Contraceptive use among young people: a case study of university students in Durban, South Africa.

By Mandy Lombo

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COLLEGE OF HUMANITIES

DECLARATION - PLAGIARISM

I, Mandy Lombo declare that:

1. The work in this this dissertation is my own original work, except where otherwise indicated and such sources have been referenced.

2. This dissertation has not been submitted for any degree or examination at any other university.

3. Data, pictures, graphs or other information, sourced from other authors have been acknowledged as such.

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ABSTRACT

There have been many studies conducted on the issue of contraceptive use among the youth. This is because the issue of contraceptive use among the youth is considered an important one, in the midst of high rates of unwanted/ unplanned pregnancies in the developing world. Unplanned pregnancies can have a negative impact on the studies of an individual. The rate of unplanned/ unwanted pregnancies is highest among young people. This category of individuals is most likely to be at a tertiary institute, this is why this study opted to try and understand the perceptions of the youth in the university context. This study also aimed at understanding how the interpersonal and social networks of these students impacted their contraceptive attitudes and use. This study draws on the theory of unsafe sexual behaviour to understand these interpersonal and social networks and if they have any impact on the decision of the participant in this study

A qualitative approach was taken, in the form of 20 in-depth interviews with students at the University of KwaZulu-Natal. The study found that interpersonal networks of an individual did influence their contraceptive decision-making. Many of the participants that were using a contraceptive admitted that if their friends had negative opinions about contraceptives then they too would most likely have a negative perception of contraceptives as well. This was because friends were identified as the main source of information on sexual matters in the absence of parental advice. The interpersonal and social relationships also had an influence on the type of contraceptive to be used. Therefore it must be taken into consideration that individuals do not exist in isolation to their interpersonal networks. It became clear that the issue of contraceptive use by students is multi-dimensional and thus the approach should also be multi-dimensional. Campaigns aimed at changing the sexual behaviour of youth should focus on encouraging society as a whole rather than isolating youth.

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ABBREVIATIONS AND ACRONYMS

ASRH&R- The National Adolescent Sexual & Reproductive Health Rights Framework Strategy

AIDS- Acquired immunodeficiency syndrome

CPR - Contraceptive Prevalence Rate

DoH- The South African National Department of Health

DMPA- Depo Provera hormonal contraceptive

EC- Emergency contraceptives

EI- Education Index

HIV- The human immunodeficiency virus

IUD- The intrauterine device

IPV- Intimate partner violence

KZN- KwaZulu-Natal

MDG- Millennium Development Goals

SADHS- The South African Demographics & health Survey

SDG- Sustainable Development Goals

SRHR- Sexual Reproductive & Health Rights

STI- Sexually transmitted infection

WHO- The World Health Organisation

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Chapter One

Introduction

1.1 Background to the study

The World Health Organisation (WHO) has defined family planning as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births", this is achieved through the use of contraceptives and the treatment of involuntary fertility (WHO, 2011). In an effort to plan pregnancies couples may use contraceptive methods. Contraception refers to any method that is designed to prevent pregnancy by temporary or permanent means (Peer &London, 2013). There are traditional and modern methods of contraception. Traditional methods include coitus interruptus and the rhythm method; these do not require the intake of any hormones or the use of any barriers (Ram et al. 2014). Modern contraceptive methods are products or medical procedures that interfere with a reproduction from acts of sexual intercourse (Hubacher &Trusell, 2015). Contraceptive use, sexual and reproductive health is an integral part of the lives of couples worldwide and it is a process that needs to be explored vigorously.

This study was motivated by the high prevalence of unplanned and unwanted pregnancy among youth in South Africa (Willan, 2013). However South Africa does have a lower fertility rate which is the average number of children born to a woman in her lifetime (Roser, 2016) when compared to other Sub-Saharan African countries, it has been estimated that the fertility rate in the province of KwaZulu-Natal had decreased from 3.53 during the period of 2001-2006 to 2.98 during the period of 2011-2013 (Statistics South Africa, 2014). Africa as a whole has a fertility growth rate averaging at two per cent growth each year; this can have negative social, economic and environmental consequences (Ezeh et al, 2012). Annually an estimated 67000 women in developing countries die from complications related to unplanned pregnancies (Izale et al. 2014). It is argued that 42 million of pregnancies that are terminated by women were reportedly unplanned, these have resulted in the inconsistent and correct use of contraceptives (Izale et al. 2014). High fertility is believed to also cause political instability because it leads to a young population that then has to compete for scarce resources such as jobs that may be low paying (Bongaarts &Sinding, 2011). High fertility rates may have negative effects on the economic growth and development of a country. However, low fertility growth can also be problematic, for example, China has an estimated yearly fertility growth of between 0 and 1%. This is a problem because it leads to the population ageing simultaneously thus causing an

unsustainable burden on the state that is required to provide pensions, this can also cause slow economic growth (Ezeh et al. 2012). Thus it is important to keep population growth at a manageable and acceptable rate through the provision of adequate family planning services but most importantly family planning services should be available to those who choose to use them.

There are also many circumstances that may act as barriers to accessing contraceptive services, one such circumstance may be poverty. The provision of health services to the poor remains a challenge because of their socio-economic standing (Creanga et al. 2011). Access to contraceptives may also be hampered by ignorance. A study conducted by Seutlwadi et al (2012) found that 79.1% of the women in South Africa that had experienced an unwanted pregnancy were however not motivated to use a contraceptive method after such a pregnancy. This shows that even though some women, may not necessarily desire a pregnancy, they will continue not to use a contraceptive method nonetheless further risking another unwanted pregnancy. Adequate access to contraceptives does not lead to automatic use. Therefore it is not enough to simply have contraceptive methods readily available to the public, it is important to educate and encourage couples to use them as well. This duty often falls on government because in many countries government is the main supplier of health services which includes services related to sexual and reproductive health. Other reasons that contribute to low contraceptive use amongst students are high levels of alcohol consumption, drug use and exchanging sex for money (Hoque, 2011).

The responsibility supply of contraceptives may lie with the government but the social and interpersonal networks of individuals also play a significant role. These social and interpersonal relationships include family, friends, partners and the community that the individual exists in. These networks can become great influencers and/or barriers to contraceptive use for the individual. Family and contextual structures such as the parent's education, marital status and sibling composition have been noted to have an influence on a young person's sexual behaviour. Youth from single parent households have been reported to be more likely to start engaging in sexual intercourse earlier and are less likely to use contraceptives if they see their parents engaging in such behaviour in the home (Miller, 2002). The young person tries to emulate the behaviour of their parents and thus if they see their parents engaging in a certain behaviour they feel that such a behaviour is acceptable and find it easier to engage in such a behaviour. Therefore the contextual and proximal factors such as the physical and organisational environment have a great influence on the life of a young person, this should be taken into consideration when a study on the use of contraceptives by youth is done (Eaton et al. 2003).

The parent's behaviour and attitudes towards contraceptive use most often will influence a young person's attitude and use of contraceptives. Parents have a big role to play in shaping their children's attitudes and encourage the use of contraceptives. It would be wise if they are targeted in interventions that aim to encourage and increase the contraceptive prevalence rate among the youth in South Africa.

The province of KwaZulu-Natal had the fourth highest fertility rate in the country, between the period of 2011 to 2016, it was estimated at 2.98 (Statistics South Africa, 2014). The province of KwaZulu-Natal may not necessarily be facing a crisis of low contraceptive use, but it is still important to study the dynamics of contraceptive use among the youth in this province. The focus of the study is on the youth because a large percentage of unwanted pregnancies occurs in those between the ages of 18 and 19 years (Willan, 2013) and at least 30% of youth in South Africa report being pregnant at least once in their lives (Willan, 2013). It is important to study the attitudes, perceptions and use of contraceptives among the portion of the population that are soon to become the leaders and are also considered to be agents of social change (Gresh, 2010).

The University of KwaZulu-Natal had 32,363 in the year 2007 (South African Regional Universities Association, 2007) and 41,762 registered students in the year 2011(Statistics South Africa, 2013). Therefore the University of KwaZulu-Natal caters to a very large percentage of youth in the province of KwaZulu-Natal making it the ideal location to study test the perceptions, attitudes and rate of use of contraceptives among university youth. Youth at a university may be influenced by other factors that may be different to youth that is not in the university context, in addition to those that exist at home. There have been previous studies that have suggested that educated youth experience and view contraceptive use differently to those outside of the university. This study aimed at understanding the reasoning behind the difference in their views and the reasons behind these. One such a study was by Pillai & Teboh (2010), the study found that as the level of the education level of the individual autonomy increases so does the contraceptive use. This meant that those at university were expected to have better knowledge about contraceptives and this would lead to a higher use of contraceptives at tertiary institutions. However, other authors have estimated that the rate of pregnancy at South African tertiary institutions has increased at a rate of 250% per year since the year 2005 (Ndima, 2013). This increase in the number of pregnancies at tertiary institutions suggests the view that knowledge and use of contraceptives in universities is high may be incorrect. High unplanned pregnancy rates at tertiary institutions in South Africa have affected

the graduation rates. Unwanted pregnancies often lead to abortions, these abortions may be done legally or illegally. Illegal abortions are referred to as 'back street abortions'. The abortions (whether backstreet or not) may cause the student to have post-abortion stress and may affect the student's academic performance (Ndima, 2013). This rate of unplanned pregnancies continues to soar even though contraception is readily available especially within tertiary institutions in South Africa (Ndima, 2013). "The significant increase in unplanned pregnancies and the termination of pregnancies amongst students pose a multiplicity of problems for academic institutions" (Ndima, 2013:1). The effects of these pregnancies are often multi-layered and not only affect the academic life of the student, they spill over to other areas of their lives.

The education Index (EI) in Sub-Saharan Africa has increased from 0.34 to 0.39 between 2000 and 2010, the expected years of schooling have also increased from 3.9 to 4.4 with South Africa having an average of 8 years in school. This means that individuals are spending more time at school than before; leading to a higher number of graduates. In most Sub-Saharan countries the modern contraceptive prevalence rate (CPR) have increased between 10-19%, this suggests a correlation between education and contraceptive use (Emina et al. 2014). It has been argued that this correlation is caused by the fact that women are able to make more informed decisions with a higher educational qualification. However, this is not the case in all countries because inaccessibility to contraceptives continues to be a barrier regardless of education. The converse is also true, easily accessible contraceptives will increase usage even in the absence of high education (Emina et al. 2014).

This research will focus on the use of contraceptives by young people at a university in Durban, South Africa. There is clearly a need for this type of research based on the high number of unwanted pregnancies among youth not only in Durban but in South Africa as a whole. Pregnancy rates among the youth have been reported to be on the rise in South Africa since 2011, it was estimated at 68,000 in 2011, 81,000 in 2012 and at 99,000 in 2013. KwaZulu-Natal was had the highest rate at 26,000 followed by the Eastern Cape at 20,000 in the year 2013 (Sibanyoni, 2013). The United Nations, for statistical purposes, defines 'youth', as those persons between the ages of 15 and 24 years (WHO, 2013:2), a considerable number of these individuals would be at the university level. It is imperative that universities and government understand the perceptions that youth hold when it comes to contraceptives and what influences these perceptions. Once this is understood policy and interventions that aim to encourage the use of contraceptives among the youth can be better designed to be more effective in the future.

This study hopes to provide information on the perceptions and attitudes that youth hold towards contraception and how their interpersonal and social networks influence these; this is the gap that has been identified in the research related to contraceptives among youth in South Africa.

1.2 Family planning: the unmet need in Sub-Saharan Africa and South Africa

Contraceptive use is motivated by the desire for couples to plan their pregnancies. Contraceptive technology has advanced tremendously since the women in China consumed mercury in an effort to prevent pregnancy. Recently it has become as easy as applying a patch to the body. However, there remains a high unmet need for contraceptives in Africa, 1 in 31 women of reproductive age die from maternal complications compared to 1 in 9400 in Europe (Mesce &Clifton, 2011). WHO estimated that in 2013 out of the 800 maternal deaths that occur worldwide, 500 occurred in Sub-Saharan Africa, 190 occur in Asia and only 6 occur in Europe (WHO, 2013). Many of these deaths could have been easily preventable with the use of contraceptives and access to other prenatal healthcare. Statistics such as this show the difference between access to sexual and reproductive health care for women in developed countries and those in developing countries. There is still a wide gap that needs to be filled when it comes to providing contraceptives to women in developing countries.

Some of the earliest types of contraceptives have been behavioural; some examples are withdrawal (coitus interruptus) and breastfeeding (Dexter-McCormick, 2012). As old as withdrawal and breastfeeding are they are still widely used today even with new, advanced and more reliable methods. Many contraceptive methods have been used in the past, for example in the 21st-century women used the mucus method, this is when beads are used to count and identify safe days for sexual intercourse. Women had to identify mucus secretions excreted by the body to identify when it was safe to engage in sexual intercourse but this method required knowledge of the menstrual cycle to be able to plan pregnancies accordingly (Knowles, 2010). This shows that women have desired to plan pregnancies for centuries; it is not a new phenomenon.

Current research shows that there is a fertility transition happening in Sub-Saharan Africa (SSA), this is supported by records that show changes in fertility patterns. Contraceptive prevalence rates are said to be rising steadily in Sub-Saharan Africa. There is a declining use of traditional methods and a higher use of modern methods (Sharan et al. 2011). Contraceptive technology has advanced regardless of attitudes and the access to contraceptives has improved

tremendously. Contraceptives have been available free of charge to the South African population since 1974 when the National Party government introduced the National Family Planning Programme (Maharaj &Rogan, 2007). Before this family planning services were offered by the private sector thus excluding access to the poor and mostly black African community. The black community did not trust the family planning services being provided by the National Party (Chimere-Dan, 1993; Burgard, 2004). The context of the provision of contraceptives in South Africa was on the backdrop of population control (Wood & Jewkes, 2006). Many black Africans felt that the reason why the National government had become interested in providing them with family planning services was to curb their growth and to make it easier to control them and therefore they did not see any benefit in using family planning services (Maharaj & Rogan, 2007).

Another factor that became a barrier to Black women accessing contraceptives was that they were not given good service at the clinic; this is unfortunately still the case in the new democracy where many users complain about the attitude of the nurses at public clinics (Chimere-Dan, 1996). The negative attitude of the black community to contraceptives has carried over to present day South Africa (Mfono, 1998). The fact that government provided limited options when it came to planning made the population even more weary of contraceptives, injections were the most popular choice and at times given without client consent. The issue of family planning became a political issue and not just a health issue. Since the homelands had to provide their own health services, this meant that there was limited funding in most homelands and family planning was not seen as a priority and received even less attention. This also allowed for cultural biases against certain contraceptive methods to affect which contraceptives black women in the homelands could access if they were allowed to access contraceptives at all. Another serious limitation of the provision of family planning was that such a service would have to go through traditional authorities that were the leaders in the homelands. Many traditional leaders were not in favour of family planning and this further hindered access to contraceptives in the homelands (Kaufman, 1998). It is such situations that have made family planning unpopular with the black African portion of the population which happens to be the majority of the population in South Africa; this has made it difficult for the post-apartheid democratic government to implement family planning strategies effectively among the black South Africans.

The new democratic government has tried to break old stereotypes and problems surrounding provision of quality family planning to the majority of the population with limited success. It

is unfortunate that the negative perceptions about contraceptives still resonate with many South Africans regardless of the efforts of the new government. The new government has implemented policies in an effort the increase the use of contraceptives especially among the young black South African. Recent population policies that have been introduced have been designed to be in line with human development and women empowerment. There is still an unmet need for contraceptives especially among the poor (Creanga et al. 2011). The poor may desire to plan their pregnancies but may not have access to the same services and interventions as the rich, therefore their need for contraceptives may be considered as unmet (Creanga et al. 2011).

Youth in South Africa may have adopted the attitude of the older generations regarding contraceptives as has been stated earlier that they are influenced by what they see and hear around them, regardless of more information being available and their being greater access to contraceptives. Lower fertility rates can be attributed to higher economic development, education and higher contraceptive use (Panday et al. 2009). Therefore economic status and education among youth can be a factor that influences contraceptive use. Some of the reasons that have been given for this low use of contraceptives by the youth are the unfriendliness of the health care workers at the clinics when they try and access contraceptives (Willan, 2013). Health workers may also possess limited knowledge about certain types of contraceptives and are thus not be able to advise appropriately (Van Ziyl et al. 2010). Youth were also afraid that their parents would find out that they were using a contraceptive and were sexually active. Therefore keeping a clinic card was risky (Mkhwanazi, 2010). Parents are often unwilling to discuss sex and contraceptives with their children especially with the female child; this was seen as a societal norm. If parents suspected their daughter of being sexually active they would try and restrict her movements or use corporal punishment at times (Mkhwanazi, 2010). This was because parents were against contraceptive use by their children. Youth often discussed sex and contraceptives with their peers. Those who were using a contraceptive may not be using it consistently. Females have reported that friends had advised them that it was good to take breaks from contraceptives to give their body a break (Mkhwanazi, 2010).Usage rates among the youth continue to be higher with methods that did not require daily fidelity (Fleming et al. 2010). Males reported that they may not use a condom consistently because there was a lack of communication with the partner and sometimes they would consume alcohol or drugs before sexual intercourse and this would lead to non-use of a contraceptive (Chirinda & Peltzer,

2014). At the university level especially, youth have been reported to be influenced by alcohol and drugs not to use a contraceptives (Hoque, 2011).

There was also an issue of coerced sex and early sexual debut among youth that impact on contraceptive use. Sexual debut occurs between the ages of 17 and 20 internationally, the age of sexual debut in Sub-Saharan Africa is not any higher (Pettifor et al. 2009). The age of sexual debut in South Africa is 16 for males and 17 for females. Early sexual debut can lead to negative social consequences for women such as accepting violence and male domination in relationships (Ritcher et al. 2015). Young women were in danger of violence in relationships where they may be unable to make decisions about contraceptive use if a partner refuses (Jewkes &Morell, 2012). There are a variety of reasons that influence contraceptive use among South Africa youth, some which will be discussed in this study.

1.3 Rationale for study

South Africa is a signatory to a number of international commitments that seek to address the sexual and reproductive health of girls and women in South Africa but somehow this has not translated into good policies with a positive effect on contraceptive use and reproductive health in general (Willan, 2013.) Some authors have argued that the South African government may have neglected the area of contraception by focusing on the increasing HIV and AIDS pandemic, this did not happen in South Africa only but it was a worldwide phenomenon (Barron & Pillay, 2013). The area of HIV and AIDS was given priority because it may have been considered a priority especially with the rising number of new infections in South Africa year on year. Even though these two areas may be linked it is important that government encourage the use of other contraceptives beside the condom among the youth in order to be more effective. International funding for family planning programs to developing countries declined by 30% between 1995 and 2008 (Bongaarts & Sinding, 2011). This decline in funding may have hindered governments' interventions because of lack of funding. In times of limited resources governments are often forced to cut public spending, a large percentage of public spending in developing countries is healthcare. Therefore a cut in public spending may equal a cut in the provision of certain services in healthcare. This is also a concern because family planning interventions are viewed as a luxury that can be cut under limited resources. The attitudes of policy makers and governments in general should change and family planning should remain a priority even in times of economic hardships.

The South African government has tried to address the issue of increasing the contraceptive prevalence rates and access to contraceptives among users by enacting various acts and policies that will allow for this, such policies and acts include the Choice of Termination Act no 92 of 1996; this act allows females to voluntarily terminate a pregnancy between 0-12 weeks without parental consent, this particular act should help reduce the number of unplanned births. The aim of this act was to allow a young female the right to choose whether or not to have a baby even if the pregnancy was unplanned. The South African Children's Act of 2005 as amended by the Children's Amendment Act no 41 of 2007 which allows children above the age of 12 years to get HIV testing, contraceptives and termination of pregnancy also without parental consent (Willan, 2013). This Act aimed to break the barriers that may have been preventing young adults from accessing contraceptives and other prevention methods by making it a law and a crime for health care providers to deny youth access to these services (Willan, 2013). This act was an effort to address the issue of health care workers refusing to provide contraceptive services to youth.

The international community has regained interest in fertility issues especially family planning, the reasons for this being that there has been an increase in the food and energy prices as well as strong evidence that global warming is putting pressure on the environment (Bongaarts & Sinding, 2011). It has become important to control population growth again. After the London Summit on family planning that was held in July 2013, there has been renewed interest in contraception use and provision. The South African government has re-evaluated its policy on contraception and revised it to be in line with the Millennium Development Goals (MDG) of 2015; goal 4 and 5 of the MDG is the reduction of maternal deaths and morbidity and the increased access to voluntary contraceptives (Patel, 2014). The inclusion of sexual and productive health issues in the Millennium Development Goals shows that the world is taking the issue seriously.

The South African Department of Health (DoH) believes that the use of contraceptives in South Africa is influenced by the following factors:

- Women's socioeconomic status and residence in rural versus urban areas. They believe that poor women and women in rural areas still lack knowledge about contraceptives and this is why they do not use contraceptives.
- Women's education levels. The more educated the woman is the more likely she is to use a contraceptive, therefore uneducated women are less likely to use a contraceptive.

- Partner, family and community expectations around fertility. Partners may coerce women to prove their love for them by bearing children and society may pressure women to have children.
- There may be a lack of correct knowledge about how conception actually occurs.
- Knowledge about contraceptive choices. There may be limited knowledge about the types of contraceptives available in the market or health facility.
- Access to contraceptive services and types of contraceptive methods. Unfriendly or insufficiently skilled health care providers may discourage women from using contraceptive through their disapproving behaviour.
- Counselling on health-related side effects of some contraceptive methods. The health care providers may not be able to deal effectively with the side effects of contraceptives especially the injectables.

(DoH, 2012).

Therefore the new policy aims to take a closer look at the area of contraceptive use in South Africa, with the aim to expand the choice of contraceptives available at public health care centres to include the emergency contraceptive pill often called 'the morning after pill'. The government would try to integrate contraceptive and fertility services with other health services. The department hopes to offer training and capacity building of the health care staff where skills are lacking. The need to have an enabling legislative framework has also been identified. Communication strategies will be adopted that are evidence based to increase awareness of services. Monitoring and evaluation of services will take place; where research policy and service delivery guidelines are to be guided by evidence and the appropriate monitoring and evaluation (DoH, 2012).

The DoH policy on sexual and reproductive health and rights (SRHR) acknowledges that sexual and reproductive health is a priority. It aims at contributing towards the "establishment of a society that provides a high and equitable quality of life for all South Africans in which population trends are commensurate with sustainable socio-economic and environmental development" (DoH, 2015: 2). The Department of Health in South Africa has also adopted the National Adolescent Sexual & Reproductive Health Rights Framework Strategy (ASRH&R), the ASRH&R aims to address the issue of unwanted pregnancy among the youth. The framework recognises that there is a lack of knowledge concerning the legal rights around

Sexual, Reproductive & Health Rights (SRHR), including the termination of pregnancy and the emergency contraceptive; this has contributed to the high rates of unwanted pregnancies and low contraceptive use among the youth (DoH, 2012). The framework also recognises that there is a reluctance among health care workers to provide adolescents with sexual and reproductive health services at public health centres.

The DoH policy on SRHR takes into account the social and cultural factors which undermine access to and use of sexual and reproductive services in the country. Poverty, gender equity, violence and poor management of the health system at the district level as additional factors that act as barriers to reproductive health and rights, (DoH,2011). Poverty can be a barrier to an individual if they cannot afford transport to access sexual health services such as contraceptives or if poverty forces an individual to exchange sex for financial resources thus diminishing their power to make decisions about their sexual and reproductive health (DoH, 2011).

Gender inequity and other sources of prejudice in society tend to see women as unequal to men and thus a women's right to decide on sexual health becomes limited. Women are exposed to gender and sexual violence because of these beliefs, this makes it easier for women to have an unwanted/ unplanned pregnancy or to contract HIV and other STI`s (DoH, 2011). This accepted culture of violence has marginalised women; this is caused by masculinity being associated with violence. Men are unable to develop mutually respectful sexual relationships with their female partners (DoH, 2011). There is a lack of adequate information on the social dynamics that effect SRHR. This is a serious societal problem that needs to be addressed by a community as a whole because SRHR can only be advanced through the participation of the society as a whole because it is often affected by societal concerns.

Lack of stewardship and poor management of the district health system has been identified as a barrier to SRHR, as the government has admitted that the public service health is lacking proper management. There is a need for good management, support and training of staff (DoH, 2011). Abuse between health care staff and users has been reported as increasing. The current system is not sensitive to the needs of the youth, those with disabilities and male users (DoH, 2011). Service needs to be integrated with an effective referral system between the levels of care that is supported by adequate infrastructure and technology.

The aim is to adopt an integrated human rights approach to service provision at the district level; this includes care for the caregivers and an inter-sectoral collaboration as a solution to

the problem of access and provision of SRHR. The government aims at using social mobilisation by allowing the individual, family and community to promote and protect SRHR. Mass media and community campaigns have been identified as strategies that would be used to promote SRHR (DoH, 2011). The momentum around SRHR has increased but in many spaces, the conversation is still not receiving the required attention (DoH, 2012). Therefore there is a need to open the conversation about sexual decision-making with the aim of reducing unwanted pregnancies.

It is thus important to study the use of contraceptive methods among university youth because they are considered social change agents (Gresh, 2010). Their attitudes and behaviours represent the attitudes and behaviours of future adults and leaders. It is important that they have positive attitudes toward contraceptive use in order to curb unplanned and unwanted pregnancies and the spread of sexually transmitted infections (STI).

The aim of this study is to:

- determine the accessibility and barriers to the use of contraceptives for youth at the university.
- explore the perceptions of students towards contraceptive methods
- explore the role that social and interpersonal networks play in influencing the use of family planning methods within the university.

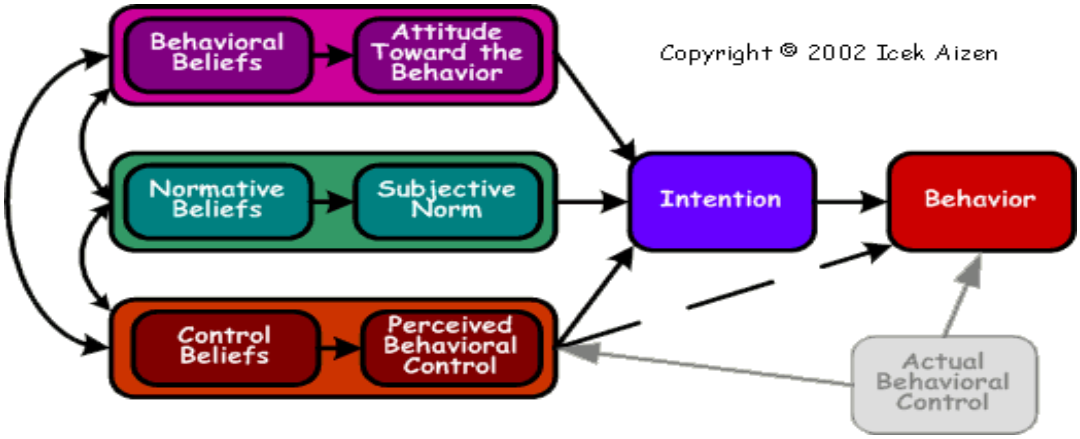
The study used a qualitative method that consisted of in-depth interviews. The sample population included 20 male and female students.

1.4 Theoretical Framework

This study made use of the theory of unsafe sexual behaviour developed by Eaton et al. (2003); Eaton's theory is a response to the theory of reasoned action and the theory of planned behaviour (TRA &PB) that was developed by Ajzen &Fishbein (1980). The theory of reasoned action and planned behaviour is based on the assumption that human beings make rational decisions through the use of the information they may have at their disposal (UNAIDS, 1999). It assumes that people consider the implications of their actions before they decide whether or not to engage in certain behaviours (UNAIDS, 1999). Attitudes are seen to predict behaviour; a person’s intention to engage in certain behaviours is influenced by that person’s attitude towards that behaviour. Therefore if the person has a positive view of the outcome of

performing that behaviour they will be motivated into doing it and if they have a negative attitude they will abstain from it (UNAIDS, 1999). Human beings are assumed to behave the way that they intend in order to gain positive results as well as to meet the expectations of those they admire (Eagly & Chaiken, 1993). If others view the behaviour as negative, the person will want to meet the expectations of others, especially those they consider as important to them and thus refrain from performing the act (Tlou, 2009). Therefore behaviour is determined by behavioural intention. Attitude is determined by the person's beliefs and subjective norms associated with the behaviour.

Figure 1.1: The theory of reasoned action and planned behaviour.



Source: Ajzen (1991)

According to Eagly and Chaiken (1993) people with negative attitudes towards something may still perform that negative action; for example smoking (Eagly &Chaiken, 1993). The behavioural extension tries to take into consideration factors that the individual has no control over (Tlou, 2009). This theory excludes behaviours that may be brought on by substance or drug abuse. These actions happen with little or no thought from the individual (Eagly & Chaiken, 1993). It also excludes behaviour that may occur independently of attitudes such as habits. The theory also refers to attitudes towards behaviours and not towards targets (Eagly &Chaiken, 1993).The goal of the theory of reasoned action and the theory of planned behaviour (TRA & PB) is to understand behaviour (Chang, 1998). There can be other factors besides intention that can determine whether or not an action is performed (Chang, 1998). This particular study will examine the reasons for contraceptive use or non-use among young adults and the effects of interpersonal and social networks/relationships on the individual's choice to use or not to use. This is because according to the TRA&PB, an individual will take into consideration the views of his or her peers and loved ones when deciding whether or not to use

contraceptives. Therefore attitudes towards a certain behaviour may have a substantial impact on individual decision-making.

The theory of unsafe sexual behaviour critiques these models because they focus too much attention on behavioural, personal and interpersonal factors (Eaton et al. 2003). The belief here is that a person's behaviour is only influenced by his or her own beliefs and evaluations. Such theories are more suitable for western developed countries because in developing countries factors beyond the individual may influence their decisions and factors (Eaton et al, 2003). The theory focuses on factors within the person as well as their proximal and distal factors within their context. They refer to personal factors as cognitions and feelings in relation to sexual behaviour. The proximal are the person's interpersonal relationships and their physical and organisational environment. The distal context includes cultural and structural factors which are traditions, norms of the larger society, and the social discourse within their society and shared beliefs (Eaton et al, 2003). Structural factors may be any legal, political or economic factors of their community (Eaton et al, 2003) Eaton et al. (2003) argues that such structural, distal and interpersonal relationships play a major role in the individual's decision to use a contraceptive and should be taken into consideration in order to understand contraceptive use in the South African context. The individual in the developing country with certain cultural beliefs has to take these into account because culture for many South Africans is a way of life and it at times provides answers to their problems. Culture is community centred and very anti-individualism, therefore it is very important for a person to be conscious of the norms of his community and blend in by adhering to those norms. Therefore a solution that is individualistic may be rejected because it goes against the basis of African culture which is community centred. It is important that the community accepts a form of contraceptive in order for the individual to accept it.

Figure 1.2 Theory of unsafe sexual behaviour

Source: Eaton et al. (2003, 150)

1.5 Organisation of chapters

This dissertation is divided into five chapters. The first chapter contextualises the study. It looks at the history of contraceptive use with a specific focus on South Africa as well as some of the factors that act as influencers and barriers to contraceptive use for young people.

Chapter two reviews the relevant national and international literature on the issues surrounding contraceptive use among the youth. It also considers the gaps and contradictions in the literature on the perceptions and use of contraceptives among the youth.

Chapter three discusses the study methodology, including the study location, research methodology used and tools used for data collection, and analysis. It also looks at ethical considerations and limitations of the study. Chapter four summarises the main themes and findings of the in-depth interviews. Chapter five discusses the main findings of the study and provides recommendations.

Chapter two

Literature Review

2.1 Introduction

There have been many studies conducted on contraceptive use among youth both internationally and nationally over the past few years. This section will look at all the relevant literature relating to youth contraceptive use and the factors that influence or hinder use. The aim will be to understand these factors and to identify any contradictions and gaps in the literature. It is important to study contraception because it has a major impact on the lives of many young people in their childbearing years regardless of their income and social status. In order to design effective and practical contraceptive methods, it is important to understand the intended user's feelings and perceptions as well as their sexual behaviour. This literature review will touch generally on the levels and barriers to the use of all contraceptives by South African youth but will focus more on the condom which has been identified as the most popular contraceptive among the youth and will also focus on the emergency contraceptives as they have been referred to as the best-kept secret in sexual and reproductive health, making their use very low. Not to say that other methods are not important, the focus will be on the most and least used methods with the aim of understanding the barriers to these contraceptives.

2.2 Family planning in South Africa

In South Africa, most modern contraceptive methods are available at government health facilities free of charge. However, among black females between the ages of 15-24 that are sexually active only 64.4% are reported to be using contraceptives (Seutlwadi, 2013). This is an unsatisfactory number considering that contraceptives are available for free at public health clinics (DoH, 2011). It is important to understand if race or economic status play any role when it comes to contraceptive prevalence rates (CPR) in South Africa, black women are reported to have the lowest CPR and white women have the highest (Peer & London, 2013). Therefore apartheid in South Africa may have acted as a barrier to contraceptive use for the black South African. The South African Demographic and Health Survey (SADHS) reported that there was a decline in contraceptive knowledge between 1998 and 2003, which may have impacted on the levels of use (Izale et al. 2014). There are also economic and social benefits to the prevention of pregnancy among young poor women, there is an increased economic burden on the family of the female because there is now an extra mouth to feed that they may not be able to afford especially because in most cases the father of the child refuses to take responsibility for the baby or he himself cannot afford to support the child. Studies in South

Africa have found that factors that influenced the youth to use were; never being pregnant, possessing post-secondary school, access to condoms, HIV status and having contracted an STI in the last 12 months, not having an early sexual debut (Seutlwadi et al, 2012). These were identified as the factors that encouraged current contraceptive use. Other factors that have been identified have been demographic factors for example age and gender. Culture and traditional beliefs are also taken into consideration (Makhaza & Ige, 2014).

Contraceptives come in different forms such as drugs (hormones), devices, agents, surgical procedures and sexual practices (Nordqvist, 2009). The effectiveness of a contraceptive is measured using the Pearl Index which measures the number of pregnancies in 100 women using a contraceptive technique for one year (Steyn &Roets, 2015). If the index is 5, this means that it is likely that 5 women will get pregnant while using that contraceptive correctly. The lower the index, the more reliable that contraceptive method is. Therefore methods that index fewer than 3 pregnancies per 100 users are considered very effective.

2.3 Contraceptive types

Traditional or natural contraception methods include methods that do not require the intake of any hormones or the use of any barriers (Ram et al. 2014). Examples of natural methods are:

Abstinence or Celibacy- couples using this method avoid penis-in-vagina intercourse or penetration. This method one of the safest and most effective, it not only prevents pregnancy but it also prevents sexually transmitted diseases because there is no penetration thus there is no exchange of bodily fluids.

Withdrawal (Coitus interruptus) - this method requires the man to ejaculate outside the vagina (Nordqvist, 2009). Because there is no sperm, fertilisation of the egg does not occur. However its effectiveness depends on the man's ability to withdraw in time, this is sometimes miscalculated and can result in pregnancy (Steyn &Roets, 2015). Its effectiveness on the Pearl Index is 8 out of 17; this makes it a rather risky method (Steyn &Roets, 2015).

The cycle method, the woman keeps a menstrual calendar. This allows her to predict her most fertile days and avoid sexual intercourse on those days. This method has no side effects because hormones are not taken, it can be up to 80% effective if it is used correctly but it is often not (Steyn &Roets, 2015).

Modern contraceptive methods are products or medical procedures that interfere with the reproduction from acts of sexual intercourse (Hubacher &Trusell, 2015). Modern contraception methods include barrier and hormonal devices. Barrier methods are those that block the sperm from entering the uterus to fertilise the egg while hormonal methods are those that use oestrogen or progesterone hormones to stop the release of the egg, this prevents fertilisation (Steyn &Roets, 2015). Examples of modern methods are:

The male and female condoms- these are mechanical barriers which prevent pregnancy by preventing the sperm from entering the vagina through the creation of a barrier. This method is also the also one that prevents both pregnancy and sexually transmitted infections (Nordqvist, 2009). The condom can be very effective if used consistently and correctly. The effectiveness of the condom on the Pearl Index is 3:15 (Steyn & Roets, 2015).

Spermicides- these are sperm-killing chemicals placed inside the vagina of the female (Nordqvist, 2009). Sperm-killing chemicals are available as a gel, foam, jelly, foaming tablets, vaginal suppositories or cream. Each dose may be active for up to an hour. They are readily available over the counter at pharmacies (Steyn & Roets), 2015).

The Oral Pill- these are pills that are made of oestrogen and progesterone to stop the woman from ovulating or releasing an egg and make the lining of the uterus thin and unsuitable for pregnancy (Nordqvist, 2009). Its effectiveness on the pearl index is less than 1 provided it is used correctly (Steyn &Roets), 2015).

The Patch- this is a transdermal patch that is stuck on to the skin of the female usually in the arm or buttock area, the patch slowly releases oestrogen and progesterone hormones into the body (Nordqvist, 2009).

The Injection- this injection is injected into a woman every two or three months depending on the brand, it stops the woman from releasing an egg (Nordqvist, 2009). This is one of the most reliable methods against pregnancy (Steyn &Roets), 2015).

Implants- this is a rod that is inserted into the upper arm of the female, it has a core of progesterone, and this particular method is effective up to three years (Nordqvist, 2009).

Inter-uterine device (IUD) - it is a t shaped device that is inserted into the uterus of the female, it can last between 5 and 10 years (Nordqvist, 2009). This method measures at 0.3-0.8 on the Pearl Index, only 8 out of 1000 women using the IUD may fall pregnant within a year of use, the risk of pregnancy decreases with the number of years it is used (Steyn & Roets, 2015).

Tubal Ligation- the fallopian tubes are cut and sealed to prevent fertilisation. This is a permanent contraception (Nordqvist, 2009). This method is recommended to those who are not planning to have children in future.

The morning after pill- this is an emergency type of contraception, it is taken after unprotected sex, it prevents ovulation and fertilisation or implantation of the embryo. It is effective within the first 72 hours after exposure (Nordqvist, 2009).

2.4 Safety and benefits of contraceptives

Contraceptive methods help women to plan their pregnancies. Most of the contraceptive methods are safe and easy to use. There are positive side effects that have been reported with the use of certain methods such as the pill. The pill is reported to improve skin conditions like acne, it helps to regulate menstrual problems by creating a regular menstrual cycle and decrease in the blood (Picavet et al. 2011). However there have been concerns over the link between contraception use and cancer, there is also an increased risk of thromboembolism (blood clots) that may come with the use of certain hormonal methods. Contraceptives also have other side effects that range from headaches, depressive moods, nausea and a decrease in libido (Picavet et al. 2011).

There has been considerable concern over the use of the hormonal injection called Depo-Provera, a study conducted by Heffron et al 2011 has come to a conclusion that the use of Depo-Provera (DMPA) hormonal contraceptive may increase the risk of infection with HIV-1, thus DMPA hormonal contraceptives influence susceptibility to HIV. This is likely caused by the changes in the vaginal structure, cytokine regulation and cervicovaginal HIV-1 shedding (Heffron et al. 2011). It has also been recommended that it is unwise to promote the use of DMPA contraceptives in areas with high rates of HIV and AIDS (Heffron et al. 2010). The benefits of a DMPA contraceptive are the decreased menstrual blood loss over time, the decrease of seizures in women with epilepsy and protection against endometrial cancer (Burke, 2011).

However, health professionals are of the view that the benefits that are offered by contraceptives use generally outweigh the side effects. This being said it is important that women be counselled correctly on the risks associated with the use of contraceptives when they

are being offered the different methods, this will allow them to make informed decisions and take the necessary precautions.

2.5 Barriers to accessing Contraceptives

Barriers are "possible blocks or hindrances to engage in preventive behaviours, including such factors as cost, inconvenience and unpleasantness" (Agha et al. 2001:149). Barriers to contraceptive use for youth in South Africa have been identified as fear of side effects, poverty, and opposition from male partners, attitudes and accessibility of contraceptives at public health centres (Ramathuba, 2012).

2.5.1 Fear of side effects

Females fear side effects that may arise from using a hormonal contraceptives, side effects include irregular or prolonged periods (Wood & Jewkes, 2006). These concerns made females stop using a contraceptive because they feared they may not be able to conceive in the future or that they may be pregnant if they do not have a period for a long time. Nurses were not adequately trained to assist users with the side effects that developed from contraceptive use, many times the nurses refused to change the contraceptive method over side effects. They only considered change of method if there was a serious medical concern (Wood & Jewkes, 2006). It is important that users are given contraceptive methods that are compatible with their medical profile and they should be offered adequate assistance should they encounter side effects. If a user has an unsatisfactory experience with contraceptives the first time they try it, they may be discouraged from using it in the future.

2.5.2 Limited contraceptive choice

Many users are also dissatisfied with the methods offered at public facilities; there is a need for a wider range of choice. Clinics may have limited options for youth and nurses may force certain methods on users (Wood & Jewkes, 2006). If users are dissatisfied with the choices, they may discontinue with the method which may lead to unintended pregnancies (Spear &Clark, 2008). There needs to be a wider variety of contraceptives at public clinics to cater for the different needs of users. Contraceptives such as the emergency “morning after pill” are often not available or inaccessible to youth at public health facilities. The emergency contraceptive (EC) can be a very effective method to prevent pregnancies where a more permanent method is not used, this lack of availability acts as a barrier and leads to unwanted pregnancies especially among young people. EC are not seen as a priority because they are not

barrier methods and given the high prevalence of HIV and AIDS health care providers do not prioritise EC`s (Rogan et al. 2010). Health care workers are concerned that women use the EC the same way they should use a long term contraceptive, females avoid using long-term contraceptives such as the pill and injectables and condoms. Women repeatedly use the EC and thus causing setbacks to family planning interventions that try and encourage the use of long-term contraceptives (Mbanje, 2014). However this should not discourage health care workers from recommending EC to potential users.

2.5.3 Access as a barrier to contraceptive use

Access to contraceptives in KwaZulu-Natal is considered to be fairly easy by the Department of Health, however long queues at public health centres may become a barrier to contraceptive use (DoH, 2011). Emergency contraceptives were often the most difficult to access for youth in South Africa, the attitude of service providers toward women requiring EC`s has been quoted as a barrier to women accessing and using EC correctly. The government is the main supplier of contraceptives in South Africa; contraceptives are provided without charge at public health care centres. There may be long queues at public centres and therefore it becomes more efficient to go to a pharmacy (Rogan et al. 2010). Clinics are far away and they often offer contraceptives during school or work hours`, access becomes difficult for those whom are studying or working (Willan, 2013). In order to access a contraceptive a young person may have to take a day off school or work to make time to go to the clinic and queue for a contraceptive. This is not always possible to do and thus it becomes difficult to access a contraceptive resulting in non-use. The government should consider this barrier and allow contraceptives to become accessible over weekends.

The issue of confidentiality was also a concern among the youth, who feared that nurses would divulge information about their use to others (Flanagen et al. 2013). Nurses need more training and guidance on the importance of maintaining confidentiality. The attitudes of the health care providers such as nurses have also been cited as a barrier. The nurses often did not treat youth well at clinics, often humiliating them. The nurses need an attitude change, this could increase the levels of contraceptive use especially among the youth (Ramathuba, 2012), (Wood & Jewkes, 2006).Nurses have also been accused of refusing to assist users, especially those that they considered to be “too young for sex”, access to contraceptives (Hoffman-Wanderer et al. 2012). The nurses often lecture youth about engaging in sexual activity. This discourages youth from returning to the clinic to access a contraceptive.

2.5.4 Culture as a barrier to contraceptive use

Other barriers cited were that contraceptive use was not allowed culturally (Ramathuba, 2012). It has been as culturally taboo to discuss contraceptives and sex. Therefore requesting or discussing a contraceptive is seen as admittance to sexual behaviour causing disapproval (Hoffman-Wanderer et al. 2012). In South Africa, there is now a need for a woman to prove her fertility before 'lobola' can be paid for in African culture (Todd et al. 2011). This is a move away from the requirement that a woman bears children within a marriage setting. This discourages women from using a contraceptive. The high prevalence of HIV and AIDS has somewhat modified this requirement especially in the province of KwaZulu-Natal where virginity has become very valuable in lobola negotiations. Culture requires a man to pay more cows for a virgin. However, HIV AND AIDS may have made it more desirable for a woman to save herself for marriage but not for a man to do so. Therefore culture can be used as a barrier for women accessing contraceptives in certain settings.

2.5.5 Poverty

Poverty has been identified as a barrier to contraceptive use in South Africa (DoH, 2011). Poverty can be a barrier if the individual wishing to access contraceptives is unable to do so because they cannot afford the service, either because the clinic is far and they do not have the money to pay for transport or that their desired method is unaffordable to them. There is therefore a relationship between poverty, access to contraceptives and use of contraceptives. Even though South Africa offers free contraceptives at public health clinics, poverty can still act as a barrier especially where an individual is forced by poverty to exchange sex for money thus diminishing their ability to negotiate the use of a contraceptive (Adebowale et al. 2014; DoH, 2011). Poverty has been identified as a barrier to consistent condom use. If the condoms were not available within short distance to the user, they would not be able to access it if they had limited resources (Chirinda & Peltzer, 2014).Their socio-economic status puts women at the mercy of those who have money and can offer financial assistance to them. Females especially those who are poor, have less autonomy over their bodies. This low autonomy means that they are unable to make decisions regarding their bodies because they are dependent on someone else for financial support, this source of support may be a male partner. This has been associated with low contraceptive use (Bamiwuye et al. 2013).

The relationship between poverty and contraceptives has many aspects. It has been found that a wide gap in the income of the poor and the rich can impact access to health care of the poor. It has also been found that planned child birth can allow a woman the opportunity for employment (Longwe-Ngwira, 2014). The woman is able to earn an income and support her family and she is also more likely to find employment outside the home. Births that are less than two years apart may restrict her to low paying work in agriculture (Longwe-Ngwira, 2014). Poverty may have adverse effects on individuals such as restrict their access to contraceptives, lack of access to contraceptives may force individuals into further poverty causing a vicious cycle of poverty in the long term. Barriers to students using contraceptives were the parents' level of education and income that in turn affected the income of the student (Miller, 2002. The students often did not have money to purchase contraceptive methods that are not obtainable without charge. Therefore poverty can act as a serious barrier to students accessing and using a contraceptive.

2.5.6 Knowledge

It is often assumed that student's low use of contraceptives can be attributed to lack of information. Therefore it is also assumed that with adequate information individuals are more likely to use a contraceptive. Authors have found that students' knowledge concerning contraceptive did affect their subsequent use (Makhaza & Ige, 2014). However other studies have concluded that increasing information will increase use, there is a contradiction in the literature on this topic but the dominant view is the view that knowledge will increase use. Studies in the past have also indicated that there is adequate knowledge about contraceptives (Panday et al. 2009). Knowledge that has been identified as lacking includes information related to how conception occurs and information on the effects of inconsistent use of contraceptives such as the oral pill (Willan, 2013). It is also important that youth are armed with correct information to allow them to use contraceptives correctly and consistently. Lack of information may cause the youth to be uncertain about using a contraceptive for the fear of side effects and myths. The youth therefore should be encouraged through the dissemination of correct information.

2.5.7 Sources of contraceptive information

It has been argued that is it can dangerous, problematic and misleading to assume that university students have any or sufficient knowledge about issues surrounding unprotected sex (Ndima, 2013). Therefore it is better to assume that there is limited knowledge. The main

sources of information about contraceptives for youth were friends (Hoque & Ghuman, 2012). It is easier to discuss contraceptives with friends because of age and openness that exists in friendships. Youth preferred friends and informal sources rather than schools and clinics (Makhaza & Ige, 2014). Many of the youth could not discuss the issue of contraceptives with their parents because there was a lack of open communication (Ramathuba, 2012). This was out of fear that the parent would find out that they were sexually active. There seems to be a culture not to discuss sex or contraceptives with children; it is seen as the norm (Mkhwanazi, 2010). Talking openly about contraceptives becomes a cultural taboo (Cobb, 2010). This becomes a barrier to the youth receiving information on sexual health and contraceptives from their parents and guardians. It has been noted that there is a lack of reading material on contraceptives for the youth especially in the rural areas; and much of the reading material is not in the language that is spoken by the youth (Lebese et al. 2013). The youth would like to receive information in a language that they speak at home. This would make reading material easier to understand.

2.6 Gender relations & contraceptive use

"Girls subordinate position in the gender and social hierarchy contains their ability to make real choices around pregnancy.' (Jewkes, Morrell and Christofides, 2009:675)"

Little has been done to examine how social issues act as barriers to contraceptive use, with the non-use often leading to unwanted or unplanned pregnancy. The decision to use a contraceptive may not rest with one partner in the relationship, it is therefore important to explore how gender relations impact on contraceptive use. A study conducted by Peer & London (2013) in a low income community in the Western Cape aimed at determining the socio-demographic, substance use, psychosocial and partner characteristics associated with women's contraceptive use. The study found that women that believed that men were entitled to make decisions relating to contraceptive use were more likely to use a contraceptive. These couples often discussed contraceptives and decide together. Therefore the male partner played a supportive role in the decision to use a contraceptive.

2.6.1 Role of the male partner on decision to use a contraceptive

There are different views on the role and influence of the male partner on the decision to use a contraceptive but there seems to be consensus that they do play a role. It is therefore important to ascertain how much influence they actually have in different communities under different contexts. The introduction of safe contraceptive methods has changed gender dynamics; it has

changed the way that women are seen by society. It has afforded women the opportunity to pursue higher education and employment thus resulting in greater financial and social autonomy (Kavanaugh & Anderson, 2013). Therefore access to contraceptives can be seen as a step forward for women's rights. However not all women are able to access contraceptives, many women are barred by their partners from accessing and using such contraceptives. Women may fear violence from a male partner and this may become a barrier to the use of contraceptives. The balance of power in relationships directly affects the use of contraceptives (Do &Kurimoto, 2012).

2.6.2 Notions of Masculinity

Studies conducted in the Eastern Cape found that women had very little autonomy once they had consented to a relationship. Woman are not able to insist on the terms of sexual intercourse once they have consented to the relationship, therefore consent to the relationship is consent to be under the authority of the man (Jewkes & Morrell, 2012). Men may practise what is called hegemonic masculinity, this entails the man becoming the dominant figure and having control of a woman through violent and nonviolent means within a relationship, this is considered the cultural ideal of manhood (Jewkes &Morrell, 2012). The theory of hegemonic masculinity was coined by Connell (1987-1995); many authors have believed that this particular theory legitimises unequal and violent relations between men and women in society (Jewkes & Morell, 2012). Hegemonic masculinity structures gender relations between men and women, between men themselves and between masculinity and femininity. This causes and legitimates hierarchies between the genders and thus supports gender inequality. Hegemonic masculinity can be analysed on 3 levels; the local which is the face to face interaction of families, regional which is the society wide level of culture and the global which is the transactional arena such as the world politics and the media (Messerschmidt, 2012). This has been seen as the reason for the high levels of violence against women because by its very nature hegemonic masculinity requires that the man dominates and control the woman, and violence erupts in an effort by the man to control the woman.

Other scholars has disputed this and claim that hegemonic theory only accepts the existence of such relationships where there are agreed values and practices and this is not necessarily associated with violence and repression (Jewkes & Morell, 2012). It has also been argued that hegemonic masculinity needs the buy-in of the women, therefore women who over emphasise femininity are in fact perpetuating their own oppression. Therefore hegemonic masculinity may

be indirectly practiced by women themselves (Jewkes &Morell, 2012). There are at least 3 types of hegemonic masculinities in South Africa, they are built on certain ideals, gender norms and images of what men and women should look like and how they should behave. The women is portrayed as being submissive to her male partner and the male having authority over her thus further fuelling violence against women (Morrell et al. 2012). A study conducted by Talbot and Quayle (2010) found that women wanted the men in their relationships to provide for them, protect them and be in control and be dominant. In the social arena though they expect men to treat women as equals and be gender progressive. This is confusing for both men and women as they are expected to assume different roles in different settings. The study showed that gender roles "are produced contextually and are validated by both men and women" (Messerschmidt, 2012:65).

Women are exposed to patriarchal power and inequality from a very young age in South Africa. They then learn to negotiate the terms of their sexuality under these harsh conditions. The female is seen as passive and defenceless in these heterosexual relationships where hegemonic masculinity exists but this is not necessarily true, it has been well documented that many woman are able to trade sex for money and other goods and services (Jewkes &Morell, 2012). Many women are able to have more than one partner and are able to choose a partner that they think is suitable. A suitable partner is typically one that they could respect, submit to and made them feel good and feminine. A woman often has agency at the point of choosing a partner but once in a relationship with the chosen partner she must submit to him (Jewkes & Morrell, 2012). Once the woman has submitted to the partner in an effort to keep him, they lose any power they may have had. This leaves them vulnerable and unable to negotiate better treatment or have a say in the decision to use a contraceptive (Jewkes & Morell, 2012). This seems to be a norm that women accept, they view such behaviour as their choice, and this is what made their lives more culturally meaningful. This is the opposite of what a 'modern' woman would want, which is to be free (Jewkes &Morell, 2012). The women are unable to terminate the relationship even if the partner is unfaithful or violent. It becomes even more difficult for a female to negotiate safe sexual practises in a relationship where sex is exchanged for money or gifts. The partner that is supplying the money has more power in the relationship and they can dictate the terms of sexual engagement. This may result in non-use of contraceptives; this is especially true with university students who are known to engage in these types of relationships often with older partners. This is done in exchange for money and gifts that fund their studies and lifestyles (Mazvarirwofa, 2014). The students may feel that they do not have any other

option and thus submit themselves to the partner knowing the risks associated with such behaviour. Students socialise with a large number of other young adults and this encourages sexual activity that may expose them to non-use of contraceptives and thus pregnancies (Hoque, 2011).

2.6.3 Intimate partner violence

"Violence is a consequence of gender power inequities at both a societal and relationship level, and also serves to reproduce power inequities" (Jewkes et al. 2010:41). Gender-based violence is formed by the patriarchal nature of society because ideals such as strength and toughness of a male and submissiveness of a female are celebrated. Jewkes et al (2010) argues that this translates to risky sexual behaviour, predatory sexual practices and violence against women. It is imperative and encouraged that men have many sexual partners and exercise control over their female partners. This results in more coerced sex and less condom usage (Jewkes et al. 2010). High gender-based violence in developing countries is associated with risky sexual behaviour such as multiple sexual partners and no condom use (Jewkes et al. 2010).

Intimate partner violence (IPV) is another form of violence that is perpetrated against women. The World Health Organisation (WHO) has defined IPV as “any behaviour within an intimate relationship that causes physical, psychological or sexual harm to people in the relationship” (WHO, 2013) this includes physical, sexual, emotional violence and controlling behaviour (Oluwaseyi & Ibisomi, 2015). IPV can be perpetrated against women by their intimate partners such as boyfriends and husbands. IPV is a serious and frequent form of gender violence against women that occurs worldwide but is more prevalent in Sub-Saharan Africa (Oluwaseyi & Ibisomi, 2015). Oluwaseyi and Ibisomi (2015) argue that IPV can be a barrier to women accessing and using a contraceptive in Sub-Saharan Africa especially. The high prevalence of IPV has resulted in low contraceptive use in Sub-Saharan Africa. IPV can affect men as well however it is more common in women.

IPV is caused by gender inequality norms that promote violence against women. It is a women’s right to decide when to have children, it is a matter of health and a human right (Maxwell et al. 2015). Denial of access to contraceptive to women through IPV is a violation of their human rights and this should be frowned upon and discouraged in communities. It is critical to understand how IPV affects the women’s ability to use family planning methods, understanding this will allow for the design of family planning interventions that allow women who experience IPV to engage in fertility and HIV prevention interventions. IPV can occur

among cultural, social-economic and religious groups (Devries et al. 2010). IPV manifests itself as negative health outcomes that are related to reproductive and sexual health in women. These negative health outcomes can be; repeated pregnancies, unintended pregnancies, termination of pregnancy and HIV infection (Maxwell et al. 2015). Other consequences of IPV can affect the unborn child such as still birth, premature labour, low birth weight; it also causes low self-esteem, isolation from social networks and fear of intimacy in the victim (Oluwaseyi & Ibisomi, 2015). Low self-esteem is caused by shame and embarrassment associated with constant violation. The woman will isolate herself from her social network because she may be afraid that family and friends will find out about the abuse and violence and judge her but sometimes her partner will force her to disassociate herself from her family and friends in an effort to tighten his grip and control over her. Women are often forced into sexual activity and unprotected sex thus increasing their chances of unplanned and unwanted pregnancy and risk of STIs. Contraceptive use may be denied in order to increase a woman's dependency on the male partner; this increases the man's decision making power in the relationship. This forces the female to use a contraceptive in secret thus opting for methods that is not visible; this limits her family planning options. Gender issues such as IPV can be the only issue that stands in the way of a couple using a contraceptive. More attention and resources need to be allocated to understanding how IPV affects the use of family planning services. Not taking the issues of gender inequality and violence has made many interventions unsuccessful.

2.6.4 Early sexual debut

Coerced sexual debut can also affect the power of the women in the relationship and thus can affect the use of contraceptives. Coerced sexual debut can be defined as "the act of forcing (or attempting to force) another individual, through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behaviour against his or her will" (Ritcher et al. 2015:304). Early sexual debut can be defined as "experiencing first sexual intercourse at or before the age of 14" (Ritcher et al. 2015:304). Sexual debut may be influenced by culture and the context that the young person finds him or herself. Early sexual debut can increase the risk of sexually transmitted diseases and low contraceptive use. Sexual debut occurs between the ages of 17 and 20 internationally, the age of sexual debut in Sub-Saharan Africa is not much higher (Pettifor et al. 2009). The age of sexual debut in South Africa is 16 for males and 17 for females. Early sexual debut can lead to negative social consequences for women such as accepting violence and male domination in relationships (Ritcher et al. 2015). Gender norms in the 1990s and 2000s have been defined by masculinity that required

multiple sexual partners with the approval of the use of physical and sexual violence against female partners. The decision to use contraceptives such as condoms lay with the male, women become fearful to discuss condoms and other forms of contraceptive because of fear broaching this issue could lead to violence (Pettifor et al. 2009). Therefore gender relations and gender inequality affect how women experience sex and the risks associated with such. Studies have found that the older the partner is to the female the higher the likelihood that sexual debut will be earlier and that it may be coerced (Ritcher et al. 2015). Therefore women who are in relationships with much older partners are at risk of coerced sexual debut, this includes students who have been noted in recent studies to engage in relationships with older partners for financial gain.

2.6.5 Contraceptives available to men

The male has only a limited number of contraceptives available to him, including coitus interruptus, periodic abstinence, condoms and vasectomy. These methods have been criticised for being irreversible and permanent but sometimes they have a high failure rate such as coitus interruptus (Wersch et al. 2012). The condom is the only male contraceptive that is not permanent but also very reliable. However studies have shown that men view condoms as a method to be used with casual sexual encounters or to be used at the beginning of new relationships. Therefore they cannot be used with a permanent partner because this signals distrust or unfaithfulness. The condom is not viewed as a long-term contraceptive method (Wersch et al. 2012). This view is a contributing factor to low condom use among men.

There needs to be a wider range of contraceptives available to men. Researchers have been developing the male contraceptive pill since the 1970's but it is still not available on the market. The reasons given for this delay in its availability are psychosocial and cultural factors as well as the fear that the male contraceptive pill may have long-term negative effects on the ability of the male to have children (Wersch et al. 2012). The female contraceptive pill was introduced in the market after only 10 years of its development; the side effects were refined while it was in use but for men, there is more caution which could be a sign of a lack of interest in the development of such a pill for men. Men fear the connotations associated with using the male pill. Men feel the pill will threaten their masculinity as using a contraceptive pill is associated with women, another reason for this fear is that masculinity is based on sexual performance and fertility, the male contraceptive pill will decrease fertility and thus threaten the traditional notions of hegemonic masculinity (Wersch et al. 2012).

2.6.6 Including men in family planning

It is essential to include men in family planning interventions. This can improve access to family planning services for women and thus increase the outcomes of such interventions and gender equity (FHi360, 2012). Many men have the decision-making power in the household and this includes decisions concerning healthcare thus their support for use is imperative. It is, therefore, unwise to assume that sexual and reproductive health decisions lie with the female in the home or relationship. Family planning programs should target the males as well because they are often the bread winner in the home and pay for healthcare (FHi360, 2012). Prevention strategies have tended to focus on male condom use, making the decision of using a contraceptive such as a condom up to the man. Gender issues are not taken into account and are allocated limited resources; this creates a gap in effectiveness because gender issues play a very crucial role in access and use of family planning services. It was recommended that actions to promote contraceptive use should focus on increasing male partner support and communication. Other experts have also argued that men should be included in family planning initiatives as this was likely to yield more benefits rather than focusing on the female only (Motlala & Mpolokeng, 2010).

Including men in family planning interventions can be a long process that requires commitment because this process requires changing deeply entrenched gender norms. There can be many cultural views and myths that are against a man involving himself in family planning. Family planning spaces may be uncomfortable for a man, therefore training more males as health care providers may make it easier for men to consider using family planning services (FHi360, 2012).

It is very important that men are included otherwise interventions that only target females will be less effective as it has been established that men's attitudes can be a barrier to women accessing and using family planning. South Africa could learn from this and include men in interventions to help men understand female contraceptives and also change the attitude that contraceptives are the responsibility of the female.

2.7 Predictors and influencers to contraceptive use

Peer and London (2013) found that there were certain factors that were predictors of contraceptive use which were named as high self-esteem, having a child or previous pregnancy and level of education.

2.7.1 Level of education and contraceptive use

Education is an influencer of contraceptive use that comes up often in the literature, some authors believe that education makes a woman more determined to plan her pregnancies because of the opportunities that education provides. She may also have more autonomy and agency to make decisions that affect her life including contraceptive use because she has an income of her own. Therefore the converse may also be true, that if she lacks education she may lack the autonomy to make decisions regarding use of contraceptives and she may rely on her male partner to provide for her. It is believed that level of education increases the chances of contraceptive use (Pillai & Teboh, 2010). This is because there are more opportunities that come with further education and therefore this decreases the desire for large families (Pillai & Teboh, 2010). The women have more to lose by having an unplanned pregnancy especially if she is looking to further her career. She is also able to afford contraceptives and does not rely on state supplied family planning that is free.

In Sub-Saharan Africa, the Education Index (EI) found that education levels have increased from 0.34 to 0.39 between 2000 and 2010, expected years of schooling have also increased from 3.9 to 4.4 with South Africa having an average of 8 years in school (Emina et al. 2014). This means that individuals are spending more time at school than before leading to a higher number of graduates. In most Sub-Saharan African countries modern CPR has increased between 10-19%, this suggests a correlation between education and contraceptive use (Emina et al. 2014). It has been argued that this correlation is caused by the fact that women are able to make better decisions with a higher educational qualification. However, this is not the case in all countries because inaccessible contraceptives continue to be a barrier regardless of education. The converse is also true, easily accessible contraceptives will increase usage even in the absence of high education (Emina et al. 2014).

Wang, Alva, Winter& Burgert (2013) conducted a study into community level influences on contraceptive use such as socio-economic development, empowerment of women and access to information about modern contraceptives. They found that a community's level of economic development could have an impact on contraceptive use. For example better roads and higher

population was associated with development related closely to a woman's geographical access to family planning (Wang et al. 2013). Living in a community with high levels of economic development and modern ideas can affect a woman's ideal family size and attitude towards family planning (Wang et al. 2013). Pillai and Teboh (2010) concluded that women in urban areas were more likely to use contraceptives than women in rural areas because they were more likely to have better access to contraceptives. Therefore location of the potential contraceptive user may become a barrier to them accessing and using a contraceptive. In rural areas where clinics are far, it may be difficult for users to reach the clinic and it may be expensive to travel back and forth from the clinic. This will limit the use of contraceptives, therefore it is important for government to look into developing both infrastructure and capacity when it comes to provision and access to health care.

2.7.2 The media and contraceptive use

The media were not a seen as a major determinant of contraceptive use. The issue of media is often referred to when social marketing campaigns (SMC) are mentioned. It is not mentioned how traditional media services such television projects using sex on an everyday basis. The reality is that SMC have to compete with advertisements and programmes that portray sex as free, without consequences and 'cool'. They rarely show the consequences of unprotected sexual behaviour. The youth in South Africa rely a lot on the media for information and many of their life decisions are influenced by what they see in the media. This makes media a very important tool that can influence attitude change and thus social change. Media is a powerful tool that can be used to influence the Youth. The South African Broadcasting Corporation (SABC) has used shows in an effort to influence the behaviour of youth (Smith, 2011).

In the 1970's an American team of researchers conducted research to demonstrate that media more particularly television could influence the public's view on contraceptive use (Bakht et al. 2013). They believed that contraceptive awareness was directly proportional to the level of investment in advertisements. Therefore the more time and money that is invested in contraceptive use campaigns, the more the public is likely to use contraceptives (Bakht et al. 2013). The Netherlands was used as an example where the government invested heavily in contraceptive campaigns resulting in the increase of awareness and use. Developing countries such as Pakistan and Bangladesh have also reported an increased awareness and use of contraceptives. The results of the study that was done in India showed that there was a link in ownership of access to a television (TV) and contraceptive use. Those who had access to a TV

were more likely to use a contraceptive when compared with those that did not (Bakht et al. 2013). The Indian couples that had access to a TV were 80 to 90% more likely to use a condom or an oral contraceptive (Bakht et al. 2013). The study has highlighted the importance and role of media in increasing contraceptive use in both developed and developing countries.

The media also has a role to play in disseminating information about contraceptive use. Social marketing campaigns (SMC) have become very important in governments efforts to increase contraceptive usage. Campaigns to increase the use of contraceptives or to change sexual behaviour have become common, these campaigns can be found in TV, radio, billboards, posters, magazines and newspapers. The user of these is passive, meaning that they do not choose to be given the message but get the message as part of a routine use of such media (Wakefield et al. 2010). Those messages that are disseminated in the internet and mobile phones are of a more active nature because the user actively seeks the information.

SMC campaigns however have to compete with pervasive marketing by-products that often send opposing messages; they also compete with existing social norms that can be very influential, it is therefore very important that the content and format is planned carefully to meet the needs of the intended audience (Wakefield et al. 2010). It is not enough that the message is just constantly disseminated in the media they are not formatted correctly for the audience. Mass media often shows persuasive sexual images but do not show the consequences of risky sexual behaviour. Therefore it is important that the SMC campaign to have good understanding of the targeted audience to be able to have an impact on their behaviour. It is the duty of the government to ensure that their campaigns stay up to date with the preferences of the youth; therefore the campaigns need to evolve with time to cater for the changes in preferences. There should be campaigns directed at the youth specifically and there should be refraining from using the same campaigns for both youth and adults. A recent study in South Africa found that exposure of youth to programmes promoting contraceptive use was not associated with current contraceptive use (Seutlwadi, 2012). This shows that the current efforts by the government for encourage contraceptive use among youth need more work and are not as successful as they need to be.

2.8 The use of contraceptives by the youth

2.8.1 The condom

Even though there are many forms of contraceptives as previously mentioned, the condom is the most popular contraceptive method among youth in South Africa (Seutlwadi, 2012), (Hoque &Ghuman, 2012) hence this literature wished to explore factors that hinder and encourage condom use.

A study conducted by Maticka-Tyndale on men between the ages of 15 and 49 in 14 Sub-Saharan Africa countries about condom use revealed that men that were younger highly educated and had greater economic resources and urban dwellers were more likely to use a condom than those who were not (Maticka-Tyndale, 2012). Condoms were the jurisdiction of men and women had many social and cultural constrains when it came to introducing condoms into the relationship. The condom is rejected because it contradicts the norms of masculinity and femininity (Maticka- Tyndale, 2012).

Men feel it is their responsibility to bring up the condom but there is uncertainty about who should initiate the use of the condom within the relationship (Mantell et al. 2011). Men also feel that women do not care if a condom was used or not because they failed to ask for a condom. Men expected a woman to resist sex without a condom but otherwise, they would not insist on condom usage themselves. There is often little communication about sex in many relationships, men feel that talking about condoms and sex with a female partner is difficult because women were uneasy about the subject. They also felt that a condom was necessary amidst the increased rate of HIV infections in the country but they preferred sexual intercourse without the condom (Mantell et al. 2011).

2.8.2 Challenges to condom use

South African youth are reported to have knowledge about condoms and the risks associated with non-use yet this has not translated into consistent condom use. Factors that contribute to the inconsistent use of condoms among the genders in South Africa have been explored by researchers (Chirinda & Peltzer 2014). They conducted a study to explore the individual, social, structural and behavioural risk factors associated with inconsistent condom use among 18 to 24-year-olds in South Africa. Past studies have revealed that only 87.4% of men and 73% of women reported using a condom at their last sexual intercourse (Chirinda & Peltzer, 2014).

Condoms use remains a challenge in South Africa; some of the reasons provided for the non-use or inconsistent use of condom use include unplanned sex. Sex is often unplanned, it happens when condoms are not available (Mantell et al. 2011). Planned sexual interactions are not common among youngsters who often use opportunities when there is no adult supervision. Therefore a condom may not be available at the time of intercourse thus it may not be used. It is also risky to carry condoms at all times because of the fear that parents may find the condoms; many parents are unaware that their children are sexually active.

After some time has passed in a relationship, trust is built and condom use stops (Mantell et al. 2011; Chirinda & Peltzer, 2014). Therefore a condom is used when there is no trust in the relationship; condom use is associated with distrust and infidelity. Condom use can also stop when the female partner accepts sexual intercourse without a condom (Mantell et al. 2011). The frequency of sexual intercourse also determines condom use, if intercourse occurs more than once than the likelihood of condom use decreased (Chirinda & Peltzer, 2014). There is a perception that continued use of condoms in a relationship is a sign of distrust and unfaithfulness. This puts pressure on the couple to prove fidelity to one another by stopping condom use.

If a woman was financially dependent on the partner she has very little say whether or not a condom is used in the relationship. This was made more difficult in a relationship where either physical or sexual violence was present, inconsistent condom use was also a feature (Chirinda &Peltzer, 2014).

It is stated that men have a natural desire for frequent sexual release and diversity in partners and insemination is taken as evidence of masculinity. Depositing sperm in a female is a sign of manliness and masculinity (Maticka-Tyndale, 2012). The condom is a barrier to the sperm being directly deposited into the female thus taking away the masculinity. There are beliefs that pregnancy enhances womanhood, therefore, sperm deposit is desired as it enhances female beauty (Maticka-Tyndale, 2012). These are the various reasons given by youth for the lack of consistent use of condoms.

A recent study conducted by Chirinda and Peltzer (2014) also found that consistent condom use was affected by a number of factors. Men referred to a lack of communication with the partner, structural factors such as employment, alcohol abuse prior to sexual intercourse and HIV and STI risk behaviour such as the number of partners, previous infections, and alcohol and drug abuse over the past 12 months. Females mentioned low efficacy/ self-esteem, social

variables such as communication with a partner about condoms and not having control over one's own body in a relationship were barriers to consistent condom uses. Other factors were structural variables which included difficulty accessing condoms. There were also issues of forced sexual intercourse or transactional sexual intercourse and sex with an older partner were also barriers to condom use for many women (Chirinda &Peltzer, 2014).

There were some commonalities in the factors that acted as barriers to condom use but there were also some stark differences. Women reported more social variables than men. Many of the barriers reported by men were self-inflicted such as alcohol and drug abuse prior to sexual intercourse (Chirinda &Peltzer, 2014). This speaks to the problem of women not being treated equally by society and thus leading to many injustices being experienced by women. Women were seen to report more honestly about inconsistent condom use while men did not. This study also differed from past studies in that it did not find inconsistent condom use to be affected by the length of the relationship, early sexual debut, the frequency of sexual intercourse or HIV status (Chirinda &Peltzer, 2014). The authors recommended that future interventions aimed at increasing consistent condom use among youth in South Africa should focus on individual factors such as self-efficacy/sufficiency, attitudes, and structural concerns such as access to condoms for women and communication skills between partners. However, the authors failed to recognise many of the social barriers experienced by women such as not having control over one's body within the relationship and poverty that has forced women to engage in transactional sex. The social barriers cannot be ignored as they are the strongest barriers to sexual and reproductive health and rights experienced by women. Alcohol may also be a barrier to contraceptive use especially condom use. A study by Watt et al. (2012) revealed that alcohol made men and women more willing to have sex without protection. Women who exchanged sex for alcohol were not in a good position to negotiate condom use because by accepting alcohol from a man meant a woman was giving up control of the sexual exchange to the man. The man could then decide the terms of the sexual exchange (Watt et al. 2012).

2.9 Conclusion

This chapter has provided a summary of the literature on contraceptive use among youth internationally, in sub-Saharan Africa and in KwaZulu-Natal. This literature review suggests the issue on low contraception use is not a problem unique to KwaZulu-Natal but it is an international concern. Contradictions that existed in literature was identified along with gaps that need further research.

Chapter three

Research Methodology

3.1Introduction

There have been concerns about low contraceptive uptake in developing countries like South Africa due to the high fertility. In an effort to meet the Millenium Development Goals (SDG's) 4 and 5 which are; to reduce child mortality and improve maternal health respectively, governments have taken the issue of contraceptive use more seriously. MDG's have now been replaced by Sustainable Development Goals (SDG), SDG's are an expansion on the MDG's and they are also a plan for the next 15 years. World leaders hope to eradicate hunger but also aim to empower all women and girls (Guardian, 2015). A way to empower women and girls is through education. Higher education has been linked to higher contraceptive use (Pillai & Teboh, 2010). This study aimed at ascertaining the perceptions of university students in Durban, South Africa towards contraceptive use. The study also aimed to ascertain how social and interpersonal relationships impacted on this perception. The youth is seen as the future leaders and agents of change, therefore, their views and perceptions are of utmost importance.

This section details the methodology used to conduct this study. This study used a qualitative research method. This study answered the research questions using a qualitative approach, including a semi-structured interview. This chapter will provide a brief background of the study area and setting. It will also detail the data collection process including the sampling process. The data analysis techniques will be described including the ethical considerations and study limitations.

3.2 Study area

The province of KwaZulu-Natal also affectionately known as the "Kingdom of the Zulu" or the "garden province", is home to 10.69 million people, making it the province with the second largest population in South Africa (Statistics South Africa, 2014). It takes up 7.6 % of South Africa`s land area (Statistics South Africa, 2013). The fertility rate is 2.98, the fourth highest in the country, the life expectancy stands at 54.4 years. Unfortunately, the province has a high poverty rate with 23% of households living in extreme poverty and the majority of the top 10 poorest municipalities being found here (Statistics South Africa, 2014). The employment rate sits at 20.8% under the strict definition. However not all is doom and gloom, the city of Durban is one of the top tourist destinations in South Africa, it has been ranked second in Africa as a

business and events destination (http://www.southafrica.net/za/en/guides/entry/destinations ,Accessed December 5, 2015) because of its breathtaking views.

Figure 3.1 Province of KwaZulu-Natal.

Source: Google Maps

3.3 Background on the University of KwaZulu-Natal

The University of KwaZulu-Natal was born in 2004 out of a merger between the University of Natal and the University of Durban-Westville (http://www.ukzn.ac.za/about-ukzn/history) Accessed 5December 2015. The University Natal was founded in 1910, at this time it was known as the Natal University College with just one campus in Pietermaritzburg. It extended to Durban after the First World War, the Howard College Campus was opened in 1931 and the Medical School in 1947. In 1949 it received its independence status (http://www.ukzn.ac.za/about-ukzn/history) Accessed December 5, 2015. The university of Durban-Westville was established in the 1960s at the Salisbury Island, it originally catered for Indian students only but after many struggles it opened its gates to all races in 1984. The University of KwaZulu-Natal boasts five campuses situated between Durban and Pietermaritzburg. This study was conducted at the Howard College campus in Durban.

Figure 3.2 University of KwaZulu-Natal, Howard College Campus

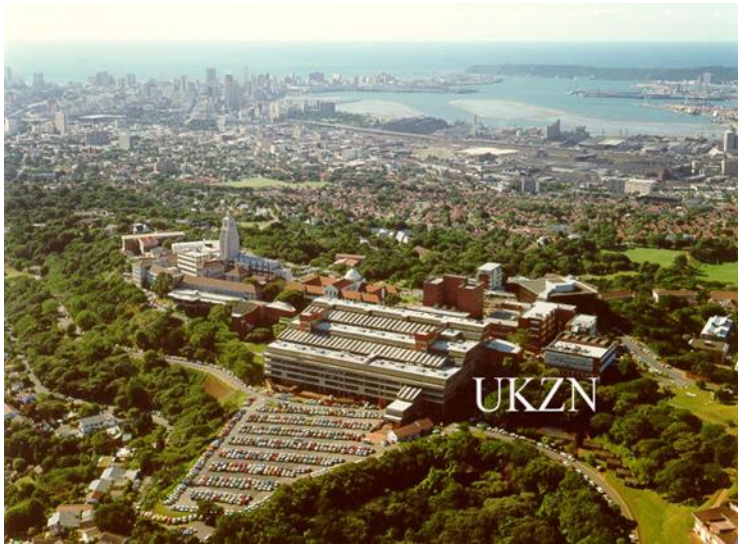


Figure 3.3 University of KwaZulu-Natal, Howard College Campus

3.4 Research design

This is an exploratory study using qualitative methods. Qualitative methods were used because the aim of the study was to understand the perceptions students had toward contraceptives, how accessible contraceptives were to students, what some of the barriers to accessing contraceptives were and how interpersonal networks influenced the student's views of contraceptives. Qualitative research is able to describe human experiences, they are also able to help understand attitudes of people and assist to discover important issues that might be influencing those human experiences (Brikci, 2007). Qualitative methods aim to answer the

"what, how and why", in order to understand how individuals feel or view a certain issue, qualitative methods are often best (Brikci, 2007). This study used face to face interviews with selected participants as a data collection method.

This research was conducted under the post-positivist paradigm; this paradigm believes that there is an existing reality but this reality is flawed because human intellect is flawed (Guba & Lincoln, 1994). The inquiry is done in more natural settings and the information collected is more situational. It takes context into consideration. The aim is to determine the meanings and purposes that the people give to their actions and lead to the prediction and control of a behaviour through a qualitative inquiry (Guba & Lincoln, 1994). Knowledge is built like a building block with each new finding adding to this knowledge block. The aim of this study was to add to the existing body of knowledge.

3.5 The selection process

The sample included both male and female students from all levels of study and across all schools. Both genders were included because contraception use should be the responsibility of both parties within in the relationship, it is also important to understand the perceptions, attitudes and contraceptive use of both men and women. It was noted during the data collection stage that males were unwilling to participate in the study due to their reluctance to discuss sexually related matters; this then allowed the majority of the students to be female. A non-probability sampling method called convenience sampling was used; therefore not all potential students had an equal chance of being selected. Convenience sampling was used to select the students that are on campus. A screening question was used to determine whether the participant was currently using a contraceptive.

3.6 Sampling

The sample included 20 students between the ages of 18 to 30; this included both male and female students. Research has found that the majority of unintended pregnancies occur among women under the age of 25 and university students are on average under 30 years. In addition, university students often become agents of social change in society and often display the general attitudes of society, this is the reason students were chosen for this study (Gresh, 2010). It is also important that the views and attitudes of the youth the examined. The study included a mix of users and non-users of contraception. The sample included undergraduate and postgraduate students from all faculties. It was originally intended that the sample should include 10 male and 10 female students but due to difficulties in accessing male participants,

only 20% of the sample were males. The majority of males were unwilling to speak about sexual matters; the reasons given were that it was uncomfortable to discuss this matter with a female researcher. Many of the males were concerned about issues of confidentiality. Female students were more willing hence the majority of the participants were female.

3.7 Data Collection

This study adopted a qualitative methodology. Students were approached directly and the interviews took place at a venue that was private and comfortable for the students. It was important that participants were comfortable in order to ensure that they could speak openly. A Semi-structured questionnaire was used for all the interviews, the questions were open-ended and students were allowed to elaborate on their answers. However, new questions were added if the need arose during the interview and depended on the answers given by the participants. Participants were given a chance to seek clarity on any question that they did not understand, and they were also be given an option to refuse to answer a question that they were not comfortable answering. Interviews were primarily conducted in English. Each interview was an average of 30-40 minutes. The interviews were recorded using a voice recorder with the permission of the participant as indicated in the informed consent form and notes were taken to ensure that all the information was captured. Information such as age, gender, the number of children as well as the level of their studies was recorded to determine whether contraception use is influenced by any of these factors. Validity, reliability and rigour of the study were ensured through triangulation which included an in-depth literature review.

The biggest challenge was booking the interviews; students were often reluctant because they were concerned about the time that the interview would take. It became necessary for the researcher to make appointments for the afternoons when lectures had ended. Many appointments were cancelled by the participants at the last minute because of other obligations. It was difficult to keep postponing but at the end, persistence did pay off. There was also the concern around confidentiality because the interview was recorded. The consent form helped to ease their concern about confidentiality.

There were many interesting interviews. Those interviews that were difficult became so because the participants were giving yes or no answers and this required a lot of probing from the researcher. There were also many participants who had questions about contraceptives and were so happy about the interview session that they introduced me to friends who they thought would be willing to participate. Those participants that had serious concerns about

contraceptives and sexual health were referred to the university health clinic for further professional assistance. The data collection lasted over two months because of the constant postponements from the participants.

3.8 Ethical considerations

Prior to the research being conducted, a proposal was written and passed through the School of Built Environment and Development Studies, it was assessed by two reviewers and then sent to the Higher Degrees Committee. It was also sent to the Ethics committee at the University of KwaZulu-Natal. This Ethics Committee granted approval (Protocol Ref number: HSS/0693/015M). The registrar was also requested to provide permission to conduct the research on the university premises. Such permission was granted to the researcher. The students were given a consent form to sign to ensure that their participation was voluntary and to ensure that they were aware that the information that they provided would remain anonymous and that their names would not be recorded. The names of the students were not used in the report so as to maintain anonymity. Each participant that was approached was given an opportunity to refuse to participate in the project so as to ensure that the data collection sessions involved only those who are genuinely willing to take part and prepared to offer data freely. This also ensured that the responses of the students were as honest as possible. Students were encouraged to be as honest as possible from the outset of each session indicating that there are no right answers to the questions that were asked. Probes were used to elicit more detailed data and iterative questioning, where the researcher returned to matters previously raised by a participant through rephrased questions to extract related data.

3.9 Analysis techniques

The interviews were transcribed and the data was analysed using thematic analysis. A coding framework was developed to base the analysis, to make comparisons and organise the data. The data was then organised into key themes that emerged from the interviews. However, it is possible that the themes were predetermined by the questions of the standard interview questions. Not all the themes were covered in the final report; a value judgement was made where the most prominent themes were used.

A triangulation method was used to ensure the validity, reliability and rigour of the study. An extensive literature review from various sources was used to verify and explain the findings. Opportunities were also seized to examine any documents referred to by students during the

actual interviews because these may shed more light on the perceptions of the participants in question.

There was also an opportunity for the proposal to be scrutinised by colleagues, peers and academics. In addition to the outside scrutiny discussed above, the researcher evaluated the data, as it developed. This was done through reflective commentary, part of which was devoted to the effectiveness of the techniques that had been employed.

3.10 Study Limitations

The study was limited firstly by the selection and sampling criteria used because not all students were able to participate in the study due to time and financial constraints. Therefore the results of this study are not generalizable to the entire population of South Africa, thus raising a need for a nationwide study of this nature. The results are however transferable to a similar setting. Secondly, the study was limited by the fact that the student's behaviour was self-reported, contraceptive use being considered a sensitive topic and meant that not every potential participant was eager to participate in the study thus leading to under-reporting of sexual behaviour. There was no guarantee that the responses of the participants were the true reflection of their views, it is possible that participants gave responses that they thought were appropriate. The researcher being a fellow student could have compromised the answers that were given by the participants, participants may have been uncomfortable about giving away information that was too personal out of fear of being judged by the researcher. As previously mentioned that male students were reluctant to participate in the study, hence the views were skewed towards females because the majority of the participants were female.

The data was analysed, coded and interpreted by the researcher who may have had her own biases as to what information was important, however, the researcher was careful to guard against such biases. The researcher being a student and a female may have been biassed towards other female students, this was however avoided.

3.11 Summary

This chapter described the method that was adopted. It also described how the sample was selected, the data collection process and the challenges that came with it. The ethical consideration and study limitations were also described.

Chapter four

Findings

4.1 Introduction

This aim of the study was to understand the perceptions of university students towards contraceptives. It looked more specifically at use and accessibility of contraceptives among the students. In addition it examined barriers to use of such contraceptives as well as the role of social and interpersonal networks in influencing use. The study draws on in-depth interviews to better understand perceptions of contraception. The responses from these interviews were analysed and the following themes are the result of that analyses. These findings are not generalizable to the entire population as earlier stated but they can be transferable to a similar setting.

4.2 Sample Characteristics

The participants in this study were current students at the University of KwaZulu-Natal at the time of the interview. A total of 20 students participated in the study. The ages ranged from 18 to 30 years and there was a mix of undergraduates and postgraduate students. There were both male and female students. There were students from rural, peri-urban and urban areas, which allowed for a wider range of views. Information such as current use of a contraceptive, whether or not they were in a relationship and whether they had any children was also collected. This was done to establish whether or not there was a relationship between current use of contraceptive and number of children. Those who had children were further asked whether they were using a contraceptive at the time of conception and whether they were using one at the time of interview. This would be helpful in determining whether having a child had encouraged them to use a contraceptive or not. Two of the female participants had children, one was in a relationship and the other was single. They were both currently using a contraceptive. Both of the participants were not using a contraceptive at the time that fell pregnant. Both participants said they had knowledge of contraceptives but they were ‘just not thinking’. The study also aimed at establishing whether being from a rural, urban and peri-urban area had any effect on contraceptive use and views.

Table 4.1: Characteristics of Sample

Gender	Level of study	Hometown	In relationship	Contraceptive use
1.Female	Undergraduate	Rural	Yes	Yes
2.Female	Undergraduate	Urban	No	No
3.Female	Postgraduate	Peri-Urban	Yes	No
4.Male	Undergraduate	Urban	Yes	No
5.Male	Undergraduate	Rural	Yes	Yes
6.Female	Undergraduate	Urban	No	No
7.Female	Undergraduate	Urban	Yes	No
8.Male	Undergraduate	Peri-Urban	No	Yes
9.Female	Undergraduate	Rural	Yes	Yes
10.Female	Undergraduate	Peri-Urban	No	No
11.Male	Postgraduate	Rural	Yes	Yes
12.Female	Undergraduate	Rural	No	Yes
13.Female	Postgraduate	Peri-Urban	Yes	Yes
14.Female	Postgraduate	Rural	Yes	Yes
15.Female	Postgraduate	Peri-Urban	No	Yes
16.Female	Postgraduate	Peri-Urban	No	Yes
17.Female	Postgraduate	Rural	No	Yes
18.Female	Postgraduate	Rural	No	No
19.Female	Postgraduate	Urban	Yes	Yes
20.Female	Postgraduate	Urban	Yes	Yes

4.3 Knowledge about contraceptives

All of the students in the study had knowledge about contraceptives; they could give a general description of contraceptives as well as identify different methods. The methods that participants knew were the oral pill, injection and the inter-uterine device (IUD). Many did not mention the condom because they were not sure if the condom was a contraceptive. Some gave advanced definitions while most just had a basic idea of contraceptives. Those participants that had given advanced definitions were those who had taken the time to find out about contraceptives, many of these participants were the nursing students. They had acquired the knowledge in lectures. The participants that had a general idea of what contraceptives were had not taken the time to gain the necessary further knowledge about contraceptives. These were mostly the male participants that admitted that they knew very little about female contraceptives.

"Contraceptives are pills or injections that are given mostly to women so they can prevent pregnancy. I am using the condom"… (Female, Participant#1).

"They (contraceptives) are things like pills, condoms. Are condoms contraceptives? I understand it to be something that is used to prevent pregnancy, HIV, like condoms and hormone injections. There are many like tubal ligation…I am using the condom" (Male, Participant#5).

"Contraceptives it's something that you use to prevent pregnancy or other STDs I guess. I say I guess because it's not every day that you get asked to explain what is a contraceptive… firstly condoms I know that they protect you from a lot of things. They specifically prevent pregnancy. There is the loop, there are injections and pills…I did put the loop 5 years ago so yes I guess I am using a contraceptive even though it's not in use now [laughs]" Female, Participant#15).

There were participants that were not too sure but could give a general definition without being able to give too many examples, they offered the following answers:

"Well, I think it's one of those things that prevent you from getting pregnant. …I know some like those pills. I can't say I know their names but I do know some of those pills and the injections too…condoms are they? Yes, I am using the condom (Male, Participant#11).

It's a pill used to prevent something in the organs of women but it prevents pregnancy … I have only heard of pills… I don't know that… because I don't really know the definition of contraceptives" (Male, Participant#4).

Many were unsure if the condom was a contraceptive method, therefore they did not list it as a method or they would ask if the condom was a contraceptive method. This shows a lack of clarity by certain participants about the different types of contraceptives especially the condom. Almost all the students did not mention the female condom; this speaks to the lack of popularity of the female condom as an option for youth. However, the male condom is still popular. The methods that were quoted by the participants were mostly female-controlled except for the male condom.

The students obtained their knowledge about contraceptives from a range of sources including friends, clinics, parents (family), church, workshops and the media. Friends ranked first as the most popular source of information, this was because the conversation with friends was said to be more casual, and it was described as less awkward. This finding is similar to what many other studies have found in the past that friends were the main source of information about contraceptives and sexual issues in general (Hoque & Ghuman, 2012). Many felt more comfortable to learn from the experiences of friends who were in the same age group as themselves; these talks with friends were termed informative. Friends were quoted as being reliable and would not report each other to parents. They were also more comfortable recommending contraceptives to others who were in the same age group because it was much easier and that their peers took each other seriously. Friends often did not judge each other but rather encouraged contraceptive use. It was reported that talks with friends about contraceptives were less intimidating then talks with parents and other adults.

"I trust my friends; they have better experience than me" (Female, Participant #7)

"Yes, I talk to some friends but some don't agree with using a contraceptive, but if we have a good talk at the end we can change their mind about it" (Male, Participant #5)

"Yes, we talk mostly about acne and other benefits of the pill" (Female, participant #9)

4.4 Accessibility of contraceptives at the university clinic.

Many students were unaware that the university health clinic provided contraceptives free of charge. It was noted that the clinic could improve their advertising of their services to increase knowledge among the students and allow better access. If the clinic could raise more awareness of their services it will give much more students access their contraceptives. The campus health clinic could be a vital tool that could help to increase contraceptive use and thus decreasing the

unwanted/unplanned pregnancies at the university. Of those that were aware that the university clinic offered contraceptive services they had become informed about this service by friends who had used it, others had been informed by the nurses at the clinic while they were there to consult about other health concerns. While others had been told about it at orientation and others had seen pamphlets and posters at the clinic.

However, there were not many students who were currently getting their contraceptive at the university clinic. Many opted to buy contraceptives at pharmacies and retail shops; others preferred private gynaecologists while some used their local clinics. The reason behind this low use could not be sufficiently determined, students quoted that nurses were not friendly at clinics in general. Therefore the attitude of the nurses on campus may stop students from going to the clinic to get reproductive health services. Other students had started accessing their contraceptive from their local clinic and just continued to do because they found it easier.

One participant said he had figured it out for himself and had this to say *"I'm not aware, I know that obviously clinics will have such sort but I'm not aware because I was not told. I knew that through my own knowledge. I figured it out because all clinics should have but nobody brought it to my attention"* (Male, Participant#5). He himself had not accessed a contraceptive at the university clinic because he was currently abstaining from sexual intercourse for religious reasons.

This participant also did not know that the clinic provided this service and expressed the need for such services to be advertised, she also feared that many students did not know there was a clinic on campus as she herself had just recently found out. *"No, I didn't. I don't really go there anyway. Eish, I'm not sure but then I don't, I've never seen anything about the clinic. I'm sure maybe is it me, but then I don't think so. I think for it's those sisters or nurses who work in the campus clinic, maybe they should post about it because there are so many on campus. Some people you will find that don't even know that there is a campus clinic coz myself I didn't know"* (Female, Participant#1).

Participant number 1 is a nursing student and was quite knowledgeable about contraceptive issues and she was concerned about the attitude of nurses. She hoped that this negative perception of nurses would change in the further when she was a qualified nurse. *"There are so many reasons coz maybe if I was young and probably the nurses. Sometimes nurses are very judgemental, ok I'm not gonna be judgemental like you what you want here? Why do you want this? You know they judge you but at the end of the day, you are responsible. Coz it's very very,*

how do I put this? It's known, it's well-known that nurses right now are very rude, judgemental and everything yah but then we will change that (laughs). I think so they bring their own opinions to work instead of just doing what they are supposed to do" (Female, Participant#1)

This male participant was aware that the university health clinic provided contraceptives as he had tried to access them in the past. He was disappointed that as a male he was unable to access the morning after pill. He attributed this to him being a male. The morning after pill was only accessible to the female. He was concerned that this limited him and that this could lead to unwanted pregnancies especially if his partner was not a student at the university. This meant that his partner could not go to the university clinic to access the morning after pill and he also could not access them. *"Yes but the morning after pill is not accessible to men, they don't give you. They say come with your girlfriend and she must be the one. What if your girlfriend is ugly and you don't like her being or if you don't want to be with her there? [If you ask] They will say no….but sometimes you will find that if you have two girlfriends and you don't want to be seen walking with the other girlfriend. And sometimes she is not a student here at the university, they will reject her anyway"* (Male, Participant#11).

4.5 Communication between parents and participants

Many of the students had discussed contraceptives with their parents. Those that discussed sex and contraceptives with their parents reported that it was very awkward and uncomfortable. They often did not tell speak openly about the topic, they mostly just listened to what the parents had to say because they feared being judged by their parents. Many of the talks were more like lectures where you were told what not to do rather than learning sessions about how to protect yourself. Students felt that they were disrespecting their parents if they divulged too much information about sex or contraceptives. Students stated that they would prefer more interactive sessions with parents where they would be free to ask questions and generally be more comfortable, but this space was often not provided.

However this was not the case with all the parents, there were parents that were open about discussing contraceptive with their children and some had gone as far as providing their children with contraceptives themselves. Participant 11 was one such a student, his parents provided condoms to him and therefore he used condoms without fear and he could always have access to condoms even when he did not have money to buy them. *"Yes, it was ok; they (parents) used to bring me condoms. They found out that I was using them so they said instead of me coming in a situation where I didn't have the money for them at least I will know that*

they are there (Male, Participant#11). Those students whose parents had discussed contraceptives with them were more confident with using contraceptives and felt that they had adequate information to make informed decisions about contraceptives. They also felt that they could always go back to their parents for more information and assistance should something go wrong and they would receive assistance from the parents. This created a relationship of openness between the parent and student; hence the student was unlikely to not use a contraceptive. One participant had discussed contraceptives with his parents and was currently using a contraceptive. *"My mum told me just in case I'm involved, she explained to me about the condom and how to protect myself against HIV and unplanned pregnancy"* (Male, Participant#5). He was confident about using a contraceptive. Other participants had tried to initiate such a conversation with the parents with no luck. *"We talked about how we never talked about it; they expected me not to be active"* (Female, Participant #10). Participant number 5 had discussed how they never talked about contraceptives with her parents but her parent's response was that they expected her not to be active.

Slightly fewer participants reported not having had the conversation with their parents about contraceptives. They wished that they had discussed this issue with parents but many parents were not open to such discussions and so the youth have to find other sources of information such as friends because this was more comfortable and they felt that they had nowhere else to go. A male student felt it would be nice to get his parents perspective on contraceptives. *"Yah to just to get their view you know about contraceptives and what they think of contraceptives and just the general stuff*" (Male, Participant#5). Clearly, there is a gap here where parents could be more open with their children and offer assistance in the future. In future campaigns to create awareness and encourage contraceptive use should also include the parents. Parents have a major role to play in the sexual health of their children.

Cultural taboos were quoted as some of the reasons that made parents reluctant to talk to their children about sex and other issues surrounding sexual health. Students were clearly interested in having such conversations with their parents. Some students reported that their parents felt that if they discussed contraceptives with them they were encouraging sexual activity and parents were generally against this. This is why those who did use contraceptives had to hide these from their parents because they feared how their parents would react if they found out that they were sexually active.

4.6 Information relating to risks of sexual activity

Students were asked if they felt that they were adequately informed of the risks associated with sexual activity and contraceptive use, many of the students felt that they were adequately informed about contraceptives regardless of not talking to their parents about them. One male participant in particular felt very confident that he could make good decisions regarding sex because he had discussed contraceptives with his parents and since he tested for HIV AND AIDS, he received additional information about contraceptives and sex at the testing centre, *"Yes, every time I go to test they tell me" (Male, Participant#11*). His ability to make these informed decisions was closely tied with the open relationship he had with his parents regarding sex in general and contraceptive use.

Some male participants reported that they did not know much about female contraceptives, one participant stated this outright *"Yes but I'm not informed about female contraceptives" (Male, Participant#12)* he wished to acquire more information so he could understand them better and make better decisions concerning them. Many campaigns on contraceptives have been neglecting the male thus resulting in the lack of knowledge regarding female contraceptives. This makes men uncomfortable with female contraceptives because they may have heard many myths about them and they do not have the correct information. It became difficult for men to understand the dynamics of female contraceptives because they were not informed about them. Makhaza &Ige (2014) suggest that males should receive the same education as females regarding contraceptives at the tertiary level. This would not only make them more knowledgeable but they may become receptive towards these contraceptives. There has also been a call to include men in campaigns targeted at increasing contraceptive use in communities (FHi360, 2012). One male, in particular, complained that they are always told to use a condom but no one informed them about how to use a condom correctly and what to do if there are problems while using a condom.

Many participants felt that they could make an informed decision about sex and the risks associated with sexual activity. However, there were those that felt that they needed more information regarding sex and the risks thereof and contraceptives and they were not confident that they would be able to make an informed decision. They did, however, have some information but they were not confident that they knew enough. *"Yes, not 100% but I know what I should know (about contraceptives)" (Female, Participant#7).* They admitted that they did not know enough. *"I am in the middle, I don't know. Maybe I don't have it covered" (Female, Participant#10).* There was a need even for the female participants to receive more information

about contraceptives. Those female participants that had not discussed contraceptives with parents were less likely to be confident that they could make informed decisions. The third group were those that did not know if they had adequate information. They were open to receiving more information about the risks associated with sex and contraceptives.

4.7 Preferred space to access information regarding contraceptives.

When students were asked where they would be the most comfortable receiving information about contraceptives, they stated a range including television, internet, lectures, during counselling sessions but the most popular place was the clinic, many felt more comfortable at the clinic if only the clinic offered this service to students. Participants voiced that at the moment a clinic was not a good space but they stated that if the services at the clinics improved they would be most comfortable to go there. They stated that this was because the nurses are qualified health professionals therefore they would be confident that the information they would receive there would be accurate. *"I prefer the clinic, they know what they are talking about"* (Male, Participant#8)

The clinic would be less awkward than discussing it with parents, it would be good to speak to an adult that was not their parent. However there were was a small percentage that were very explicit that they did not want to receive any information from the clinics because currently they did not feel wanted there. A female participant was worried in particular about the lack of confidentiality at clinics. *"You know people are always scared to actually go there because they are like "people are going to know that I'm sexually active you know", especially like if there's someone maybe your parents know at that clinic, they are afraid that they are going to tell my mom. You know nurses don't respect confidentiality and all that. They will tell your mom that so and so came"* (Female, Participant#9). She feared nurses would tell someone who knew her that she had been to the clinic to get a contraceptive, she had bad experiences at public health centres especially since she had recently given birth and had the injection forced on her. This participant was not the only one who had a bad experience at the public health centre, another female had a similar experience. *"At the clinic they are horrible, nurses mock you"* (Female, Participant#6), she had been mocked at the clinic and did not wish to return there in future. A male participant said he would prefer a clinic where no one knew him because he also feared information about his visit to the clinic would get to his parents ears. *"Where no one knows me, a clinic"* (Male, Participant#13), even as a male he had the same fear about the

nurses at public health centres. The clinics that have nurses whom have an open mind about providing contraceptives to youth could have more youth accessing contraceptives there.

There were participants that preferred to have a class that would teach them about contraceptives as they did not feel comfortable at the clinic, *"Not the clinic, maybe a class"* **(**Female, Participant#10). The students felt that first year students at the university should be offered a workshop on sexual and reproductive health and that it should be compulsory for students. They felt that first years became exposed to too many new things and that they go wild and "*do things that they are not supposed to do".* It was believed that first years were the most impressionable and with the new found freedom they should be taught how to take care of themselves. This responsibility fell on the university in the absence of parental communication.

The public health care workers was named as the main authority that should encourage the youth to use contraceptives. The reason for this was that the health of people of South Africa was generally seen as the responsibility of the government. It was stated that if the youth got pregnant or sick it would become the responsibility of the state, therefore the state should encourage prevention. *"Mostly health workers because they are the ones that deal with us when we get pregnant, when we get STDs, I think it's their duty to actually ensure that every one is aware of such things"* (Female, Participant #9).

The parents were number two on the list of those that should encourage contraceptive use among the youth, this is in line with the desire of the youth to have discussions about contraceptives with their parents. Participants felt that it would be beneficial for them to learn from the experiences of their parents. This is because parents often play the role of teacher to their children. Practically children learn most of their skills for example from imitating their parents. Numerous authors have stated that children try and emulate the behaviour of their parents whether it be good or bad (Miller, 2002). Some authors have gone as far as suggesting that children that grow up in a home where the parent engages in reckless sexual behaviour the chances that their teenage children will do the same are high (Miller, 2002). The converse may also be true.

Even though friends were currently the main source of information for contraceptives they were ranked as the third preferred source of information. Participants valued the input of their friends but they preferred to learn about contraceptives from adults that had more accurate information such as their parents and/or nurses. *"I think the nurses and the parents and the*

sisters, if I had a younger sister I would definitely suggest it" (Female, Participant#14). Friends are the main source of information where such information is not available from heath care workers or parents. Therefore friends play the role that participants expect their parents to play, suggesting that parents have a high level of influence over some of the more important decisions. And whether they are seeking counsel from parents or friend, the contextual and interpersonal relations have a huge role to play in encouraging contraceptive use. *Well, with your friends it's easy because obviously you can't talk about such things in front of your parents or in front of people you are not comfortable with because you know people, people might get other ideas. People always judge you based on what you talk about so people may not even know what you are talking about but the fact that you are talking about contraceptives might give them the [wrong] idea"* (Male, Participant#5). Participants preferred individuals that they could trust to encourage them to use contraceptives and to provide them with the required information, therefore trust was a great concern. This is the same reason that those whom did not want to go to the clinic feared the nurses would break their confidentiality and therefore they could not trust them.

4.8 The efforts of the government to encourage contraceptive use.

Many of the students felt that the government was doing more than enough to try and encourage contraceptive use and allow for easy access. They felt that at the end of the day the decision lay with the individual and that the government *"could take the horse to the water but they could not force it to drink*" (Female, participant#13). The current Minister of Health was commended for his stance and efforts to encourage contraceptive use, he was described as proactive. The fact that he as a man was actively promoting contraceptive use was seen as a good strategy that could change the perception that contraceptives were the sole responsibility of women; it would encourage men to become more involved.

There was however a concern that it was difficult for the government to measure the outcomes of the campaigns and it was difficult to judge if the campaigns were effective or not. The issue of how many youth were using contraceptives because of government interventions was also difficult to calculate and this made it difficult to rate the efficacy of the campaigns with the youth in particular. Participants felt that there was also need to dispatch healthcare workers in under resourced and rural areas where there was a substantial number of youth in need of reproductive health services. These rural youth missed out on important information. This was also another factor that led to a high number of unplanned pregnancies in the rural areas. Youth

in rural areas were also faced with the issue of clinics being far from their homes, this was expressed by those participants that were from the rural areas.

"Its [unplanned pregnancy] is very high, even primary school children are getting pregnant. In mostly rural areas the kids get pregnant because they are not taught that these things. Yes there is a clinic, ok, it's a big area but then the clinic is near my home but then you find that there are some girls who are far from that clinic and then maybe they couldn't afford to go there, or they just don't want to or maybe they are embarrassed to go at their age to go and ask for condoms while they can't afford them" (Female, Participant#1)

The fact that campaigns were often in English was a barrier for those who were could not communicate in English especially in rural areas. It was suggested that campaigns in South Africa should be in more vernacular languages that most South Africans could understand. One participant herself being from a rural area felt strongly about the issue of campaigns being delivered in English:

"I'll start by promoting such in rural areas, I think that's where most people, there's a high rate of unwanted pregnancies and teenage pregnancies because people are unaware of such things. Most people are not educated because these things are taught or delivered in English and people don't exactly understand them?" (Female, Participant#9).

It was noted that information regarding contraceptives also missed school dropouts; especially if information regarding contraceptives was disseminated at schools where the drop outs were no longer involved, this was recognised as an area of improvement for those wishing to encourage contraceptive use (Female, Participant#16).

One particular participant was concerned that the legal age of 14 (this is incorrect, in South Africa youth from ages 12 are able to access SRH services without parental consent (Children's Act, 2006) for children to have sex was too young, because they were too young to understand the consequences of sexual intercourse. The participant suggested that the age should be moved to 18 years as this was more appropriate. Another concern was that the child support grant was working against campaigns for contraceptive use because they encouraged pregnancy as women tried to access these grants through pregnancy. Another participant was concerned about the approach taken by government to encourage contraceptive use, she resented the top down approach currently being used by the government. She would recommend that the government get their information from the people on the ground regarding their expectations, fears and preferences. She felt that the evidence based research approach was a better way that

would increase the contraceptive prevalence rate among youth because it would not impose certain types of contraceptives and it would also allow the government to learn from the gaps.

"First and foremost my philosophy is get the information from the people on the ground, from the young teenagers or young adults. You know get information from them; what are their expectations. Let them talk about their fears and about their sexual health. Let them talk about whether they would use contraceptives. I think evidence based research should be the starting point for decision making. I feel sometimes this whole thing of the government imposing all these things on us and that backfiring, I feel it's better that it starts from small research and if it works in a pilot study, it can be rolled out slowly as they learn of the gaps and challenges along the way" (Female, Participant#18).

However overall the government was commended for doing a good job, the fact that contraceptive use did not increase could not be attributed to the government but rather to the youth made their own decisions regardless of the campaigns being run by government and could not be forced to use a contraceptive.

4.9 Contraceptive use

The majority of the students that participated in the study were currently using contraceptives. The reasons offered for the use of a contraceptive were:

4.9.1 Wishing to prevent pregnancy

Pregnancy was the biggest concern for the students while HIV and AIDS was a secondary concern. Many of the female participants that were on contraceptive methods such as the pill and the injection were not too worried about contracting HIV and AIDS and many did not mention HIV and AIDS as a concern. They were happy that they could avoid pregnancy. They justified this lack of concern over contracting HIV and AIDS with the fact that when you have been with a partner for a long time it was easier to trust that partner. The females also felt that a condom was not necessary in a long term relationship. *"In a long term relationship you can't use a condom, you trust that person"* (Female, Participant#15), this particular participant was currently using the loop after she had a baby and felt that it was adequate.

The finding that being in a long term relationship stopped contraceptive use especially the condom use has been reiterated by many studies except Chirinda and Peltzer, (2014) who found that the length of the relationship had no bearing on consistent condom use. It was surprising that in an era of a high HIV and AIDS prevalence especially in the province of KwaZulu-Natal there is low condom use. One would expect the concern over HIV and AIDS to be a high

concern for the youth. This also reiterates the belief that condom use is associated with promiscuity and lack of trust within the relationship (Mantell, 2010). Male participants stated that they used condoms with their side partners and not with the main partner, this spoke to the perception that condoms should be used with partners that they did not trust and that trust was something that could be built over time. *"They say they use them to a certain extent, there are people they use them with and then there are people whom they don't even think about the contraceptive when they are about to be with them. How can I put it, for their girlfriends their straight girlfriends they don't use but for the others they make sure to use them, the side people. You can't trust a side person"* (Male, Participant#12).

The concern over pregnancy is motivated by the fear that it would be difficult to afford a child whilst they were a student and that they may be expected to give up their studies in order to care for the child. There was just too much at stake and they wished to stay at university in order to one day be able to secure employment and provide for their families. This supports some of the studies that have been conducted that have stated that females with higher education were more likely to use a contraceptive because they wished to plan their pregnancies to be in line with their careers (Emina et al. 2014). It is also believed that the level of education increases the chances of contraceptive use (Pillai & Teboh, 2010). Men were concerned that women did not take HIV and AIDS seriously because women were concerned about pregnancy more than HIV. A male participant stated: *"To them (women) it's usually about pregnancy more than the diseases…. That usually drives the rate of people not using condoms…all they are thinking about is pregnancy*" (Male, Participant#11). This they felt was one of the driving causes of non-use of condoms. Men also voiced that women did not explicitly request the use of a contraceptive, and often went along with what the man wanted. One participant voiced that he did not trust a woman that was on a contraceptive other than the condom because it was more likely that she was not condomising.

4.9. Wishing to prevent contracting HIV

The male participants were worried especially about contracting HIV and they were among those who explicitly mentioned being concerned about the disease. Even though some of the male participants were only using the condom with the casual partner, they did mention wishing to avoid the disease. Women in this particular study did not expressly say this. This was in line with the concerns of the male participants that females did not seem to be too concerned with HIV and AIDS, it was often a secondary concern. Females were satisfied if they used hormonal contraceptives and condoms were not a concern for them.

4.9.3 For other medical conditions other than preventing pregnancy

Some of the female participants had used a contraceptive to regulate a period when they had experienced irregular periods. They had used the contraceptive until they had a regular period and then stopped soon after. Two of the participants in this study had experienced this, they had stopped using a contraceptive because they felt it was no longer necessary because they both were not sexually active. One participant mentioned that her mother had recommended an oral contraceptive to her sister who was experiencing heavy periods and cramps. Another participant had used the oral pill in the past for her acne problem, as she had heard from friends that the pill was good for clearing acne. She said this was the common use of the pill among her and her friends, they were not necessarily trying to avoid pregnancy.

4.10 Contraceptive methods being used by the participants

Popular contraceptive methods among the participants were the condom, Pill, injection and IUD. Reasons for the popularity of the condom were that; it was easily accessible either at clinics or at retail shops. One did not require a prescription to access a condom as it was purchased over the counter. A consultation with a health care worker, therefore, was also not necessary, this was a benefit for those that were not comfortable with going to clinics they could avoid this. It also protected against sexually transmitted infections (STI) in addition to preventing pregnancy. It was considered as an effective and easily accessible method for youth. It was considered a good method because it did not require daily usage, it was only used when it was necessary i.e. during intercourse. There was also a wide variety of brands to choose from, many did not like the free government issued condoms.

They preferred to purchase condoms as there was a concern that the free condoms were not of good quality. Free condoms were accused of becoming dry too quickly and thus tearing. Some of the other concerns regarding the condom were that it could break and cause pregnancy and/or HIV infection. Therefore it was advisable to use more trusted brands and also have a backup plan should a condom break. The place of purchase was also a concern, some students preferred to purchase condoms at garages because they felt that the ones available at retail shops were not of good quality because they spend long periods of time on the shelf whilst those at the garage were bought more often thus their stock was always new and of good quality. Participants thus often purchased condoms at petrol stations/garage. There was a concern that flavoured contraceptives could give the female an infection. The concern here was that the flavouring and colouring are what caused an infection inside the female.

One particular participant was concerned that men are always told to use a condom but are seldom shown how to correctly use it and this can be a barrier to use. This participant thought that it was always assumed that men would know how to use the condom but without proper guidance men may use a condom incorrectly. It may also discourage use if the user is unsure of how to use a condom. He suggested youth should be shown how to use a condom correctly so that it would be easier for them to be sure they were using a condom correctly.

The participants liked the oral pill because of its other benefits such as helping with acne and regulating the menstrual cycle. It was also highlighted that the pill was also slightly inconvenient because one had to ingest it each and every day consistently. One student was concerned that the pill infiltrated the entire body even though it was taken for only one purpose, she was worried about the long term effects of this daily intake on her body.

" Like our generation in the 20`s now basically we are guinea pigs so they don't have, I mean there were some (studies) in the 60`s and stuff that was released but we are the ones taking it full time like from the beginning of our menstruation cycle till who knows, till we have kids. And also that when you take the pill especially it has to go through the whole body while actually they are needed at just a specific place" (Female, Participant#19). She was against taking the pill daily as if she were sick, this was the reason she was adamant on changing to another contraceptive. The pill was also quite difficult to hide from parents for those who desired this.

The injection was also an option that the participants in this study liked because this method helped to regulate the menstrual cycle. The satisfaction level with this method was very low among the users. One student had been given this method against her will after giving birth at a public hospital, she stated that she could not wait for it to be out of her system. She planned on switching to the pill, as she, like many, was worried about gaining weight from the injection. There was a consensus that the injection was not a good or preferred method of contraceptive because it made the female gain weight. It was also accused of making the body wobbly. However, this method was easy to use since it required the student to visit the clinic once every two or three months and it could be easily hidden from unsupportive parents or partner. Men felt that this method made women promiscuous because they did not worry enough about HIV and pregnancy. Women voiced concern over the lack of choice and the variety of contraceptives at public health care centres, they preferred private health centres because there they were treated with respect as they were paying for the service.

The IUD (loop) was reported to be very convenient. It was inserted once and needed to be replaced every 5 years. However, one user reported that it had made her menstrual cycle longer from 3 days to 5 to 6 days long. *"Yes before I inserted it I had 3 day periods and it was 5 to 6 days"* (Female, Participant#15), she was rather unhappy about this but she did not express wanting to change to another contraceptive.

"I remember my one friend telling me the IUD makes you bleed so much, I don't know though it is termed one of the best contraceptives that prevent pregnancies. But for me, the side effects won't freak me out" (Female, Participant#18).

4.11 Contraceptive decision-making

The majority of the students were of the view that the decision to use a contraceptive should be a joint one between partners. The reason that the decision should be a joint one was that it was important to accommodate both partners in the relationship. No one partner's decision was more important than the other. *"I think both partners should talk about these things and decide which are they comfortable with and then use it…* (Male, Participant#12).

"I think both of them should decide because they do whatever they do together it's not one person…you find a method maybe one that you are more happy with, not him. If he doesn't agree with using it. I think it would be more about me. I would tell him that I have to use a contraception whatever it may be, then he would be forced to be ok with that I guess. It's either my way or no way at all" (Female, participant#7).

Participants felt that partners are supposed to do everything together and deciding on a contraceptive should be one of those things that they also do together.

It was also stated that if the couple could not agree then they should compromise and find a contraceptive that they were both happy with. If one partner is unhappy with a contraceptive then they cannot be forced. It was also dangerous to assume that your partner is using a contraceptive. Therefore it was important to have open communication about contraceptives or the couple would together suffer the consequences.

There were those that felt that a female should decide on whether or not to use a contraceptive in the relationship because she was the one that became pregnant at the end of the day. The man was expected to just go with what the female decided. It was stated by the female participants that men generally did not like condoms but women had to be decisive when it came to their bodies. One particular participant emphasised that she had intended to keep firm

control over her body (Female, Participant#17), she was currently using a condom as a contraceptive but stated that in future she would explore a more permanent solution as she did not intend to have any children. She was adamant that if her partner did not want her to use a contraceptive then she would do so regardless. "*It's entirely my decision, I have firm control over my body should a partner not want to use a contraceptive then he can find a girl that doesn't want to use a contraceptive"* (Female, Participant#17)

Many of the females also stressed that the decision was ultimately the females and that men could be consulted but that it was not a necessity. They felt that at the end of the day it was the female that fell pregnant and therefore the decision was hers. *"I think it's the girl because if anything happens but then she is the one who is going to fall pregnant and stuff so I think she should decide"* (Female, Participant#13).

"I think it should be a woman's decision and then she can if she likes tell her partner. I mean what if her partner says no? I mean after all it is you at the end of the day who will fall pregnant because the guy can just walk out" (Female, Participant#14)

There was a reoccurring theme of lack of communication between partners. The issue of communication between partners was important to the students but unfortunately not a common practice. It is shown by the fact that many of the students had not discussed the decision about using a contraceptive with the partner before, during or after intercourse. Some students were of the view that there was no need to discuss this matter with a partner and that the decision was theirs alone to make. A male participant stressed that there was no need to discuss the issue of contraceptives because he "always uses his condom" regardless of what his partner desired (Male, Participant#12). These were those participants both male and female that did not see much need to decide with a partner, they wanted to do what they felt was best for them.

4.12 Influence of family and friends

Many of the students felt that the opinion of family and friends was very important to them. Therefore how family and friends viewed contraceptives often influenced their own perceptions, and subsequently their use of contraceptives. Therefore the approval of contraceptives by friends and family was extremely important and it could be the deciding factor of whether a contraceptive is used or not. Many of the participants that were currently using a contraceptive had sought advice from friends and/or family before attempting to use a

contraceptive, they felt that it was important to learn from the experiences of the friends and/or family to better understand contraceptives. Because it was easy to discuss contraceptives with friends many did so regularly. Others admitted that if the perceptions of friends had been negative this would have influenced them to be negative towards contraceptives. *"I wouldn't use it (contraceptive) if they (friends) were negative"* (Female, Participant#15). Luckily within the university context contraceptive use was supported and considered a necessity in order for one to continue their studies, this was a view held by the female students. Students tried to encourage each other especially friends that were not using a contraceptive to do so, in an effort to protect each other from unplanned pregnancy that could lead to them dropping out of university.

The family was also cited as a great influencer of contraceptive use, parents especially had a great influence. If the parents discussed contraceptive with their children, youth became very confident about using a contraceptive. Those participants whose parents disapproved of contraceptive use, were reluctant to use contraceptives themselves, however, others used contraceptives without the knowledge of their parents. This is why many participants preferred methods that they did not have to carry on their person in case their parents found them. Some students cited that their parents expected them not to engage in sexual activity at all and thus did not encourage contraceptive use. This was however considered unrealistic on the part of the parent. Parents, therefore, had the potential to become a barrier to contraceptive use. One participant was currently not using a contraceptive but had used a contraceptive in the past when she did not receive a regular period but stopped thereafter, she had the following to say about the influence of friends and family on her decision not to use a contraceptive: *"Yes, it makes sense, we know the people around you influence you to do so many things. If they are like ok, I have family members that think that contraceptives should not be used for religious reasons but the majority feel that contraceptives are a good thing"* (Female, Participant#7). It had been her mother that had recommended that she try using the pill when she was not experiencing a regular period but because her parents expected her not be sexually active they had encouraged her to stop after she had her period regularly.

Other participants, however, felt that as much as they valued the opinion of friends and family, the decision to use a contraceptive should be a personal one. Therefore participants took advice but made a decision that was best for themselves. The general consensus was that opinions of friends and family could influence but did not always do so.

4.13 Influence of partner on contraceptive use

Some of the male participants were against the use of female contraceptives, some went as far as saying that they did not trust women that used contraceptives because it means the female is not using a condom and there was a huge chance that the woman had infectious diseases. The men felt they could and needed to control this aspect of the relationship. The general consensus among the males was that the condom should be enough and that female contraceptives would make the partner promiscuous. Some of the male students insisted on using the condom with partners that were using other contraceptives and also with casual partners because of the lack of trust. This is in line with the findings of many other studies where men expected the woman to resist sex without a condom but women often did not (Mantell, 2010). Men felt that the females did not want to use the condom because they did not explicitly ask for it during intercourse. Women would just 'lie there and not say anything' expecting the guy to make a decision whether or not to use the condom. Women were also accused of trying to avoid condom use by mentioning that they were on the pill or injection before intercourse. Men felt that they should not be blamed for lack of condom use because women were just as much to blame and that women liked to play victims. The females however felt that men just assumed that women were on a contraceptive and therefore did not bother to ask them if they actually were using one. The men would then take it upon themselves not to use a condom. One female participant felt that this kind of assumption could be disastrous:

"I think it should be a joint decision because at the end of the day should anything happen the responsibility will be like for the two of you. But then again some relationships are tricky, you can never tell what someone is thinking, what anyone is planning. So I have noticed that most guys assume that once the relationship is sexual, you know how to protect yourself. Like you are on a contraceptive or something. So it's something that you have to sit down and discuss your options…working on assumptions has been disastrous" (Female, Participant#16).

"It's up to the girl because of anything happens she is the one to fall pregnant, the guy must just go with it" (Female, Participant#13).

4.14 Reasons for non-use of contraceptives

The number of students that were currently not using a contraceptive was high. Many of the non-users were currently abstaining from sexual activity altogether therefore they did not see the need to use a contraceptive. This is contrary to popular belief that the majority of university youth were involved in sexual intercourse. There were participants that were not sexually active

but had used contraceptives in the past, this was done to regulate their menstrual cycle and to reduce menstrual pains. Inconsistent use of contraceptives (such as condoms) was caused by the fact that there was no partner communication prior to sexual intercourse therefore the male did not know whether they should use the condom or not. It has been noted time and again in studies that lack of partner communication about condoms lead to non-use (Mantel, 2010). It was also stated that many times the males were afraid that the female will change her mind while he scrambles to put on a condom, thus leading to non-use. This is because sexual intercourse is something that happens spontaneously, it is not planned. Therefore communication within a relationship is very important to ensure sexual health.

Students that had chosen not to use a contraceptive had also stated that they were afraid because of the myths associated with contraceptive use. Many were also afraid of "falling in the bracket of those seeing the condom as useless" (Female, Participnat#16) and becoming susceptible to HIV. Therefore as long as they were not using contraceptives such as the pill or injection they would be encouraged to use the condom to avoid pregnancy and at the same time prevent HIV.

4.15 Myths about contraceptive

The myths surrounding contraceptive use were that it could make a woman infertile in the long term. This was the main myth that students quoted. The second myth was that one could develop many weird skin diseases. The majority of the students were aware that these were just myths and that contraceptives were generally considered to be safe. They were also aware that each person was different and therefore their experiences with contraceptives were likely to be different. It was noted that it is important to find a contraceptive that was best for the individual and not to take others experiences and knowledge as the bible on contraceptives. One participant felt that she herself had failed to be proactive when it can to sourcing the correct information regarding contraceptives, she knew that everyone reacted differently to contraceptives. Her mother was generally against hormonal contraceptives because of bad experiences in the past but she wanted to have her own experience. Another participant was concerned that sometimes women just focus on the negative aspects of contraceptives without seeking proper information.

Overall there were concerns about the myths surrounding contraceptive use but there was the knowledge that myths do not apply to everyone and that it was the duty of the individual to acquire reliable information about contraceptives and make an informed decision about which method was best for them.

4.16 Barriers to contraceptive use

The reasons for youth not using contraceptives were:

4.16.1 Ignorance

Ignorance was the number one barrier that was noted by students. They felt that young people had a "don't care" attitude towards life in general. This also influenced the way they viewed contraceptives because at the end of the day the decision lay with the individual and there is nothing that can be done if the individual had made up their mind. Many of the participants described youth as not being worried about disease or pregnancy, they refused to use contraceptives such as the condom because it diminished the pleasure of sexual intercourse. Many thought that it was unnatural to "eat a sweet with the plastic" or "eat a banana with the peel", this was how using a condom was seen.

4.16.2 Lack of knowledge

The participants were of the view that there was enough information out there, they believed that technology offered vast information. It was believed that if an individual did not have the information they were not actively trying hard enough to get information. However, the excuse of lack of knowledge was only a factor in the rural areas where the campaigns were not reaching the targeted audience. The lack of knowledge was further exacerbated by campaigns being in languages that the target audience could understand. Lack of knowledge in the rural areas was also caused by not having reliable sources of information. This came into play when the participants were unable to get reliable information from their parents and they were too scared to go to the clinic for information. This often leads to participants engaging in sexual intercourse without using a contraceptive. Accessibility to clinics was also a barrier as clinics can be a distance from many areas and this may require a person to travel a long distance.

4.16.3 Culture and religion

Culture and religion were seen as potential barriers to contraceptive use especially for women; culture could be used against women to stop them from using a contraceptive. A participant noted that the demand in rural areas was high and that having many children was desirable, this placed a burden on the women to produce more children. A female participant stated that men often used culture and/or religion to further their own agendas (Female, Participant#1). Men changed the culture for their own benefit to the detriment of the woman. She noted that in the past African culture valued purity and virginity and therefore women were encouraged to

remain pure until marriage, hence there were many "umemulo" (coming of age ceremonies). Recently the South African woman has become required to prove her fertility even before marriage but this was a requirement for married women only (Female, Participant#1). A male participant was concerned that churches did not discuss their stance on contraceptive use; they rather forbade sexual intercourse before marriage. They, therefore, concentrated on the deed (sexual intercourse) and failed to address other issues such as sexual health in general (Male, Participant#4). Many also believed that using a contraceptive was tantamount to killing their babies and this was against many religions. Therefore religious belief could act as a barrier to contraceptive use.

4.17 Summary

The findings of this study were similar to studies conducted before it, many of the reasons for use of the contraceptive confirmed earlier study findings. However, there were some differences such as the fact that many of the youth were quite knowledgeable about contraceptives and that there was a number that was using a contraceptive. There was also a category of youth that was not using a contraceptive simply because they were abstaining from sexual activity. There is, however, a concern that women did not worry enough about HIV and AIDS in comparison to pregnancy, this concern was raised by the males in the study. Youth was often open to discussing contraceptive and sexual health with parents but parents failed to play their role in this area leading to youth turning to friends for information, this becomes risky as the information obtained from friends was not always correct or accurate. There were, however, parents that did discuss contraceptives with their children and even supplied contraceptives such as condoms to them. This made the youth more confident and open to using a contraceptive. Clearly, there is a role that can be played by parents to increase contraceptive use among the youth. There was overall a positive perception about contraceptives among the youth that participated in the study, however, the sample size did not allow for a generalisation to all the youth at the university level in Durban, South Africa.

Chapter five

Discussion and recommendations

5.1 Introduction

This chapter discusses the key findings of the study. It also places the findings into context by comparing it with findings from previous studies in the literature. This chapter will also provide recommendations relating to the findings.

5.2 Discussion

Eaton's theory of unsafe sexual behaviour (2003), was a critique of the theory of reasoned action and planned behaviour (TRA&PB) (Ajzen& Fishbein, 1980). The TRA&PB emphasised that human beings make rational decisions by using information at their disposal. They consider the implications of their actions before they act them out, their actions are predetermined by their attitudes, and thus a positive attitude will equal positive behaviour toward an action. They will always try and live up to the expectations of those that they admire (Eagley &Chaiken, 1993). Conversely, they will refrain from a behaviour if those they admire disapprove of it (Tlou, 2009).

Eaton et al (2003) found the TRA&PB-theory to be inapplicable in the context of the developing world because there was too much focus on behavioural factors i.e. the personal and interpersonal factors. It was possible for a person not to be influenced by his or her own beliefs and this was especially true in the developing world. In the developing world, people may be influenced by factors beyond their control such as the social, cultural and physical and structural which may influence access to and use of contraceptives. The theory of unsafe sexual behaviour takes into consideration the proximal and distal factors within the person's context (Eaton et al, 2003). The proximal includes the interpersonal relationships that the person finds themselves in, it also includes the physical and organisational environment. The distal include the cultural and structural factors (Eaton et al, 2003).

In a developing country with limited resources, contraceptives may not be easily accessible and thus it may be impossible for an individual to use contraceptives even if they believe in them personally. It has been seen that when a country is going through an economic crisis, public spending is often the first to be cut which includes health care. As discussed by Rogan et al. (2010) contraceptives may not be a priority for the government in times of limited resources, resources may also affect the variety and types of contraceptives available. The

example that was given was that emergency contraceptive which is seldom a priority for the health department as expressed by some of the health professionals (Rogan et al, 2010). Thus people may not have access to the contraceptive of their choice and may not use a contraceptive regardless of the positive attitude toward it. Therefore it is unwise to assume that the attitude and expectations of potential users will automatically equate to the use of contraceptives. It is very likely that they may engage in sexual intercourse sans a contraceptive, even if they have considered the implications of such an action. In this study, it was found that it was possible for students to have a positive attitude towards contraceptive use but still fail to use one. All the students had a positive attitude towards contraceptives but this differed according to type, however, not all of the participants were using a contraceptive. This was caused by various reasons some personal, some social and some structural.

The view by Eaton et al 2003 that proximal and distal factors should be taken into account has merit. As found by this study interpersonal relations are very capable of influencing contraceptive use. Friends and parents were found to be the main source of information and influence over contraceptives use, showing how these interpersonal relationships came into play. Therefore it cannot be assumed that just because contraceptives are available to the student, they will be used by the student. There are many considerations to be taken into account. Organisational factors such as lack of choice at public health facilities and certain methods being forced onto users by health care workers became a barrier at times. Where friends endorsed a contraceptive, their use was high, where parents disapproved of a contraceptive their use was low. Parents disapproving of contraceptives often forced students to choose methods that they could hide from parents thus limiting the options for the students to those methods that could be hidden. Parents that did not discuss contraceptives and sexual health with their children were seen as following a societal norm that regarded such issues as taboo. It was these societal taboos that were barriers that came in the form of interpersonal and social networks.

Structural factors were also cited which included access to contraceptives in rural areas where clinics may be far and where it may be expensive to travel back and forth from the clinic. The participants only had such a concern in the rural areas and not in the urban areas. Thus the area of residence could also be considered as a structural factor.

Literature suggests that there may be a problem of unplanned or unwanted pregnancies at tertiary institutions in South Africa, the rise of unwanted and unplanned pregnancies is said to

have risen by 250% since 2005 (Ndima, 2013). This may disrupt the studies of the students. Factors such as lack of knowledge, access that may be caused by poverty, gender relations and the attitude of health care workers were quoted as barriers to contraceptive use for youth in Durban. This occurred despite the efforts of the government through the National Department of Health to try and increase the CPR among the youth. These findings tried to ascertain the attitudes of the youth towards contraceptives and explore the barriers and influencers of these perceptions.

This study found that the youth had a generally positive attitude toward contraceptives and contraceptive use. Many wished to avoid unplanned/unwanted pregnancies in order to continue with their studies. The fear of contracting HIV was also a concern even though it seemed to be of secondary importance. This finding was alarming because of the very real threat of HIV and AIDS especially in the province of KwaZulu-Natal. Many of the participants in the study were currently using a contraceptive in the form of a condom, pill, injection or IUD. Those that did not use were currently abstaining according to their responses. There were issues or concerns with the use of contraception in the long term but many still wished to continue using a contraceptive until such time that they desired children.

Participants reported that it was generally easy to access contraceptives. They were provided free of charge at public health care centres. The attitudes of the health care providers was a concern but that did not deter the students from accessing a contraceptive when they needed to. There were complaints of the lack of variety of contraceptives at public centres. The nurses were also accused of forcing certain methods on users, the method that was the most popular with health care providers was the injection that was forced on those that have just given birth at public health centres. The students required more options and an attitude change from health care workers.

Those using the condom were also of the opinion that it was easy to access it. Many preferred to purchase the condom rather than to use the free government issued condoms. They did not trust the quality of the government condoms, which were accused of drying too quickly thus making them prone to breakage. Retail shops such as Pick n Pay and Shoprite were also not trusted because they kept stock for extended periods of time thus diminishing their quality. Garages were preferred as the stock was said to be replenished more regularly, this shows that many of the students were able to afford a contraceptive hence they could choose to purchase

rather than use free contraception. Poverty could not be seen as a barrier to contraceptive use in this case.

Those who were not using a contraceptive were also confident that it could be accessed easily when they needed to access it. The majority of the participants were not aware that the university health centre offered contraceptives, the health care centre needed to promote or advertise their services more aggressively. Overall accessing contraceptives was not a problem among the participants, however, there should be more awareness about the services offered at health care centres more especially at the clinic on the university campus. Therefore the decision not to use a contraceptive by the participants was not influenced by the lack of access.

This study found that the influences of perceptions to family planning methods were the desire to avoid pregnancy and or HIV and AIDS and also to regulate the menstrual cycle. These were the commonly cited reasons behind contraceptive use. The desire to avoid pregnancy was the most common because for many of the students a pregnancy meant that they would have to drop out of university to care for the baby. Hence the finding by Emina et al. (2013) that women with higher education make better decisions regarding their sexual and reproductive health is supported. The perceptions surrounding contraceptives was overall positive, many were confident that they were adequately informed about contraceptives.

There were concerns surrounding the side effects and long-term effects on fertility that may be caused by contraceptives but this did not deter students from using a contraceptive. These side effects were cited as weight gain, skin diseases and infertility in the long term. However, it was realised that people were different and that they are most likely to react to different contraceptives and therefore one could not disregard contraceptives based on someone else's bad experience.

There was no shame in using a contraceptive in the university context, it was considered a necessity to stay at the university. Recklessness was not considered something that was desired by students. A concern, however, was that the threat of contracting HIV was not the number one factor driving contraceptive use because even those who did use a condom stated that they used it with a side partner and not the main partner. Others stated that they used a condom at the beginning of a new relationship after a certain amount of time had passed in a relationship condom use should cease because they felt that they could trust their partner, this was the case especially with the female students. This is an area that needs to be explored further in the future.

There were, however, males who expressed worry that females were not concerned enough with the threat of HIV and this made them uncomfortable with engaging in sexual activity with a female that was on a hormonal contraceptive. Men were worried that these females had a higher risk of having contracted HIV. This was an unexpected and interesting finding that men were more concerned about HIV and AIDS than women. Studies have always seemed to paint men as barriers to condom use and as those that spread HIV and AIDS through having multiple partners and not using a condom consistently.

Reasons behind inconsistent condom use were based on lack of communication between partners. Partners generally did not discuss the issue of contraceptive use and therefore there was uncertainty about whether or not to use it. Men felt that because sex was often unplanned they did not want to fiddle around to find a condom as the female may change her mind, hence they continue without a condom if the female does not protest. The men also stated that women often did not ask for a condom and this decision was left to them.

5.3 Recommendations

Even though the results of this study are not generalizable to the whole population because of the approach used, it became clear that the issue of contraceptive use by students is a multi-dimensional issue and thus the approach to increasing the CPR among the youth should also be multi-dimensional. The youth cannot be divorced from the society in which they exist in by focusing campaigns on them alone. Campaigns should focus on encouraging society as a whole, including the parents to adopt a positive approach to contraceptives. It should encourage families to discuss contraceptive use to make it more socially acceptable. This will allow for more access to contraceptives for those who wish to use them because they will no longer face disapproval from their interpersonal and social networks. The study has identified a gap where parents are not discussing contraceptives with their children because of cultural or religious reasons thus disadvantaging the children in the long run.

It can also be recommended that men receive the same information about contraceptives as the females to encourage men to view contraceptive use as the responsibility of the men and women together. As we have seen that often society places the burden of using a contraceptive on the female. It has been pleasant to see the efforts by the South African Department of Health in recognising the importance of including men in campaigns encouraging contraceptive use among the youth. They are currently advocating for couples to “double up” by using both a

male condom and female hormonal contraceptive. This places the burden of prevention of pregnancy and STI on both parties in the relationship.

It can also be recommended that government re-enforces the South African Children's Act of 2005 as amended by the Children's Amendment Act no 41 of 2007, which makes it a crime for health care workers to deny a contraceptive to anyone over the age of 12 in South Africa. This act should also emphasise the importance of allowing youth the chance to choose a contraceptive of their choice, this will improve the services offered to youth and also encourage the health care worker to adjust their attitudes about giving contraceptives to youth. It has become common for health care workers to force certain methods on individuals especially those who are young. This makes the young person's experience with the contraceptive a negative one thus discouraging them from using it in the future. This then works against the campaigns of the government that try and encourage increased and consistent use of contraceptives. This cannot continue in a country that is said to have one of the best constitutions in the world. Policies need to start having practical benefits for the citizens instead of theoretical ones.

Finally it is recommended that the university health clinic find a way to allow access to EC for males, males have complained that they are not allowed access to such methods. While it is understandable that the EC is consumed by the female but it has been voiced that sometimes their female partners are not students at the university and are unable to go to the clinic themselves. Perhaps the male student should have access to the EC if they bring the female partner along to the clinic. Men cannot be denied access to the EC based on their gender, this will discourage the efforts to include men in contraceptive decisions in order to build a more gender equitable university community and thus a more equitable society.

Bibliography

Adebowale, SA. Adedini, SA. Ibisomi, LD. Palamuleni, ME. (2014). Differentiated effect of wealth quintile on modern contraceptive use & Fertility: evidence from the Malawian women. *BMC Women's Health* 14:30

Agha, S. Karly, A. Meekers, D. (2001). The promotion of condom use in non-regular sexual Partnerships in Mozambique. *Health Policy and Planning* 16(2):144-151.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.

Bakht, MB. Arif, Z. Zafar, S. Nawaz, MA. (2013) Influence of media on contraceptive use: A cross sectional study in four Asian countries. *Journal of Ayub Medical College* Abbottabad, (25):3-4

Barron, P. Pillay, Y. (2013). Contraceptive policy overhauled. *The Mail & Guardian*, 14 June 2013. Available from: http://mg.co.za/article/2013-06-13-contraceptive-policy-overhauled

Bamiwuye, SO. De Wet, N. Adedini, SA. (2013) Linkages between autonomy, poverty and contraceptive use in two sub-Saharan African countries. *African Population Studies* (2):164-173

Bongaarts, J. Sinding, SW. (2011) Family Planning as an Economic Investment. *SAIS Review, The Johns Hopkins University Press* vol.XXXI. (2):35-44

Burk, AE. (2011). The state of hormonal contraception today: benefits and risks of hormonal contraceptives: progestin-only contraceptives. *The American Journal of Obstetrics and Gynaecology*.pp:s14-s17

Burgard, S. (2004) Factors Associated with Contraceptive Use in Late- and Post-Apartheid South Africa. *Studies in Family Planning*, Vol. 35, (2):91-104

Brikci, N. (2007). A Guide to Using Qualitative Research Methodology, London School of Hygiene and Tropical Medicine

Cobb, T.G. (2010). Strategies for providing cultural competent health care for amongst Americans, *Journal of Cultural Diversity* 17(3), 79–86.

Connell, R. (1987). *Gender and Power: Society*. The Person and Sexual Politics Sydney: Allen and Unwin. Cambridge, Polity Press; Stanford, Stanford University Press.

Connell, R. (1995). *Masculinities.* Cambridge, Polity Press: Sydney, Allen & Unwin; Berkeley, University of California Press.

Chang, MK. (1998) Predicting Unethical Behavior: A Comparison of the Theory of Reasoned Action and the Theory of Planned Behavior. *Journal of Business Ethics* 17: 1825–1834

Chimere-Dan, O. (1993). Population policy in South Africa. *Studies in family planning.* 24(1):31-39

Chimere-Dan, O. (1996). Contraceptive prevalence in rural South Africa. *International Family Planning Perspectives*. 22(1):4-9

Chirinda, W. Peltzer, K. (2014*).* Correlates of inconsistent condom use among youth aged 18-24 years in South Africa. *Journal of Child &Adolescent Mental Health.* 26(1):75-82

Creanga, AA. Gillespie, D. Karklins, S. Tsui, AO. (2011). Low use of contraception among poor women in Africa: an equity issue. *Bull World Health Organ* 2011 (89):258–266

Devries, K. M., Kishor, S. Johnson, H. Stöckl, H., Bacchus, L. J. Garcia-Moreno, C. & Watts, C. (2010). Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reproductive Health Matters,* 18, 158-170.

Dexter Mc Cormick, K. (2012). A History of Birth Control Methods. *The Katharine Dexter McCormick Library*. www.plannedparenthood.org

Dickson-Tetteh, K. Pettifor, A. Moleko, W. (2001). Working in public- sector clinics to provide adolescent-friendly services in South Africa. R*eproductive health matters*. 9(17):160-169.

Do, M. Kurimoto, N. (2012). Women's Empowerment and Choice of Contraceptive Methods in selected Africa Countries. *International perspectives on sexual and reproductive health,* 38(1): 23-33

Eagly, AH. Chaiken, S. (1993). *The Psychology of Attitudes*. Harcourt Brace Jovanovich College Publishers: University of Michigan.

Eaton, L. Flisher, A & Aaro, L. (2003). Unsafe sexual behaviour in South African youth. *Social science &Medicine (56)* (2003) 149–165 Elsevier Science.com

Emina, JBO. Chirwa, T. Kandala, N. (2014). Trend in the use of contraception in Sub-Saharan Africa: does women's education matter*? Elsivier (90)*:154-161.

Ezeh, AC. Bongarts, J. Mberu, B. (2012) Global population trends and policy options. *Lancet* (380): 142–48

Family Health International (FHI360). (2012) *Increasing Men's Engagement to Improve Family Planning Programs in South Asia.* http://www.fhi360.org/resource/increasing-mens-engagement-improve-family-planning-programs-south-asia

Flanagan, A. Lince, N. Durao de Menezes, I. Mdlopane, L. (2013). Teen Pregnancy in South Africa: A Literature Review Examining Contributing Factors and Unique Interventions.

Fleming, KL. Sokoloff, A. Raine, TR. (2010). Attitudes and belief about the intrauterine device among teenagers and young women. *Elsevier*, Contraception 82, 178-182

Gaurdian, The. (2015) Sustainable development goals: all you need to know. https://www.theguardian.com/global-development/2015/jan/19/sustainable-development-goals-united-nations

Government of the Republic of South Africa: Children's Act. In Government Gazette, Vol. 492, No 28944. Cape Town: Government of the Republic of South Africa; 2006.

Gresh, A. (2010) 'Demand for Medical Abortion: A Case Study of University Students in Durban, KwaZulu-Natal, South Africa'. MA Thesis. University of KwaZulu-Natal.

Gutin, SA. Mlobeli, R. Moss, M. Buga, G. Morroni, C. (2011). Survey of the knowledge, attitudes and practices surrounding the intrauterine device in South Africa. *Elsevier, Contraception* (83): 145-150

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (105-117). London: Sage.

Heffron, R. Donnel, D. Celum, C. Were,E. Mugo, N. Nakku-Joloba, E. Ngure, K. Klare, J. Coombs,RW. Baeten,JM. (2012). Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study. *Lancet infectious Diseases* 12:19-26

Hoffman-Wanderer, Y., Carmody, L., Chai, J and Rohrs, S. (2013). Condoms? Yes! Sex? No! Conflicting Responsibilities for Health Care for Professionals under South Africa`s framework on Reproductive Rights. Cape Town: *The Gender, Health & Justice Unit*, University of Cape Town

Hoque, ME. (2011) Sexual practices among male undergraduate students in KwaZulu-Natal, South Africa. *South African Journal Epidemiology Infections* 26(3):157-160

Hoque, ME. Ghuman,S. (2012). Knowledge, Practices, and attitudes of Emergency Contraception among Female University Students in KwaZulu-Natal, South Africa. *South African Journal Epidemiological Infections: 26*(3):157-160

Hubacher, D. Trusell, J. (2015). A definition of modern contraceptive methods. *Elsevier*, Contraceptive 92, 420-421

Izale K, Govender I, Fina JPL, Tumbo J. (2014) Factors that influence contraceptive use amongst women in Vanga health district, Democratic Republic of Congo. *Journal Primary Health Care Family Medicine*. 2014; 6(1), 599- http://dx.doi.org

Jewkes R, Abrahams N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine*; 55(7):1231-1244.

Jewkes, RK. Dunkle, K. Shai, N. (2010). Intimate partner violence, relationship power inequality and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet.com*. (376): 41-48

Jewkes, R., Morrell, R and Christofides, N. (2009). Empowering Teenagers to Prevent Pregnancy: Lessons from South Africa. *Culture, Health & Sexuality*. 11(7), 675-688

Jewkes, RK. Morrell, R. (2012). Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practices. *Social Science and Medicine.* 74:1729-1737

Karra, M and Lee, M. (March 2012). Human Capital Consequences of Teenage Childbearing in South Africa. *Research Brief.* USA: Population Reference

Kaufman, C.E. (1998). Contraceptive use in South Africa under apartheid. *Demography*, Volume 35-Number 4: 421-434

Kavanaugh ML. Anderson RM, (2013) Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers, New York: *Guttmacher Institute*, http://www.guttmacher.org/pubs/health-benefits.pdf

King, R. UNAIDS (1999). Sexual behavioural change for HIV: Where have theories taken us? Joint United Nations Programme on HIV/AIDS. http://www.who.int/hiv/strategic/surveillance/en/unaids_99_27.pdf

Knowles, J. (2010). Tracking your fertility pattern to prevent pregnancy. New York: *Planned Parenthood Federation of America.*

Lebese, RT. Maputle, SM. Ramathuba, DU. Khoza, LB. (2013). Factors influencing the uptake of contraception services by the Vatsonga adolescents in rural communities of Vhembe district in Limpopo Province. *Health SA Gesondhied* 18(1) http://dx.doi.org/10.4102/hsag.v18i1.654

Longwe-Ngira, A. (2014). Family Planning in sub-Saharan Africa: A missed opportunity for economic growth & poverty alleviation. *The population reference Bureau.* http://www.prb.org/pdf14/family-planning-in-sub-saharan-africa.pdf

Macleod, C.I &Tracy, T. (2010). A decade later: follow up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. *South African Journal of psychology*, 40(1) pp18-31

Maharaj, P. (2012). Stalling contraception? Perspectives and experiences of sexually active women and men. *Agenda* 26(2), 100-110.

Maharaj, P. Rogan, M. (2007). Reproductive Health and Emergency Contraception in South Africa: Policy Context and Emerging Challenges. *Working paper 48*

Makhaza, M. Ige, KD. (2014). Knowledge and Use of Contraceptives among Tertiary Education Students in South Africa. *Mediterranean Journal of Social Sciences*. Vol 5, No 10 (2014)

Mantell,JE. Smit, JA. Beksinka, M. Scorgie, F. Milford, C. Balch, E. Mabude, Z. Smith, E. Adams-Skinner, J. Exner, TM, Hoffman, S. Stein, ZA. (2011). Everywhere you go, everyone is saying condom, condom. But are they being used consistently? Reflections of South African male students about male and female condom use. *Oxford University Press*. 26(5): 859-871.

Maticka-Tyndale, E. (2012). Condoms in sub-Saharan Africa. *Sex Health*. 2012 Mar; 9(1):59-72.

Matlala, SF. Mpolokeng, M. (2010). Knowledge, Attitudes and Practices of rural men towards the use of contraceptives in Ga-Sekororo, Limpopo Province, South Africa. *Professional Nursing Today*. Vol 14, No 2 (2010)

Maxwell, L. Devries, K. Zionts, D. Alhusen, JL. (2015). Estimating the effect of intimate partner violence on women's use of contraceptives: a systematic review and Meta-analysis. *PLoS ONE*, 10(2)

Mazvarirwofa, K. (2014). Having a sugar daddy is not prostituting, say sugar babies at Wits. *Witvuvuzela.com.* [9 May 2014]. Available at http://witsvuvuzela.com/2014/05/09/having-a-sugar-daddy-is-not-prostituting-say-sugar-babies-at-wits/

Mbanje,P. (2014). Emergency: stigma and neglect conspire against South Africa women. *Mail &Guardian* [August 12 2014]. Available from: http://mg.co.za/article/2014-08-12-emergency-stigma-and-neglect-conspire-against-sa-women

Mesce, D. Clifton, D. (2011). Abortion facts and figures. *Population reference Bureau*. http://www.prb.org/pdf11/abortion-facts-and-figures-2011.pdf

Messerschmidt, JW. (2012). Engendering gendered Knowledge: Assessing the academic appropriation of Hegemonic Masculinity. *Men and Masculinities* 1(15)56-76 SAGE

Mfono, Z. (1998). Teenage contraceptive needs in urban South Africa: A case study. *International family planning perspectives*. 24(4):180-183

Mkwanazi, N. (2010) Understanding teenage pregnancy in a post-apartheid South African township. *Culture, Health & Sexuality*, 12:4, 347-358

Miller, BC. (2002) Family influences on adolescent sexual and contraceptive behaviour. *The Journal of Sex Research* Volume 39, Number 1, February 2002: pp. 22-26

Morell, R. Jewkes, R. Lindergger, G. (2012). Hegemonic masculinity/ masculinities in South Africa culture, power and gender politics. *Men and Masculinities* 15(1) 11-30 SAGE Publications

Naidoo, U. Zungu, L. Hoque, ME. (2013). Awareness, utilisation &attitudes towards emergency contraception among women attending a primary health care clinic in Durban, South Africa. *Biomedical Research* 2013 24(3)

Ndima, L. (2013) Unplanned pregnancy derails grad plans. *Grocotts Mail*. 25 Oct, 2013. Available from: http://www.grocotts.co.za/content/mymakana/mystory/graduation-plans-derailed-unplanned-pregnancies-25-10-2013 [accessed 19 November 2014].

Nordqvist, C. (2012). What is contraception? What is birth control? *Medical News Today*. 2 September 2009. Available at http://www.medicalnewstoday.com/articles/162762.php

Oluwaseyi, SD. Ibisomi, I. (2015) Intimate Partner Violence & Contraceptive behaviour: evidence from Malawi and Zambia. *Southern African Journal of Demography* Vol 16(1)

Panday, S. Makiwane, M. Ranchod, C. Letsoalo, T. (2009). Teenage pregnancy in South Africa- with a specific focus on school-going learners. *Child, Youth, Family and Social Development, Human Sciences Research Council.* Pretoria: Department of Basic Education.

Patel, M. (2014). Contraception: Everyone's responsibility. *The South African Medical Journal.* Vol 104, No 9 (2014)

Peer, N. London, L. (2013*). Factors associated with contraceptive use in a rural area in Western Cape Province.* South African Medical Journal 103(6): 406-412.

Pettifor, A. O`Brien, K. MacPhail, C. Miller, WC, Rees, H. (2009) Early coital debut and assosciated HIV risk factors among young women & men in South Africa. *International Perspectives on sexual & Reproductive health* 35 (2) 74-82

Picavet, C. Van der Leest, L. Wijsen,C. (2011). Contraceptive Decision-Making Background and Outcomes of Contraceptive Methods. *Rutgers WPF*. http://www.rutgers.nl/sites/rutgersnl/files/PDF/Contraceptive_Decisions_Report-def.pdf

Pillai, VK. Teboh, C (2010). A Decade of contraceptive use in Cameroon: influences of structural changes. *Open Access Journal of Contraception*, 2011:2 5-11.

Ram,F. Shekar,C. Chowdhury,B. (2014). The use of traditional contraceptive methods in India & its determinants. *Indian J Med Res* (140). S17-s28

Ramathuba, DU. (2012). Knowledge, attitudes and practice of secondary school girls towards contraception in Limpopo Province. *Journal of the Democratic Nursing organisation of South Africa*. Vol 35, No 1 (2012)

Ritcher, L. Mabaso,M. Ramjith, J. Norris, SA. (2015) Early sexual debut: Voluntary or coerced? Evidence from a longitudinal data in SA- the birth to the twenty plus study. *South African Medical Journal* 105(4) 304-307

Rogan, M. Nands, P. Maharaj, P. (2010). Promoting and prioritising reproductive health commodities: understanding the emergency contraceptive value chain in South Africa. *Journal of Reproductive Health*, 14(1):9

Rosen, M. (2016). "Fertility" *Published online at OurWorldInData.org.* Retrieved from:

https://ourworldindata.org/fertility/ [Accessed 25 July 2016]

Seutlwadi, L. K, Peltzer. G, Mchunu. Contraceptive use and associated factors among South African youth (18 - 24 years): A population-based survey. (2012). *South African Journal of Obstetrics and Gynecology* 2012; 8(2):43-47

Sharan, M. Ahmed, S. May, J. Soucat,A. (2011). Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons learned. *World Bank:* Chapter 25 http://siteresources.worldbank.org/AFRICAEXT/Resources/258643-1271798012256/YAC_chpt_25.pdf

Sibanyoni, M. (2015) *'Alarming stats for teen pregnancy'*. *Eyewitness News*, August,2015. Available at: http://ewn.co.za/2015/09/06/Alarming%20stats%20for%20teen%20pregnancy [Accessed on 10 November 2015].

Spear, S. J. Clark, B. (2008). Techniques for effective contraception consultation. *The Female Patient,* 33, 42 46.

Speizer, I.S, A. Pettifor, S. Cummings, C. MacPhail, I. Kleinschmidt, and H.V. Rees. 2009. Sexual Violence and Reproductive Health Outcomes among South African Female Youths: A Contextual Analysis. *Journal Information* 99(S2)

Steyn, PS. Roets, P. (2015). Contraception. *MediClinic*. Available at: https://www.mediclinicinfohub.co.za/contraception/ [Accessed November 5, 2015].

Statistics South Africa, Midyear Population estimates 2013. www.statsa.gov.za

Statistics South Africa, Midyear Population estimates 2014. www.statsa.gov.za

Statistics South Africa, Midyear Population estimates 2015. www.statsa.gov.za

Smith, R A. (2011). Youth, Media & Lifestyles: An audience study on the media (television) consumption and the lifestyles of the black youths living in both Durban & Alice, South Africa. Doctor of Philosophy; Culture, Communication & Media studies. University of KwaZulu-Natal.

Todd, CS. Stibich, MA. Laher, F. Malta, MS. Bastos, FL, Imbuki, K, Shaffer, DN. Sinei, SM. Gray, GE. (2010). Influence of culture on contraceptive utilisation among HIV positive women in Brazil, Kenya & South Africa. *Springer Scienec+Business*. 15:454-468

Tlou, ER. (2009). 'The Application of the Theories of Reasoned Action and Planned Behaviour to a Workplace HIV/AIDS Health Promotion Programme'. Doctor of Philosophy Thesis. University of South Africa.

The Choice of Termination Act no 92 of 1996. https://www.capetown.gov.za/en/CityHealth/Documentation/Documents/Act_Choice_on_Termination_of_Pregnancy_Act_92_of_1996.pdf

The South African Children's Act of 2005 as amended by the Children's Amendment Act no 41 of 2007. https://www.capetown.gov.za/en/CityHealth/Documentation/Documents/Act_Childrens_Act_38_of_2005_(as_amended_march_2010).pdf

The South African Department of Health (DoH), (2011). *Sexual & Reproductive Health & Rights: fulfilling our commitments, 2011-2021 and beyond.*

The South African Department of Health (DoH), (2012). *National Contraception Clinical Guidelines: A companion to the National Contraception and Fertility Planning Policy and Service Delivery Guidelines*.http://www.mm3admin.co.za/documents/docmanager/3c53e82b-24f2-49e1-b997-5a35803be10a/00037761.pdf

The South African Department of Health (DoH), (2015). *The National Adolescent Sexual & Reproductive Health and Rights Framework Strategy* (2014-2019).

South African Regional Universities Association, 2007 http://www.sarua.org/?q=uni_University%20of%20KwaZulu%20Natal (accessed December 5 2015)

Guide to South Africa, Plan your itinerary http://www.southafrica.net/za/en/guides/entry/destinations (Accessed December 5, 2015)

The University of KwaZulu-Natal, http://www.ukzn.ac.za/about-ukzn/history (Accessed December 5 2015)

Van Ziyl, S. Morroni, C. Van de Spuy,Z. (2010). A survey to assess knowledge and acceptability of the intrauterine device in the Family Planning Services in Cape Town, South Africa. *Journal of Family Planning Reproductive Health Care:* 36(1)

Wang, W. Alva, S. Winter, R. Burgert, C. (2013). Contextual influences of modern contraceptive use among rural women in Rwanda and Nepal. *ICF International/DHS*. http://paa2014.princeton.edu/papers/141380

Wakefield, MA, Loken, B. Hornik, RC. (2010). Use of mass media to campaigns to change health behaviour. *Lancet* 376, (9748):1261-1271

Watt, MH. Aunon, FM, Skinner, D. Sikkema, KJ. Kalichman, SE. (2012) "Because he has bought for her, he wants to sleep with her": Alcohol as a currency for sexual exchange in South Africa drinking venues. *Social Science & Medicine*. (74): 1005-1012.

Wersch, A. Eberhardt, J. Stringer, F. (2012). Attitudes towards the male contraceptive pill: psychosocial and cultural explanations for delaying a marketable product. *Andrologie* (2012) 22:171-179.

Willan, S. (2013). A Review of Teenage Pregnancy in South Africa – Experiences of Schooling, and Knowledge and Access to Sexual & Reproductive Health Services. *Partners in sexual health*, 2013.

Wood, K. Jewkes, R. (2006). Blood Blockages and Scolding Nurses: Barrier to adolescent contraceptive use in South Africa. *Reproductive Health Matters*. 14(27); 109-118

World Health Organisation (WHO), (2011). Family planning definition. Available from: http://www.who.int/topics/family_planning/en/ [Accessed 10 December 2015]

World Health Organisation (WHO), (2012). Emergency contraception definition. Available from: http://www.who.int/mediacentre/factsheets/fs244/en/ [Accessed 10 December 2015]

World Health Organisation (WHO), (2013). Definition of youth. Available from: http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf [Accessed 10 December 2015]

World Health Organisation (WHO), (2013). Maternal mortality. Available from:

http://www.who.int/gho/maternal_health/mortality/maternal_mortality_text/en/ [Accessed 10 December 2015]

Appendix 1- Interview schedule

1.1 How old are you?
1.2 What is your level of study? (1st, 2nd year etc)
1.3 Which best describes your home town: Rural, Urban or Peri-Urban?
1.4 Are you currently in a relationship/dating?
1.5 Do you have any children? If yes did you know about contraceptive at the time you conceived the child?
1.6 Have you heard of contraceptives?
1.7 Could you give me your understanding of the term contraceptive?
1.8 Are you and your partner using a contraceptive?
1.9 If yes:
1.9.1What type of contraceptive are you using?
1.9.2 Why did you decide to use contraception?
1.9.3Why have you chosen this method of contraception?
1.9.4 Are there any side effects to your chosen method, if there are any, elaborate?
1.10Where are you currently accessing your contraceptive? Is it easy to access your contraceptive?
1.11Why have you chosen not to use a contraceptive?
If no, how are you avoiding pregnancy if you are not using contraceptives?
1.12 If your partner is not aware that you are on a contraceptive, why have you decided not to tell him/her?
1.13 How does your partner feel about the type of contraception that you are using?
1.14 Have you tried contraceptives in the past? Which methods?
1.15 What has been your experience with using contraceptives? (If you have used them in the past), negative?
1.16 Do you have any specific concerns about using contraceptives?
1.17 Do you think your views about contraceptives may change in the future?
1.18 How do your family/ friends feel about contraceptives?
1.19 Has your parent/guardian discussed contraceptives with you and why?
1.20 Would you like to have this conversation with your parent/guardian? And why.
1.21 Have you discussed contraceptives with anybody? If yes, was the conversation informative/ embarrassing?
1.22 Do you think you are adequately informed about risks associated with sexual activity and contraceptives?
1.23 Where would you prefer to receive information regarding contraceptives?
1.24 Do you think first year students should be given a workshop on sexual and reproductive health and why?
1.25 Have you recommended contraceptives to your peers? How did they react to this?
1.26 Are you aware that the University health clinic offers free access to contraceptives including the morning after pill?
1.27 Have you accessed contraceptives at the University Clinic? How was that experience for you? What are some of the positives and negatives of this experience?
1.28 f you were to become the next minister of Health in SA, how would you promote contraceptive use among the youth?

Appendix 2- Informed consent

Protocol Ref number: HSS/0693/015M

School of Built environment and Development Studies,
College of Humanities,
University of KwaZulu-Natal,
Howard College Campus,

Dear Participant

INFORMED CONSENT LETTER

My name is Thobile Mandy Lombo; I am a Master of Arts Development studies candidate studying at the University of KwaZulu-Natal, Howard College campus, South Africa.
I am interested exploring the perceptions that the students at the university hold on family planning methods. To gather the information, I am interested in asking you some questions.
Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 20-30 minutes.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at:
Email: 210535794@stu.ukzn.ac.za
Cell: +27 725270625

My supervisor is Professor Pranitha Maharaj who is located at the School of Built environment and Development studies, Howard College campus of the University of KwaZulu-Natal.
Contact details: email: Maharajp7@ukzn.ac.za Phone number: 031 260 2243

You may also contact the Research Office through:
P. Mohun

HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I…… (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

…… ……

Appendix 3- Ethical clearance

8 July 2015

Miss Thobile Mandy Lombo 210535794
School of Built Environment and Development Studies
Howard College Campus

Dear Miss Lombo

Protocol reference number: HSS/0693/015M
Project title: Contraceptive use among young people: A case of University students in Durban, South Africa

Full Approval – Expedited Application

In response to your application received on 8 June 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

[redacted]air)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Pranitha Maharaj
Cc Academic Leader Research: Dr C Sutherland
Cc School Administrator: Ms R Naicker

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix4: Permissions to conduct research

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

18 June 2015

Miss Thobile Mandy Lombo
School of Built Environment & Development Studies
College of Humanities
Howard College Campus
UKZN
Email: 210535794@stu.ukzn.ac.za

Dear Miss Lombo

RE: PERMISSION TO CONDUCT RESEARCH

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

"Contraceptive use among young people: a case study of university students in Durban, South Africa".

It is noted that you will be constituting your sample by approaching students, who are willing to participate in an interview, on the Howard College Campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

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

Data collected must be treated with due confidentiality and anonymity.

Yours s[redacted]

MR B P[redacted]
REGISTRAR (ACTING)