articles for publication and presenting in conferences so that other interested people may learn from our study.

Please note that, if you have agreed to participation, and you wish to withdraw from participating, you can raise that up and the interview will be stopped. There will not be any penalties for wishing to withdraw.

The benefit of the study is that you will get an opportunity to benefit from other people's experiences on contraceptives when you are given back the report.

For more information or questions, please talk to us directly by contacting my supervisor – Mr. Thabo Sekhesa on 033 260 5370 or email him at: Sekhesa@ukzn.ac.za

…… ……..

Signature Date

Appendix 3: Confidentiality Pledge

In my participation in this group, I pledge that I will not to discuss, with any person who was not part of the research, what was talked about during the focus group discussion. I also pledge that I will also not tell other people about the identity of the focus group members.

By this, I promise that I will keep all the discussions of the focus group confidential.

Signed _____ Date: _____

Appendix 4: Consent to audio record interview/focus group

We would like to request the permission to record the discussion using a digital recorder. This is because we want to be able to understand clearly what was said by each participant in the interview/focus group, and to be able to remember it. After the discussion, the research listen to audio recording and write exactly what was said verbatim.

Your name and any other identifying information will not be associated with the recordings including the information written from the recording. The researcher will give you a fake name or a code name, using numbers, for example P1_Interview 5.

If you agree, please sign below:

Sign here _____ Date _____

Appendix 5: Letter to the Child and Family Centre.

School of Applied Human Sciences
Discipline of Psychology
University of KwaZulu-Natal
P/Bag X01
Scottsville
3209

CFC

School of Applied Human Sciences
P/Bag X01
Pietermaritzburg
3209

Re: Measure to secure psychological support for participants in research study

Dear Mrs. N Buthelezi

This letter serves to inform you about a Masters study regarding students' contraceptive myths. This study seeks to find out the myths and misconceptions of contraceptives amongst female student population from University of KwaZulu-Natal. The study wants to find out the impact these myths have on the effectiveness of contraceptive use.

Contraception is a delicate and sensitive subject because there are many other factors at play. This topic could aggravate emotions that some participants might be struggling with.

In trying to mitigate these possible risks, I would like to request to make arrangements for the counselling services that CFC provides should students start develop these emotions. Participating students will be notified that they can go to CFC and make an appointment for counselling.

This is a precautionary measure taken in the event of such an outcome during the study which is unlikely. A reply may be communicated via email. I would be glad if you take my request into consideration.

Sincerely

Thobeka Shozi
Cellphone: 0844226052
Email: 209529801@stu.ukzn.ac.za

Appendix 6: Letter to Registrar

University of KwaZulu-Natal, Westville Campus
Registrar: Mr. Convy Baloyi

Dear Mr. C. Baloyi,

Re: Request for permission to do a study using students of University of KwaZulu-Natal.

My name is Thobeka Shozi and I am currently doing my Masters in Psychology, in the School of Applied Human Sciences (UKZN, PMB Campus), the title of my study is "Contraceptive Myths: A qualitative study investigating contraceptive myths amongst Black female students at the University of KwaZulu-Natal."

The purpose of this research is to find out what myths students may hold regarding contraceptives and their use.

Students will be recruited using posters that will be pasted all around university. All the necessary ethical precautions (including informed consent, confidentiality and anonymity, and voluntary participation and freedom of withdrawal from the study), will be adhered to during my work with students.

Should you have any further questions regarding my study, please contact me on 0844226052 or my research supervisor, Mr. Thabo Sekhesa, on 033 260 5370 or Email: Sekhesa@ukzn.ac.za

I would like to request permission from you to conduct this study using UKZN students.

Sincerely
Thobeka Shozi
209529801
Cell phone number: 0844226052
Email: 209529801@stu.ukzn.ac.za

Appendix 7: Letter to the University Department

To Whom It May Concern

Re: Letter Requesting to Conduct Announcements in Psychology Lectures

My name is Thobeka Shozi currently doing my postgraduate studies from the Discipline of Psychology. I am doing research on students' ideas about contraceptive myths. I am writing this letter to request permission of announcing this research in various lectures of any level of study in your Discipline.

If permission is granted, the advertisements of the study will be organized with the lecturers with the lecturers of these courses. Informing students about the study will be very brief and should not be disruptive to those attending the lectures. The researcher will give a short description of the research that will be conducted and all that will be expected of the participants. Students will also be asked if they would like to be a part of the study at a date already set by the researcher.

For more information or clarity regarding this study please contact Thobeka Shozi (0844226052) or my research supervisor Mr Thabo Sekhesa on 033 260 5370.

Thank you for your consideration,
Regards
Thobeka Shozi

Appendix 8a: Questions for Individual Interviews

Background Questions

1. Are you sexually active?

2. Do you have a partner?

Knowledge of Contraceptives

1. What are contraceptives?

2. What kinds do you know about?

3. How do they work?

Experiences of Contraceptive Use

4. What kinds of contraceptives do you use (or not) and why?

    - Is your partner supportive on your use of contraceptives?

Sources of Information

5. Who are your sources of knowledge about contraceptives?

6. What influence would you say these information agents have on your use (or not) of contraceptives?

Myths and Misconceptions

7. What is a myth?
8. What misconceptions do people hold about contraceptives?
    - Negative myths?
    - Positive myths?
9. Are you aware of any myths about contraceptive use among female and male peers?

Perceived Impact of Myths on Behaviour

10. What impact do these misconceptions have on contraceptive use?

11. Do you know of any stigmas associated with using contraceptives?

Perceived Barriers and Enablers of Contraceptive Use

12. What makes contraceptive use difficult?

13. What makes contraceptive use easier?

Appendix 8b: Focus Group Schedule

Participants will be presented with myths (in the form of vignettes) that will be derived from individual interviews with participants and literature on contraceptive myths. They will be asked general questions and questions regarding the myths in front of them.

1. What are contraceptives?

2. What different kinds of contraceptives do you know about?

3. What kinds of contraceptives are most used and why?

4. Is there anything that could stop people from using contraceptives or that could make people be uncertain to use them?

    - If yes, what is it?
    - If no, what is it?

5. What makes contraceptive use difficult?

6. What makes contraceptive use easier?

7. Where do people get to hear for the very first time about contraceptives?

8. What is a myth?

9. What myths do people hold about contraceptives?
    - Negative myths?
    - Positive myths?

10. Are you aware of any myths about contraceptive use among female and male peers?

11. Do you know of anything negative that people say when you are using contraceptives?

For each myth:

1. What are your views on the contraceptive myth presented to you?

2. Is this an accurate depiction of some of the myths available on contraceptive use?

3. Are you aware of any other myths on contraceptive use?

4. Do you believe that these vignettes are an accurate explanation for why some people choose not to use certain contraceptives?

Appendix 9: Poster

CONTRACEPTIVE MYTHS

Would you be interested in participating in research exploring contraceptive myths?

Are you sexually active, considering becoming sexually active or would you be willing to share your ideas, thoughts and experiences about contraceptive myths and a female student from University of KwaZulu-Natal and over the age of 18?

I am looking for female students who are willing to participate in the study.

If you are interested in participating in this study or would like more information, please email, sms or call Thobeka
Email: 209529801@stu.ukzn.ac.za or call 0844226052.