

**A GENDERED STUDY OF CONTRACEPTIVE USE
AMONG STUDENTS AT THE UNIVERSITY OF
NATAL, PIETERMARITZBURG CAMPUS.**

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DECLARATION

I, Oluwaseun Adeola, Oyedeji do hereby declare that the work contained in this dissertation is my own.



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TABLE OF CONTENTS

| | |
|--|-------|
| Acknowledgements | ii |
| Abstract | 4-5 |
| 1: Introduction | 6 |
| 1.1 Background Information on Thesis | 6-8 |
| 1.2 Purpose of Research | 8-9 |
| 1.3 Problem Statement | 9-10 |
| 1.4 Aims of Research | 10-10 |
| 1.5 Research Objectives | 10-11 |
| 1.6 Research Questions | 11-11 |
| 1.7 Definition of Concepts | 11-13 |
| 1.8 Significance of Study | 14-15 |
| 1.9 Limitations of Research | 15-16 |
| 2: Literature Review | 17 |
| 2.1 Introduction | 17-17 |
| 2.2 Gender and Contraception | 17-20 |
| 2.3 Contraception | 20 |
| 2.3.1 History of Contraception | 20-23 |
| 2.3.2 Methods and Types of Contraception | 24-27 |
| 2.3.3 Methods of Contraception Available at the University of Natal, Pietermaritzburg Campus Clinic | 28-29 |
| 2.4 Advantages and Disadvantages of Contraceptives. | 29-32 |
| 2.5 Responsibility for The Prevention of Pregnancy | 32-34 |
| 2.6 Young Adults/ Teenagers Use of Contraceptives | 34-37 |
| 2.7 Contraception as an Empowering Agent | 37-38 |
| 3: Research Methodology | 39 |
| 3.1 Introduction | 39-39 |
| 3.2 Setting of The Study | 39-39 |
| 3.3 The Population | 40-40 |
| 3.4 Data Collection Instruments | 40-40 |
| 3.4.1 Quantitative Method | 41-41 |
| 3.4.1.1 Quantitative Data Collection Process | 41-42 |
| 3.4.2 Qualitative Method | 43-43 |
| 3.4.2.1 Qualitative Data Collection Process | 43-44 |
| 3.5 Data Analysis | 45-45 |
| 3.5.1 Quantitative Data | 45-45 |
| 3.5.2 Qualitative Data | 45-45 |
| 3.6 Validity | 46-46 |

| | |
|--|-------------|
| 3.7 Reliability | 46-46 |
| 3.8 Ethical Issues | 47-48 |
| 3.9 Difficulties | 48-49 |
| 4: Data Analysis | 50 |
| 4.1 Quantitative Data Analysis | 50-50 |
| 4.1.2 Introduction | 50-50 |
| 4.1.3 The Instrument | 50-51 |
| 4.1.4 Pilot Study | 51-51 |
| 4.1.5 Results And Discussion of Quantitative Data | 51 |
| 4.1.5.1 Use of Contraception Among Respondents | 52-66 |
| 4.1.5.2 Respondents Satisfaction With Contraceptive Choice | 67-70 |
| 4.1.5.3 Knowledge and Attitudes Towards Contraception | 71-76 |
| 4.1.5.4 Contraception Decision- Making | 77-83 |
| 4.2 Qualitative Data Analysis | 84 |
| 4.2.1 Introduction | 84-84 |
| 4.2.2 The Instrument | 85-87 |
| 4.2.3 Results And Discussion of Qualitative Data | 88-88 |
| 4.2.3.1 Responsibility for Contraceptive Use | 89-90 |
| 4.2.3.2 Issues of Gender Power Relations | 91-92 |
| 4.2.3.3 Relating Condom With STI, HIV/AIDS Prevention | 92-94 |
| 4.2.3.4 Satisfaction With Contraceptive Service | 95-99 |
| 4.2.3.5 Contraceptive Use Is Liberating | 100-104 |
| 4.2.3.6 Blame Shifting | 104-105 |
| 4.2.3.7 Responsibility for Condom Housing | 105-107 |
| 4.2.3.8 Male Opinion on Contraceptive Use Among Women | 108-108 |
| 4.2.3.9 Misconceptions About Condom Use | 108-110 |
| 5: Summary of Findings and Conclusion | 111-117 |
| 5.1 Conclusion | 118-120 |
| 5.2 Recommendations for Further Research | 120-120 |
| Bibliography | 121-129 |
| Appendix 1: Questionnaire | 130-132 |
| Appendix 2: Interview Schedule | 133-133 |
| Appendix 3: Request letter for permission | 134-134 |
| Appendix 4: Cover letter for questionnaire | 135-136 |

List of Figures

| | |
|--|----|
| Figure 4.1 Initial Contraceptive Use Amongst Female Students | 52 |
| Figure 4.2 Use/ Combination Of Methods Amongst Female Students | 52 |
| Figure 4.3 Initial Contraceptive Use Amongst Male Students | 55 |
| Figure 4.4 Use/Combination Of Methods Amongst Male Students | 55 |
| Figure 4.5 Subsequent Contraceptive Use Amongst Female Students | 59 |
| Figure 4.6 Use/ Combination Of Methods Amongst Female Students | 59 |
| Figure 4.7 Subsequent Contraceptive Use Amongst Male Students | 62 |
| Figure 4.8 Use/ Combination Of Methods Amongst Male Students | 62 |
| Figure 4.9 A Synopsis Of Initial Contraceptive Use Amongst Male And Female Students | 64 |
| Figure 4.10A Synopsis Of Subsequent Contraceptive Use Amongst Male and Female Students | 65 |

List of Tables

| | |
|---|----|
| Table 4A. Male Satisfaction With Choice | 67 |
| Table 4B. Female Satisfaction With Choice | 69 |
| Table 4C. Male Knowledge Of Contraceptive Methods For Men | 71 |
| Table 4D. Female Knowledge Of Contraceptive Methods For Men. | 72 |
| Table 4E. A Synopsis Of Male And Female Perceptions On Contraceptive Use By Men. | 74 |
| Table 4F. A Synopsis Of Male And Female Perceptions On Contraceptive Use By Women | 74 |
| Table 4G. A Synopsis Of Male And Female Contraceptive Decision-Making Abilities | 77 |
| Table 4H. A Synopsis Of Male And Female Perceptions On Who Has The Right To Make An Individual’s Decisions For Contraceptive Use. | 80 |

ABSTRACT

This thesis explores issues of contraceptive use among members of both male and female genders. Although research has been conducted on teenage pregnancy, abortion, sexual behaviour, and contraceptive use with particular focus on the female population, a gendered study has yet to be conducted on contraceptive use among young adults, male and female that have just gone beyond their teenage years and are on the verge of entering into adulthood. Hence, this thesis reviews contraceptive use among young adult students (aged 18-25) of both genders using quantitative (survey) and qualitative (interviews) research methods. This study was based at the University of Natal, Pietermaritzburg. A total of forty students (n=40) were sampled using the convenience sampling method. Twenty of the students were male, while the remaining twenty were female.

The thesis adopts a theoretical approach that attempts to conceptualise the influence of patriarchy on contraceptive use among members of the female gender.

Also, societal reproductive role fixing is contemplated by examining the ways through which societal construction of male and female roles and stereotypes affect contraceptive use among members of both genders.

In this study, it is affirmed that societal attitudes, and misconceptions about contraceptive use play an important role in young adult, male, and female contraceptive use and attitudes towards. Evidence of this, from the survey and interviews conducted in the study, is the high use of the condom, amongst both male and female students compared with other available methods. Among female students, the use of the pill is at twenty-three percent (n=6), use of injectable methods is at thirty-one percent (n=8), while the use of the condom is considerably higher at forty-six percent (n=12). While among male students, the use of the withdrawal method is

at nineteen percent (n=4), while condom use is at eighty-one percent (n=17). Both male and female reported that they were satisfied with their choice and use of contraception. The response rate for satisfied female clients was eighty-five percent (n=22), while among male clients, it was seventy-six percent (n=16).

The high use of the (male) condom among female students was highly attributed to personal convenience and comfort with condom use as unmarried young women. While with both genders, with the male especially, it was attributed to the function of the condom as a safe sex method, rather than for pregnancy prevention

Gender is, and will remain a relevant issue in sexual/reproductive health matters globally. This work represents a contribution to knowledge in this field.

CHAPTER ONE

INTRODUCTION

1.1 Background information on thesis

“...Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.” (Beijing Platform for Action, 1981, paragraph 92).

This study is based on the understanding that women's reproductive health and choices is of great importance to them as individuals. However, its importance is not only restricted to women alone but, has come to be of global importance.

The state of women's reproductive health affects the world's population, maternal and child mortality rates, and even the spread of sexually transmitted infections (STI's) among which is the much-dreaded HIV/AIDS (Ashford, 2001).

In this gendered world however, more often than not, the male gender takes the lead in making decisions at all levels in society even in matters that concern women. Contraceptive use is one of the ways through which men attempt to control women's bodies thereby causing the women themselves to lose control of their own bodies to men to the extent that she is deprived of her humanity (Tong, 1989:72).

The issues involved in the subject of women's reproductive health are greater than merely creating awareness about the use of contraceptives, sex education and safe sex. It is, in reality, about women's bodies and the control of it. It is about their reproductive lives and rights and what they are allowed to do with their rights in terms of power relations between them and the male gender.

Tong writes, *"Because male control of the public and private worlds is what constitutes patriarchy, male control must be eliminated if women are to be liberated."* (Tong, 1989:96).

Patriarchy is represented by members of the male gender in the immediate surroundings of individual women who unquestionably affect the contraceptive choices the women make and ultimately, the rate of contraceptive use among women. For instance, prominent among the reasons why many women do not use contraceptive methods is that they *"are dissuaded by their husbands' disapproval or by family pressure to have more children."* (Ashford, 2001:14).

According to the Universal Declaration of Human Rights (article 1) adopted by the General Assembly resolution 217 A (111) of 10th December 1948,

"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."

It is therefore important that women are brought to the centre stage and that the roles they play in issues that are of fundamental importance to them are brought to the fore. They should be involved in decision making in order to enhance their health, lives and that of the society as a whole.

In society, women are assigned subordinate roles and the female gender is thought of mostly in relation to their biological function of reproduction, which is considered to be their natural/biological roles. According to MacKinnon (1982), gender dimorphism is rooted in the biological differences between members of the male sex and members of the female sex hence, the stereotyping of (gender) roles for members of each of the sexes (MacKinnon, 1982:533). Most of the time, the woman's role is constructed around her reproductive functions. However, men still have control of women's fertility, radical feminism views this control as the most fundamental form of oppression.

Sex is political primarily because the male-female relationship is the paradigm for all power relationships (Millet, 1970). Firestone (1972) expresses the opinion that patriarchy has its roots in the biological inequality of the sexes, as a result of which, she postulates that women's liberation requires a biological revolution (Firestone, 1972:10-11).

In conclusion, when the decisions that concern a person is made by him/herself, that individual is able to make the best choices for themselves and to take responsibility for their lives. Being able to make the decisions in the issues of one's reproductive health, the control of one's fertility in particular is most definitely basic to the empowerment of the individual and central to the emancipation of that individual.

1.2 Purpose of the research

The main purpose of this research is to bring out how the patriarchal construct of society affects the female gender by examining contraception both as a form of reproductive technology and most importantly as a means through which the male gender gains and exercises control over women's fertility.

It is an attempt to show that a lot of times, the use of contraception brings about or reveals the already existing power play/struggle between members of the male and female genders. The former for control of the latter's body and the latter for control of her fertility.

There however is the need for individuals, regardless of their gender to gain control of their lives (private space) and also be able to have a say in societal issues (public

space) that concern them. In order for male domination to cease, stereotypes must be erased and patriarchal systems in society must be deconstructed.

According to Millet (1970),

"Social caste supersedes all other forms of egalitarianism: radical, political, or economic, and unless the clinging to male supremacy as a birthright is finally forgone, all systems of oppression will continue to function simply by virtue of their logical and emotional mandate in the primary human situation." (Millet, 1970:25).

Male supremacy is a serious form of social caste and this is revealed through patriarchy in different forms and at all levels in society. Hence, in order to put an end to oppression, and for emancipation of the individual, from the present patriarchal status that exists in most if not all societies, there is a need for patriarchy at all levels to be deconstructed.

1.3 Problem Statement

The problem statement for this research is based on and formulated around the assumption that contraception and its use is one of the ways through which men attempt to control women's bodies thereby causing women themselves to lose control of their own bodies to men, reaching an extent that she is deprived of her independence (Tong, 1989).

In other words, the male gender attempts to control women's bodies and fertility by controlling their choice and use of contraception.

This form of patriarchy is represented world-wide by government laws and policies that restrict production and availability of adequate forms of contraception to the users. Also on day to day basis, this form of patriarchy is represented by male

authority in individual women's lives that affect their choice and use of contraception. Men manipulate the woman's use of contraceptives to benefit them, such that they, the male, and not necessarily the user is able to control her fertility and sexuality, resulting in his needs and not hers' are being met through her choice, use or non-use of contraception.

1.4 Aims of the research

One of the objectives of this study is to describe women's present reproductive state that is; who takes the responsibility for birth control and male involvement. In examining this issue, contraceptive choices available to women and those available to men will be discussed. Also, the effects (if any) of contraception on both genders will be looked into.

The study also aims to examine how women's contraceptive choices and efforts are affected by male dominance.

1.5 Research Objectives

The objectives of this study are:

- To find out how women and men view contraceptive use.
- Also to find out if it has had a liberating effect on them as a form of reproductive technology.
- The researcher also intends to find out what the rights of women are as perceived by them when it comes to making contraceptive choices.

- Finally, the researcher would like to be able to reach a conclusion on whether it is the individual or patriarchy (represented by male dominance in the individual's life) who has control of woman's fertility through the use of contraception.

1. 6 Research Questions

- How do men, and women view contraceptive use? As a form of reproductive technology, do they find it liberating?
- Who takes responsibility for contraceptive use among young adults? By using contraception, do the users consider their needs as being met, and are their interests adequately protected?
- What contraceptive/ family planning choices are there for men, in comparison to those available for women and which ones are the recipients familiar with?
- Who on the long run benefits from contraception as a reproductive technology?

1.7 Definition of concepts

Reproductive health: Reproductive health care encompasses many elements, including:

“Contraceptive information and services; prenatal care; safe childbirth and post natal care; prevention and treatment of STI's, including HIV/AIDS; abortion (where legal) and post abortion care; prevention and treatment of infertility; elimination of

harmful practices such as female genital cutting, sexual trafficking, and violence against women; and other women's health services, such as diagnosis and treatment for breast and cervical cancers." (Ashford, 2001:12).

For the purpose of this study, reference to reproductive health will be used in terms of contraceptive information and services.

Contraception: Contraception is referred to as the "*regulation of reproduction*" (Hall, 1977). During the course of the study, contraception will be referred to as such, and as a means of pregnancy prevention

Gender: gender refers to the social roles assigned to the members of a particular sex by members of society.

"Gender is a term that has psychological or cultural rather than biological connotations. If the proper terms for sex are 'male' and 'female', the corresponding terms for gender are 'masculine' and 'feminine'; these latter may be independent of (biological) sex" (Stoller, 1968:9).

It will be used in this context for the purpose of the study.

Sex: *"the characteristic of being either male or female."* (Collins dictionary, 1992:787).

Sex: shortened form of "*sexual intercourse*" (Collins dictionary, 1992:787).

Women: a woman is defined as an "*adult female human being*". 'Women' is the plural form of woman. (Collins dictionary, 1992:1002). In the course of this study, it will be used to refer to female students at the University of Natal, Pietermaritzburg who are aged 18 and above.

Men: a man is defined as an “*adult male human being*” as distinguished from a woman (Collins dictionary, 1992:510). ‘Men’ is the plural form of man (Collins dictionary, 1992:526). In the course of this study, it will be used to refer to male students at the University of Natal, Pietermaritzburg who are aged 18 and above.

Patriarchy: Tong in her book Feminist Thought refers to patriarchy as the systematic subordination of women (Tong, 1989). It is defined in Collins dictionary as

“A form of social organization in which a male is the head of the family and descent, kinship, and title are traced through the male line. A society governed by such a system” (Collins dictionary, 1992:619).

Both definitions of patriarchy will be used interchangeably during the course of this study.

AIDS: this acronym stands for “*Acquired Immunodeficiency Syndrome: a viral disease that destroys the body’s ability to fight infection*” (Collins dictionary, 1992:16). It will be used strictly in this context during the course of the study

HIV: this acronym stands for “*Human Immunodeficiency Virus*” (Collins dictionary, 1992:397), and will be used strictly in this context during the course of the study.

STD: this acronym stands for “*Sexually Transmitted Disease*” (Collins dictionary, 1992: 846), and will be used strictly in this context during the course of the study.

STI: this acronym stands for “*Sexually Transmitted Infections*”, also commonly referred to as sexually transmitted disease (Ashford, 2001:12), and will be used interchangeably in the course of the study.

1.8 Significance of study

While research is constantly being carried out on issues of women's reproductive health, about half a million women die every year from complications arising from pregnancy and childbirth, women make up the largest population of HIV carriers worldwide. (Population Reference Bureau, 2001).

The Population Reference Bureau in Washington D.C., World Health Organisation, and other institutions and Non-Governmental Organisations are constantly carrying out research on the improvement of reproductive health and rights of women. Research is constantly being conducted on the use of contraceptives, reproductive and sexual health policies and family planning methods, STD's and especially, the much-dreaded HIV/AIDS.

However, sufficiently in-depth research is yet to be conducted on the gendered aspect of contraception and its use.

It is important that people (women) have knowledge about these issues, but the important thing is the meeting point between what women know, what options are available to them and, the ability to make that choice. This makes a lot of difference by contributing towards the emancipation of an individual.

Thus, it is believed this study will further enhance knowledge and provide an insight into the views and experiences of students as young adults in a gendered society and how the power struggles affect them in an aspect of their lives that is personal to them and close to their hearts.

On the whole, it is hoped that the study would have been able to contribute to already existing knowledge and to open up new areas for constructive thought in bettering the sexual and reproductive health of women. To have contributed towards a political,

academic and socio-economic development for all peoples. And lastly, to have contributed something valuable towards the eradication of gender stereotypes and power struggles between sexes in a gendered world.

1.9 Limitations of the research

This research thesis is concerned mainly with contraception and the gendered issues that will be weaved around it. Although mention will be made of sexual health, it will not be developed as a concept on its own, it will only be alluded to alongside reproductive health.

While discussing contraception, the condom will be discussed but mainly as a method of preventing pregnancy and not as a method of preventing sexually transmitted diseases (STD's), unless otherwise stated.

Reproductive health consists of a wide range of issues that has to do with the reproductive capacities and health of women. However, for the purpose of this study, reproductive health is seen from the light of contraception and its use and does not specifically involve other issues such as: maternal and infant mortality, sexually transmitted infections, fertility issues, women's health etc except otherwise stated.

It must be pointed out that, although this is a study of contraceptive use among both genders, there is a slight emphasis on the female gender. This is because they are subject to gender and biological roles and stereotypes of procreation (Firestone, 1972; Millet, 1993; O'Brien, 1983), they are disadvantaged, and they also undergo subjugation in most societies (UNAIDS, 2000). Also, contraceptive reproductive

technology is directed at, and serves the female gender more than the male, as they are directly affected by pregnancy, and altogether, the female gender is more in need of empowerment and emancipation sexually, and reproductive wise.

It must also be pointed out that although the study and literature covers women in general, the research population consists of young men and women who can be said to be elites, and empowered in comparison to most other Black women, who are farmers, domestic workers, petty traders, and unskilled workers. This is primarily due to the fact that this population, being generally better empowered in terms of education, knowledge and social standing, arguably represent groups with better access to, and best contraceptive use. Therefore, it can be assumed to be a viable point of reference in determining use among other women.

In spite of the social distinctions and irrespective of class, members of the female gender remain the less vocal and sexually liberated in society, and are consequently, in greater need of sexual and reproductive liberation.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Reproductive rights can be conceived either to mean the rights of a person to reproduce or the rights of a person not to reproduce (Correa, 1994). In other words, the rights of a person to plan if and when they choose to reproduce. In order to exercise such rights, there is the need for access to safe and effective contraception services among other protective measures that can be taken. The concern in this study is contraception and its use both from a health and gendered perspective.

In order to carry out this study, literature from the 1970's to the present day, 21st century was reviewed.

2.2 GENDER AND CONTRACEPTION

"Socially constructed gender and reproductive roles restrict a woman's identity and behaviour"(Tong, 1989:109-110).

The roles associated with the female gender are 'feminine' roles of submission, dependency, gentleness, nurturance, passivity, emotion etc as opposed to 'masculine' roles of reasonability, dominance, independence, aggression, toughness etc that are associated and attributed to members of the male sex (Figs, 1977; Millet, 1970; Tong, 1989). Gender roles are dictated by society and the roles dictated for each gender becomes the expected norm for individuals who are categorized under that

gender thus creating gender stereotypes. This prescribes the roles of procreation, and mothering for women which dictate that women stay home and take care of the children. The roles of production for men dictate that they go out to work, hunt for produce and therefore not pay much attention to the home front (Chen, 1996; Engels, 1985).

However, the biological role of the female gender as child bearers and nurturers is believed to be the cause of women's oppression, should they be free of this role, then they would have freed themselves of the very essence of patriarchy- heterosexual reproductive functions. That is women are held in bondage by the role of procreation bestowed on the female sex by virtue of their biological physiology (Firestone, 1972).

Firestone is also of the opinion that it would only be possible to eliminate all sexual roles of 'masculinity' and 'femininity' when humans (women in particular) abandon patriarchal reproduction (Firestone, 1972:74-5). This agrees with her affirmation that patriarchy is rooted in the biological inequality of the sexes.

Some radical feminists argue that "female biology" in itself is not the cause of woman's oppression but rather, man's control of that biology (O'Brien, 1983; Tong, 1989:78).

Man's attempt to control the female body takes place through various means among which are contraception, abortion laws, sterilization, or the various forms of violence directed against women (Tong, 1989). O'Brien (1983) echoes the concern that patriarchy as a system aims to have total control over the female gender by gaining control of women's bodies, reproductive lives and organs, the only aspect of the female gender which the male gender does not have natural control over (O'Brien, 1983; Stanworth, 1987). Thus, contraception as a form of reproductive technology, is

regarded as a means through which men attempt to control a part of life which they do not naturally have control over. This comes in the form of a range of direct or indirect outside influences that affect contraceptive decision making for women. Some of these are; cultural and societal norms, limited information available, access to contraceptive services, government laws and policies (Population Reports, 2001). An indirect way through which men (patriarchy) can gain control of women's lives and reproductive freedom through contraception is when governmental laws that affect women's ability to make independent decisions are made. More direct control is gained through the making of policies that regulate access to information through the media, sex education and health literacy; and limits access to contraceptive supplies and services (Catino, 1999; Correa, 1994).

In Chad and Chile, a policy was passed that made it mandatory for women to be given permission by their husbands in order to be able to receive some forms of contraceptives. Contraceptive advertisement and/ or propaganda was banned in some countries in Africa. Ghana banned the advertisement of contraception in the mass media in 1986. A law that prohibits "contraceptive propaganda" was passed in Cameroon in 1990 to regulate the practice of pharmacies. (PRB, 2000).

These laws make it such that women who are sexually active but unmarried cannot protect themselves against unhealthy reproductive habits. Also, women who are married but whose husbands will not give them consent have to suffer the consequences of not being able to protect themselves against unwholesome reproductive habits. This way, the control of women's fertility is taken out of their reach and placed first, in the hands of the government, then in the hands of their husbands. Such policies subject women to cruel power play.

These factors consist of patriarchal influence on an individual's ability to make Informed contraceptive choices in a patricentric society. Reproductive rights are deeply rooted in the most basic human principles firmly rooted in fundamental human principles

'reproductive rights are human rights which are inalienable and inseparable from basic rights such as the right to food, shelter, health, security, livelihood, education and political empowerment.' (Correa, 1994:66).

Government policies that create policies and regulations without regard for the needs or wishes of women openly discriminate against women. Reproductive rights encompass the right to reproductive health care and the right to reproductive self-determination. By making contraceptives scarce or unavailable, such governments deny their women of these rights.

2.3 CONTRACEPTION

2.3.1. HISTORY OF CONTRACEPTION

Contraception can be defined as, *'the voluntary and artificial prevention of conception or impregnation'* (Blackwell 1994:165). Contraception can also be referred to as the *"regulation of reproduction"* (Hall, R. 1977).

Marie Stopes is Britain's foremost proponent of sexual technique and birth control. She was born on the 15th of October 1880, in Edinburgh and died on 2nd October 1958. Marie Stopes in her own personal life experienced sexual and emotional misfortune. This was the beginning of her career, which made her,

"The central figure in that social revolution by which men, but more particularly women, were freed from the miseries of sexual ignorance and haphazard reproduction."(Hall, 1977:12-13).

Marie Stopes fought for the liberation of women from the constraints and restraints of unwanted pregnancies and sexually transmitted diseases, by promoting contraception. She sought to make contraceptives accessible to lower-class women, as they were hitherto limited to the bourgeoisie. She stressed the need for clinics supported by the government and directed by trained personnel to educate the public in contraceptive use (McLaren, 1990).

Attempts at reproduction regulation began in the earlier days as far back as the 16th Century,

"In the late sixteenth century, Benedicti condemned those who violated nature or employed unnatural acts so that their wives could not conceive." (McLaren, 1990:149).

This implies that reproduction regulation methods existed long before Marie Stopes began her campaign for the acceptance and legalisation of contraception even though, the methods might have been somewhat crude, as women have controlled the number of babies they have in the past through the use of traditional medicine. However, Riddle (1992) analyses ancient contraceptive medical practices and finds that contraception and abortion were safe, effective, and commonly used (Riddle, 1992).

However, what is most obvious here is the fact that birth regulation methods were not publicly accepted both before and during the era of Stopes. This is one reaction to contraception that has prevailed through the centuries. Women have had to submit themselves to discomforts in order to avoid getting pregnant (McLaren, 1990;

Szarewski& Guillebaud, 1994). One major reason for this is the absence of proper, well-formulated methods of birth control, as coitus interruptus was the main form of contraception employed. (McLaren, 1984)

A cause of this is the rulers and lawmakers in the different societies through the centuries. In the past centuries, the governments and the various religious sects of the various communities gave different levels of resistance to the use of contraception (Hall, 1977).

"In England, as late as the 1970s, 'the Medical Defence Union advised practitioners not to fit an intra-uterine device for a woman without the consent of her husband.'" (McLaren, 1984:237)

In eighteenth-century France there was widespread employment of birth control. This was aimed at reducing family size. In the later nineteenth century the available methods were; condoms, coitus interruptus, extended lactation and abstinence and abortion. (McLaren, 1984)

In recent times, family planning initiatives in many southern countries had to confront religious, military and nationalist resistances. (Djerassi, 1981;Correa, 1994) However, unlike the past centuries, contraceptive use and safe sex methods have been widely accepted the world over by governments and the public in general. To the extent that contraception and safe sex methods have come to the fore in science and medicine. The need for the prevention of sexually transmitted disease has made the legalisation of safe sex methods compulsory.

Also, another factor that has necessitated the need for safe and effective methods of

contraception is the high rate of unwanted or unplanned pregnancies that led to abortion and that has also led to the endangering of the mothers life, high rates of maternal and infant mortality. In South Africa, maternal mortality among teenagers is high, the rate is almost double the national rate for women over 20 years old (Richter, 2003). In 1990, the Department of Health, South Africa, estimated the teenage pregnancy rate to be 330/1 000 women under the age of 19 years (Richter, 2003). This further emphasises the importance of contraceptive measures and the need for it to be accepted and made accessible in societies.

The hitherto resistance to contraception was by the legislative and the religious authorities in societies. These organisations were made up of an overtly male population (Hall, 1977). Thus, it can be observed that it was the patriarchal arm of the society that had to make the important decision in a jurisdiction that was predominantly women's.

Therefore, it can be concluded that even though contraception as a form of reproductive technology has been around since the sixteenth century (McLaren, 1990), patriarchal or male control of contraception and hence, biological reproduction, which affected mainly the female body and fertility, had already also been established. This has to do with the fact that most societies are patricentric so that the systems of governance are essentially male-dominated. Contraception has come to be of such importance as it affects world population and other aspects of human lives.

2.3.2. METHODS AND TYPES OF CONTRACEPTION

A contraceptive is '*an agent or device used to prevent conception*' (Blackwell, 1994:165). Pharmaceutical companies manufacture contraceptives. Contraceptives and other family planning services are usually gotten at hospitals and family planning clinics. Some Non-Governmental Organizations also provide such services. There are various kinds of contraceptive methods, they can be classified by their major characteristics into two groups: hormonal and non-hormonal, reversible and irreversible.

HORMONAL CONTRACEPTION:

The methods of contraception that are presently available in South Africa are, oral contraceptives, inject-ables, subdermal (implants). Under oral contraceptives falls the combination pill and progestogen-only pill (POP), which are taken on a daily basis. Another type of hormonal contraceptive pill is the morning after pill (Cooper & Smith, 1984). This pill serves as a form of corrective measure; it is called the emergency contraception (EC) and is taken in two parts after unprotected sexual intercourse has occurred. Inject-ables on the other hand are taken at monthly intervals. Inject-able contraception is classified as long acting. Depo-Provera (DMPA) is taken at an interval of twelve weeks (3 months), and Nur Isterate (NI) is taken at an interval of eight weeks (2 months). Another type of inject-able contraception is, Cyclo Provera (Szarewski & Guillebaud, 1994; Guillebaud, 1991).

Subdermal: implants are long acting. Under implants are, Norplant 6 and Norplant 2. Implants are fixed into the wearers' body through an incision usually made in the inner part of the upper arm or any other place that is safe for the wearer and unobtrusive. The wearer can have the implant in her body for up to five years, but after five years it is advised that she have another implant. This method is advised for women who have passed their reproductive years or who have decided to put a stop to childbirth.

Vaginal rings: this is placed in the vagina. The combination ring is left in the vagina for three weeks and then removed for a week while the pure progestogen ring remains in the vagina for three months. Women however, are known to often object to having a ring in the vagina and these rings are however not available in South Africa (Roux, 1995).

NON-HORMONAL CONTRACEPTION

Natural methods: classified under natural methods of contraception are methods such as abstinence, rhythm method, lactation, and withdrawal method. The latter is also referred to as coitus interruptus (Hall, 1977). This involves the withdrawal of the penis from the vagina before ejaculation takes place. Rhythm methods require periodic abstinence, as it is an attempt to determine a woman's fertile period in order to avoid coitus during that period. This can be done through about five different methods, calendar month, temperature method, cervical mucus changes (Billings method), symptothermal method and mittelschmerz (Roux, 1995).

Barrier methods: Barrier methods are used just before intercourse. Under this method we have cervical caps, sponges, the condom, and diaphragm. These methods prevent the sperm meeting with the ovum. There are male and female condoms. The male condom however is the most popular and most commonly used as the female condom (femidom) is not easily accessible for production reasons. Individuals are always advised to use condoms in conjunction with any other contraceptive method they may be using as it gives protection against STD's and STI's, HIV (AIDS) included (Szarewski et. al, 1994).

Sponges, diaphragms and cervical caps are used by the female sex through insertion into the vagina. Cervical caps are however complicated to use, and are not readily available in South Africa (Roux, 1995). It is usually advised that these two methods be used with spermicides so should there be any leakage of sperm, it is killed by the spermicide.

Inter-Uterine Device (IUD): copper (cu) T, Lippes loop etc. There are different types of IUCD's; they are inserted into the uterus of the wearer. These can be worn for three or more years. It is however advised that the wearer goes for medical examination every six months. The Mirena (IUS) is a new form of contraception and it is a type of Intrauterine Contraceptive Device. Like other IUCD's or coils it is fitted by a doctor and remains in the uterus for a fixed amount of time (up to five years), after which it must be changed. It is different however as it has a contraceptive band on the coil, and it slowly releases a very low amount of a hormone called Levonorgestrel directly into the lining of the womb. It is much more effective than usual IUCD's and avoids many of the side effects that put women off this choice of contraception. For instance, most IUCD's make a woman's menstrual flow heavier, but the Mirena actually makes

menstrual flow lighter than usual. Because of this, it is frequently used as a treatment for heavy menstrual flow, even in women who don't need contraception. The effectiveness of this method can be compared with that of Sterilization (Tucker, 2001).

Spermicides: spermicides are easy to use and are available without prescription. These come in the form of creams, jellies, pessaries, foams, suppositories, plastic filmstrips and sponges. An added advantage in the use of this is that some of them also protect the user from STD's. However, the rates of pregnancy are unacceptably high with the solitary use of spermicides (Szarewski et. al, 1994).

Sterilization: this method can be classified as irreversible. It can also be described as a barrier method of contraception as it prevents the sperm from making contact with the ovum. Sterilization is performed through surgical procedures. Sterilization is a permanent method and is usually prescribed for clients who have had at least one child. There is female sterilization and there is male sterilization. Male sterilization is called vasectomy.

Although, there is possibility of reversal of the operations, clients are warned not to consider the operation as reversible (Cooper, 1980; Szarewski et. al, 1994).

All of the above methods vary in reliability and utility and therefore, it is important that contraceptive users are well aware of what is required of them and the possible implications of their choice when choosing which contraceptive to use. Responsible decision-making is dependent upon knowledge and information.

2.3.3. METHODS OF CONTRACEPTION AVAILABLE AT THE UNIVERSITY OF NATAL, PIETERMARITZBURG CAMPUS CLINIC

At the University of Natal, Pietermaritzburg, contraceptive services are available and offered to students studying at the University. Apart from the initial and mandatory five rands each student has to pay prior to any consultation, contraceptive services are provided free of charge. Methods of contraception available at the student clinic can be categorized into three forms, the barrier method, inject-ables and oral contraceptives. Under which fall the condom; Depo Provera and Nur Isterate; every day pills (simply known as the Pill) and the morning after pill. These are available at the clinic with consultation.

Both male and female condoms are available at the clinic. The male condoms are placed in dispensers and are totally free as students can just walk into the clinic and pick them up without paying the consultation fee of five rands. However the female condoms (femidoms) are available with consultation and only on request. On speaking with one of the nurses, it was found that this is because these are less used so that demand for them is less, and consequently, production rate is much less than that of the male condom. The reason for the choice of this method (femidoms) among this set of students being less can firstly be based on availability, and accessibility as discussed above. Secondly, the nurse disclosed that clients who try them complain that they are uncomfortable to use, they are apparently, not as easy or convenient to wear as the male condom, hence, the female claim to the male condom as their personal method of contraception also (as will be observed in chapter four). The claim to the use of this male method/device (male condom) by the female population raises questions from a gendered perspective. As the male population also view the (male)

condom as their arena, something that is worn and should be carried by them. This shows women moving into the former male-only zones, taking the tool which men view as theirs, and holding on to it thus taking responsibility for male gender. Also by doing this, the female gender give themselves a voice in an issue that is considered to be the male population's, as the male still has to take responsibility for the utilization of the method thus, women take charge of their sexual lives.

Therefore, this can be interpreted as an attempt by women to control and gain power over their reproductive lives, thus resulting in a power struggle between both genders.

2.4 ADVANTAGES AND DISADVANTAGES OF CONTRACEPTIVES.

It is not only the rights of contraceptive users to be educated about all available options they also have the right to have accurate information about the risks and benefit of each of the methods.

The advantages and disadvantages of contraceptives will be looked at from two viewpoints.

Health implications:

Each method of contraception comes along with its advantages and disadvantages. Some however, are more consequential than others. Users of the natural and barrier methods of contraception are more at an advantage than disadvantage health wise. Based on the fact that most of the methods are coitus related and do not involve the

intake of hormones or chemicals in any form. They do not have any short or long-term effect and can be said to be relatively free of side effects. However, methods such as the diaphragm may cause irritation. When it comes to efficacy on the other hand, it is usually advised that natural methods be used alongside spermicides as natural methods are not sufficiently reliable enough to prevent pregnancy. One major advantage of the condom is that it offers protection against the contraction of sexually transmitted diseases and infections including the much-dreaded HIV/AIDS (Szarewski et. al, 1994).

At this point the attention will be shifted to hormonal contraceptives as these pose the most/highest risk to the users health and here, one major type of hormonal contraceptives will be discussed, inject-able contraceptives.

Like other hormonal methods of contraception, Depo-Provera and Nur-Isterate have possible undesirable side effects. These include spotting, break through bleeding, irregular or strong bleeding, amenorrhoea, weight increase/ weight loss, acne, oily skin, chloasma, depression, headaches, dry vagina, loss of libido, breast congestion, abdominal swelling, galactorrhoea etc. (Szarewski et. al, 1994).

Although some of these side effects are relative, not severe and occur in approximately ten percent of cases, they are nevertheless health implications and are some of the consequences contraceptive users have to suffer. The advantages Depo-Provera and Nur-Isterate, include the fact that it is safe- no deaths have occurred as a result of using them, they are virtually hundred percent effective, have long effect (8& 12 weekly), protects user against anaemia and partly against STD's, minimal stress as it is not coitus related, few/ not serious side effects, allows for confidentiality and

reliable usage and administration is simple under all circumstances (Szarewski et. al, 1994; Roux, 1995).

However, as with all contraceptive methods, there is always that one percent chance that it might fail and pregnancy may occur.

Gendered implications:

Firestone (1972) is of the opinion that women's liberation requires a biological revolution based on her belief that the roots of women's oppression are biological (Firestone, 1972). Tong (1989), voiced the opinion that

"Far from liberating women, reproductive technology will further consolidate men's power over women" (Tong, 1989:78).

Based on the above, there are a wide variety of contraceptive choices available through reproductive technology. Out of all the methods available, only two are specific to the male population, these are, the male condom and vasectomy. The other methods are used by members of the female gender. Apart from vasectomy, the other male method has nothing to do with the individual's physiology or anatomy. Vasectomy is carried out through a minor surgical procedure (Szarewski et. al, 1994), and no study has yet been able to show any harmful results on the man's health or sexual behaviour, and no deaths have been reported (Roux, 1995). This procedure reduces the risk of cancer in women whose spouses have undergone this procedure. Women whose spouses have not undergone vasectomy have chances higher by 4,29 times of developing cancer of the cervix (Roux, 1995).

However, men are reluctant to undergo this procedure for reasons associated with their sexual behaviour and for psychological reasons. Men who undergo it only to regret having undergone the operation can develop the appearance of long-term psychological effects (Roux, 1995).

According to Guillebaud (1985),

“If more men were prepared to sacrifice their vas deferens, it would make a vast difference” (Guillebaud, 1985:13).

The vas deferens is the tube that is blocked in order to disrupt the flow of sperm when conducting a vasectomy.

The health risks for women who use contraceptives are much higher, yet women still use these methods. Reproduction is/ should be the responsibility of both male and female, however it turns out that one gender takes the most responsibility for it and bears the brunt of it.

2.5 RESPONSIBILITY FOR THE PREVENTION OF PREGNANCY

Most birth control methods are directed towards the female population. Compared to the female population there is minimal contraceptive provision for the male population and it is believed that the female population in most societies takes the responsibility for birth control and contraceptive use. Most women and men assume that the responsibility for birth control should fall on women. One reason is that women have more at stake in preventing pregnancy

than men do, for we bear the children and, in most cultures, are primarily responsible for raising them (Bell et. Al, 1998).

In a study carried out among teenagers in Urban South Africa (1998), it was discovered that male participants considered contraceptive use to be their partner's responsibility. This indicates that among South African youths, an attitude of joint responsibility for contraceptive practice is not present (Mfono, 1998).

The fact that it is women who are only able to reproduce thus condemns them to an existence, which cannot be free. It is the thing, which differentiates them from men and which led to their oppression. Thus, the only way to remove the shackle of this form of slavery is to somehow deal differently with reproduction - either to remove it from the role of women as equality of the sexes can only be achieved when women are no longer bound by the reproductive process or, to control it (Firestone, 1972).

“ The opponents of contraception and abortion have long argued that birth-control methods actually serve to incite promiscuity. Women will only remain chaste, they assert, if they have a good reason to fear becoming pregnant. ”

(McLaren, 1984:256). Obvious here, is gender discrimination, which is embedded, in the stereotypical role assigned to women by society. Contrary to the above quotation, women by taking charge of contraception can learn to control their fertility.

Hence, women's attempt to control the reproductive process is through the contraceptive industry, regulating their fertility and planning when to or not to get pregnant and by making the choice of which contraceptive method to use and when to use it.

Rowland (1985) however expresses the concern that women's demand for choice and freedom in reproduction and sexuality may eventually entrap them thus, further limiting their choice to say no to male domination of the reproductive process. (Rowland, 1985).

2.6 YOUNG ADULTS/ TEENAGERS USE OF CONTRACEPTIVES

The Director-General of Health, South Africa, in 1999 identified teen pregnancies as one of the most critical public health problems in South Africa. Unwanted adolescent pregnancies are of worldwide concern, and this is by no means less among young South African adults, by the age of 19 years, 35 percent of all teenagers have been pregnant or have had a child. This represents a very high level of teenage fertility, a continuing source of concern to the government and researchers. Contraceptive use stands at an average of sixty-two percent, with lower proportions amongst African and coloured women. Clearly, the latter groups still experience some form of oppression when it comes to the use of contraceptives (Skewyiya, 2002).

Teenage pregnancy is more prevalent among coloured and rural African girls' (South African Demographic and Health Survey, 1998).

Sexual behaviour starts among boys at around 13 years of age, and around 15 years of age among girls (Jacobs, 2002; South African Demographic and Health Survey, 1998). The use of contraceptives among young adults is low (Boult & Cunningham, 1991; Jacobs, 2002). This is due to many factors that affect young adults and teenagers' ability to make such choices. Some of these factors are discussed below.

Lack of information. Young people often know little or have incorrect information about fertility and contraception, where to get them or how to use them. Young men are more likely than women to mention lack of knowledge and are much more likely to say that it is their partner's responsibility to avoid pregnancy (Erulkar& Mensch, 1997; Armstrong et al, 1999; Varga, 2000). Also, many young people have negative attitudes about contraceptives, have heard false rumours, and have received misleading information about contraception.

Lack of access. Even when young adults know about contraceptives, few use them. Often this may be because it is more difficult for young adults to obtain contraceptives than it is for older, married couples. Unmarried young women, usually face barriers in order to obtain contraceptives, including social disapproval of contraceptive use. Often laws prohibit or limit providing contraceptives, services, or even information to young people (Jejeebhoy, 1999). Even where law does not restrict access, some family planning services have policies or prejudices against serving unmarried people. In South Africa however, a female of 14 years and over may legally be supplied contraception without consent or permission from anyone other than the individual (Roux, 1995).

At times judgmental family planning staff may discourage some young people from seeking contraceptives. For example, in a South African study young field workers posing as clients reported that personnel at some clinics resisted their requests for condoms and often provided no instructions on condom use (John Hopkins University, 'date unknown').

Lack of decision-making and lack of power. In a case where young people have information about contraceptives and access to services, many factors affect their contraceptive practices. The extent of communication between partners, attitudes about societal and sexual roles influence young adults' sexual decision-making. Some young people cannot use contraceptives because sexual intercourse is unwanted and forced (Population Reports, 1995).

Social and cultural misconceptions about contraceptive use

'Teenage contraceptive use in South Africa is constrained by attitudes associating sexual involvement with marital commitment and stable relationships, neither of which usually characterize teenage relationships' (Mfono, 1998).

This is an ideal, and could be explained as an attempt by members of society to achieve utopia, by creating a society where young adults and teenagers conform to the sexual expectations of that society.

Some men and some women themselves may disapprove of contraception because they believe it encourages women to promiscuity. Some even believe that contraception in itself makes teenagers sexually active (Roux 1995). Among reasons for contraceptive non-use or discontinuation, among South African young adults are health-workers' judgemental attitudes towards them, verbal abuse and in some cases refusal to provide contraception. Among other factors that contribute to contraceptive non-use among this group is, false beliefs concerning the possible effects associated with the respective methods particularly with the injection, *'prolonged absence of menstruation was perceived to be problematic, as it was seen to indicate that blood was accumulating in the "abdomen", a state of dangerous blockade said to cause sickness manifested as "waist pains" '* (Maepa, 1997).

In conclusion societal beliefs and attitudes is one major factor that discourages young adults from the use of contraceptives and these attitudes increase young people's especially girls' vulnerability to sexually transmitted disease (STDs) and pregnancy.

2.7 CONTRACEPTION AS AN EMPOWERING AGENT

A lot of times an individual is not satisfied or happy with the choice of a particular method of contraception, which she might be using to avoid the use of another one she dislikes even more. So that on the long run, a woman who is a contraceptive user might not necessarily be making a choice, but she might have to use what she finds, what is available, irrespective of what it might be (Correa 1994; Population Reports, 2001). This raises issues of access to and availability of contraception, variety of available contraceptives, effects of particular methods on the user.

In contemplating contraception and its use as an empowering agent, it would seem imperative to reconsider Duelli's (1985) concerns as stated here, "Who makes the rules? Whose needs and interests are being catered for? Who profits from this control? Who benefits? And who pays the price?" (Duelli Klien, 1985:67).

In conclusion, contraception can either be a tool through which women are oppressed by societal and patriarchal constraints, or a tool through which they achieve sexual and reproductive emancipation. However, in order for contraception to serve as a means or tool of emancipation from sexual and reproductive miseries for women, there is a need for the present patriarchal status of society to be deconstructed and for present negative perceptions and societal mindsets to be done away with.

Of equal importance is the fact that women young and old need to be informed, and encouraged by society to take charge of their individual lives and pertinent issues that concern them.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Through the use of quantitative and qualitative methods, the researcher conducted an investigation into contraceptive use among students. Attempts were made to gain information on the contraceptive methods female and male students at the University of Natal, Pietermaritzburg, Kwazulu Natal, South Africa respectively choose, and their perceptions on and around contraception and its use. The researcher also attempted to extract information on whether and how the students considered themselves to be liberated sexually and as individuals, due to the use of contraceptives. In essence, the perceptions of the participants on the impact of contraception on an individual's life and ability to make decisions were investigated.

3.2 SETTING OF THE STUDY

The setting of the study was the University of Natal, Pietermaritzburg campus clinic, Kwazulu Natal.

The campus is located on King Edward Road, Pietermaritzburg. The Pietermaritzburg campus alongside the Durban campus of the University of Natal was inaugurated at Pietermaritzburg on the 15th of March 1949. Both campuses are located on the land of Natal, which was discovered and named on the 25th of December 1497.

The clinic is located on the Pietermaritzburg campus site.

3.3 THE POPULATION

The target population for this study consists of young adult Black South African students, male and female aged 18-25, based at the University of Natal Pietermaritzburg health clinic. The researcher has chosen to study this group of students in order to restrict the research to a race/culture thereby giving the study focus. Also, the researcher herself belonging within this category, as a black (African) student raised the interest to study this particular population, and it serves as an advantage, as she is able to identify with the research population. The choice of South African students is natural, as the research was conducted within this social and geographical context.

The sample population of this study consists of a total of forty students. Twenty were male while the remaining twenty were female. They were selected through the use of convenience sampling (Fink, 1995; Neuman, 1997). This means that readily available students attending the University of Natal, Pietermaritzburg campus clinic were used for the purpose of this research.

3.4. DATA COLLECTION INSTRUMENTS

Here, the researcher triangulated two methods. This, the researcher did by making use of two different data collection methods, quantitative and qualitative methods.

In doing this, the researcher was able to confirm the results derived from one method with the other, resulting in the quantitative method confirming the qualitative method.

3.4.1 QUANTITATIVE METHOD

This method was used in order to situate the research within a wider and more general range of students thus, making obtained information more viable (Fink, 1995).

Here the researcher attempted to do a convenience sample of Black students at the University of Natal, Pietermaritzburg, by conducting survey among students within the required population. This means that a group of individuals or units that were readily available at the campus clinic waiting room were used (Alreck, & Settle, 1985; Fink, 1995).

This method was employed because of its practicality in relying on readily available units. This is quite an ideal stratagem to employ when the site of research is a clinic where it cannot be ensured that the researcher will be opportune to see each participant more than twice.

3.4.1.1 QUANTITATIVE DATA COLLECTION PROCESS

This was done through a survey. It entailed putting together questions to form questionnaires, and distributing these among the above mentioned group of students.

The questionnaires were distributed at the University of Natal, Pietermaritzburg campus clinic.

The data collection process included the researcher being present at the university clinic between eight (8a.m) and twelve (12pm) everyday for two weeks. The researcher then sat in the clinic waiting room where she distributed the questionnaires

to forty students within the required research population. All the questionnaires were self-administered by the researcher.

The Instrument: The questionnaire was the instrument that was used in carrying out the quantitative research process. Closed-ended questions were asked in the questionnaire as it is aimed at sampling the opinion of women and men through survey. Closed-ended questions are fixed-alternative questions (Blaxter et. Al, 1996; McKenna, 1995). This format was utilized in order to ensure that the questions asked are standard and can be compared from person to person. Another reason for this choice is because the questions are usually clear and the respondent that is unsure of the meaning of the question can be easily enlightened from looking at the answer categories. A few opened ended questions were also asked as it allowed participants to express themselves in their own words (Bailey, 1978; Neuman, 1997).

The purpose of the questionnaire was to obtain demographic and statistical information about the contraceptive choices male and female students respectively make and what informs those choices. The questionnaire consisted of closed ended questions that are focused on contraceptive knowledge and use, the right to choose, decision- making and the opinion of individual participant concerning some of the issues raised.

3.4.2 QUALITATIVE METHOD

The qualitative method was used by the researcher as this method allows for more open discussion and respondents are able to express themselves much more freely and accurately (Bell, 1993; Garret, 1970; McKenna, 1995).

The inadequacies of the questionnaires administered were made up for through the thoroughness of the interview as the researcher was able to obtain in detail, the views and opinions of respondents. Thus resulting in a more thorough understanding of the respondents' perspectives and attitudes towards issues raised in the body of the research.

A convenience sample size was also used under this method for reasons already motivated for under quantitative methods.

3.4.2.1 QUALITATIVE DATA COLLECTION PROCESS

This also involved the researcher being at the clinic. The qualitative data was collected at the same time as the quantitative data so that the collection process were the same for both methods.

It only varied in that the researcher had to conduct interviews individually with each of the respondents in order to collect the necessary data for the method.

So that the data collection method of the study was represented by face-to-face interviews.

The Instrument: The instrument for the qualitative data collection process was the interview format. The interview format was developed in a way that allowed the interviewee to respond to the question explicitly and without bias. The interview questions address the same issues as the questionnaire. The questions were worded so that they can be easily read for logical and smooth progression of the interviews (Bell, 1993). The interviews took a 'face to face format'. Respondents were asked questions and his/her response were recorded on tape to be processed for data analysis. Some notes were also taken during the course of the interviews and observations made while sitting at the clinic was written down as part of the data analysis. Twenty interviews were conducted. Participants consisted of ten males and ten females who were also part of forty that made up the quantitative sample size. Forty questionnaires were distributed to respondents at research site for quantitative data analysis.

See questionnaire and interview format in Appendix 1 and 2.

Also because of the nature of the study, which examines issues that are considered as personal, the participants need to feel and be sure that their privacy is not being invaded and is guaranteed. Which means that asking them many personal and contact details might put them under pressure or make them uncomfortable therefore, the researcher had to ensure the participants of their anonymity by not asking participants for personal or contact details.

3.5 DATA ANALYSIS

3.5.1 Quantitative Data

The data derived in the questionnaires was analysed through Microsoft Excel program and Microsoft Word. This, the researcher used by feeding in the information in the questionnaires into Microsoft Excel in order to process the answers derived to each of the questions in the questionnaires. This was done by separating the information into data sets and variables, the researcher then manually presented the results derived in tabular form by using Microsoft Word.

The pie charts in the figures were derived through the use of Microsoft word. The researcher did this by feeding the required information into the provided space in the program, thus the charts were derived.

3.5.2 Qualitative Data

The data derived in response to the questions in the interview guide were analysed by transcribing the information that was recorded in the interview process. The transcripts derived were then analysed by searching for patterns among the data that was generated. The data was then coded and placed under categories, meaning they were given descriptive titles. A verbal research strategy was used which included the respondents excerpts being paraphrased and discussed around the themes that they generated (Neuman, 1997). As this was a purely qualitative method, which took a verbal, discuss form, there was no need for the use of statistical package in any form.

See the interview schedule, Appendix 2.

3.6 VALIDITY

The researcher ensured the validity of the research by employing the qualitative and quantitative research methods to collect the required data thus gaining valid information. In order to acquire the data presented in the study, the proposed and necessary target population, Black students aged 18-25 at the University of Natal, Pietermaritzburg were researched into. The respondents are from the same race, Black South African students at the same institution, they all get contraceptive services from the university clinic and are within the same age group. The questionnaire and the interview schedule was checked by the research supervisor. Three students completed the questionnaire as a pilot study to test if the information received was valid.

3.7 RELIABILITY

The researcher has made sure that the questions and issues raised are straightforward, and are not ambiguous, such that they can be easily interpreted. The interviews also affirm that the questions were understood and interpreted accurately and as intended.

Given the same research population, it may then safely be asserted that if the research were to be repeated the results derived will be consistent and the researcher will draw the same conclusions (Blaxter et. Al, 1996; Neuman, 1997). Information gained from the pilot test was all consistent and relevant.

Thus, the data collected and presented are reliable such that the research can safely be said to be credible and dependable.

3.8 ETHICAL ISSUES

Permission: before commencing the data collection process, the researcher sent out a letter written and signed by the director of Gender Studies programme, to seek permission to carry out research. This letter was sent to the University of Natal, Pietermaritzburg clinic administrator. Other permission- seeking letters were sent to the University of Natal, Durban ethics committee, and the faculty board of Human Sciences.

A letter was also written to each of the student participants in the research process, explaining what the research was about and asking to obtain their consent to be interviewed or to take part in the questionnaire- filling process.

See letters in appendix 3 and 4.

Volunteer participation: the letters written above also, ascertained that the criteria for participation was strictly voluntary, thus should the respondent feel uncomfortable, or be unwilling, he/she can refuse to participate in the research process.

Verbal consent was also gotten from each of the participants before giving out the questionnaire, and each of the interview respondents before commencing the interview. Permission was asked and consent also derived from each participant before tape-recording the interview.

Confidentiality and Anonymity: it was stated in the respective letters and on the questionnaire that the participants' confidentiality was guaranteed. Where the researcher saw the need, individual participants were reassured of their confidentiality and anonymity.

The anonymity of the participant was also assured by not requesting personal demographic information such as, name, date of birth, address, from participants during both the qualitative and quantitative data collection process.

3.9 DIFFICULTIES

The nature of the study as one that researches into individual contraceptive use among young adults places it in private space. This means that since the investigation requires participants to self-report on aspects of their sexual lives, the researcher has to conduct the study based on what she is told by participants, which may not be entirely true. Also, because of the sexual subject of the research, the researcher observed that participants were reluctant to divulge information about their sexual behaviour or to even admit that they had sexual lives.

Consequently, the researcher had to change the initial tactic of carrying out the survey before the interview to conducting the interviews first, and then following it up with individual questionnaires. This system was used because the researcher observed that a lot of the participants having marked 'no' to questions regarding sexual experience and contraceptive use go on to take the same stance in the course of the interview. This the researcher found to be regressive as the study aims to obtain information, and collect data on student young adults' experiences of contraceptive use from a gendered perspective. In addition, the researcher found there was a need to assure participants that their confidentiality was guaranteed. This was also done by not taking down individual details of participants such as their names, or student details.

The use of a tape recorder also resulted in some participants being uncomfortable so that there was a need for reassurance of privacy and that information given would be untraceable to them. Some participants were satisfied with this, while others refused to be part of the interview process. However, the latter population was minimal.

Also, the researcher had to make as much haste as possible despite the odds and setbacks, due to the fact that collection of data took place, a few weeks to the commencement of exams. Consequently, students had and were only willing to spare as little time as possible to participate in the data collection process.

Thus, the data collection process was slow, tedious and initially frustrating.

Another difficulty was based on the fact that students were sampled at the university clinic, which is a health seeking facility, which also dispenses contraception. This means that of all the student population that might have been using contraceptives, the researcher had to rely on only the few who visited the clinic during the duration of data collection. Thus limiting the researcher's accessibility to students.

CHAPTER FOUR

DATA ANALYSIS

4.1 QUANTITATIVE DATA ANALYSIS

4.1.2 INTRODUCTION

In this chapter, quantitative and qualitative data collected will be presented and analysed.

In analysing quantitative data collected, tables, charts, and graphical illustrations will be drawn to present statistics obtained. Then, an analysis of statistics obtained from each of the tables presented will then be carried out through discussions.

4.1.3 THE INSTRUMENT

Forty questionnaires were distributed to forty respondents. Each of this questionnaire consists of twenty-eight questions, twenty-six close-ended, and two open-ended questions. The latter two open-ended questions left room for respondents to expantiate, if found necessary. The first five questions are demographical in nature, they seek to gather personal and background information on respondents. The next questions, six to twelve ask on questions on contraceptive knowledge and opinions of respondents. Following are questions thirteen to twenty-one, which consists of questions on contraceptive use and attitudes towards contraception. The last seven questions, twenty-two to twenty-eight gather information of a miscellaneous nature on contraceptive decision-making, opinions on effect(s) on the individual (which might

affect choice-making), and who gets contraceptive benefits from respondents point of view.

4.1.4 PILOT STUDY

A pilot study was conducted to test the questionnaire before distribution. Three copies were printed out and three of them were given out to students to be filled. These three students consisted of the research population but were separate to the sample. The questionnaire was also sampled by the researcher's supervisor, a lecturer in the School of Nursing, and by authorities in the chosen field.

The purpose of this was to give the questionnaire and hence, the study validity, and to ensure that the questions are easily understandable and will generate the required answers.

The instrument for qualitative aspect of this research was also tested in this way.

4.1.5 RESULTS AND DISCUSSION OF QUANTITATIVE DATA

The questionnaire respondents consisted of male and female students, aged eighteen to twenty-five. These students were all single (never married), South African nationals currently studying for various undergraduate degrees at the University of Natal, Pietermaritzburg. The questionnaire response rate was 40/40 (hundred percent). This was due to the fact that the questionnaires were researcher administered, meaning

that, the researcher herself gave out each of the questionnaires, and waited till each one had been completely filled by respective respondents.

In carrying out the analysis and discussions therefore, total/overall number of respondents is equal to forty (n=40).

4.1.5.1 USE OF CONTRACEPTION AMONG RESPONDENTS

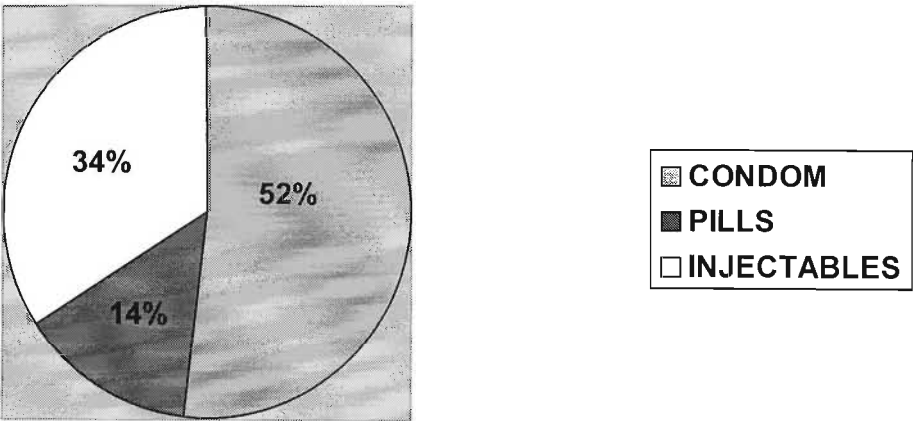


Figure 4.1 (n=20) Initial Contraceptive Use Amongst Female Students

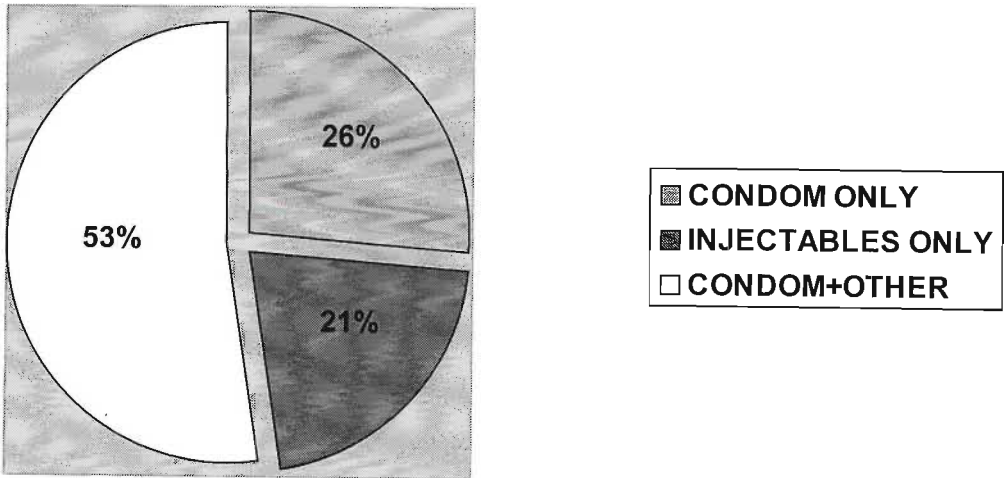


Figure 4.2 (n=20) Use/ Combinations Of Methods Amongst Female Students

Figure 4.1 represents female respondents' use of contraception. Ten respondents took part only in the quantitative data collection process that is the filling of questionnaires, while the remaining ten took part in the quantitative as well as the qualitative process, interviews.

From the figure, it can be observed that condom use has the highest percentage among female students at fifty-two percent ($n=15$), while the remaining two methods that are in use, inject-able methods and pills, have lower usage among these students at thirty-four ($n=10$) and fourteen ($n=4$) percent respectively. Together, pills and inject-able methods share a total of forty-eight percent among them, which is still lower than fifty-two percent singularly attributable to condom use.

It is interesting to observe that among female students, the condom, which is essentially a male device, has the highest population of female respondents who claim to use this method. This can be interpreted as an attempt by women to control and gain power over their sexual lives not just by use of the female-only methods, but by claiming a male method of contraception, which is as we see highly relied upon by both genders, for themselves. Meaning that they (women) are not waiting for men to take action, even though men are the users, women are taking matters into their own hands and are joining in the power-struggle for control/determination of condom use.

Figure 4.2 depicts the way in which students use contraception. We can see that fifty-three percent ($n=10$) of students combine respective contraceptive methods with the use of the condom. While a total of forty-seven percent of female students rely on the use of a singular method. So that, twenty-six percent ($n=5$) rely on condom use alone

while twenty-one percent (n=4) rely on an inject-able method for contraceptive protection. No students rely solely on the pill. The total number of students who rely on respective singular methods is lower than that of students who combine the use of more than one method. This is discovered (through the study) to be the trend among most female contraceptive users for reasons ranging from, belief in the inadequacy of protection given by other singular methods, to STI prevention.

As can be observed, three methods are commonly used among these respondents. These are, the condom, oral contraceptives (pills) and inject-able methods. It can also be observed among the above respondents that none of them have used natural methods, IUCD's implants and diaphragms. It may then be assumed, that the initial three methods are more accessible to respondents, perhaps easier to use, and probably, more convenient and suitable for their status as students. See figure 4.1.

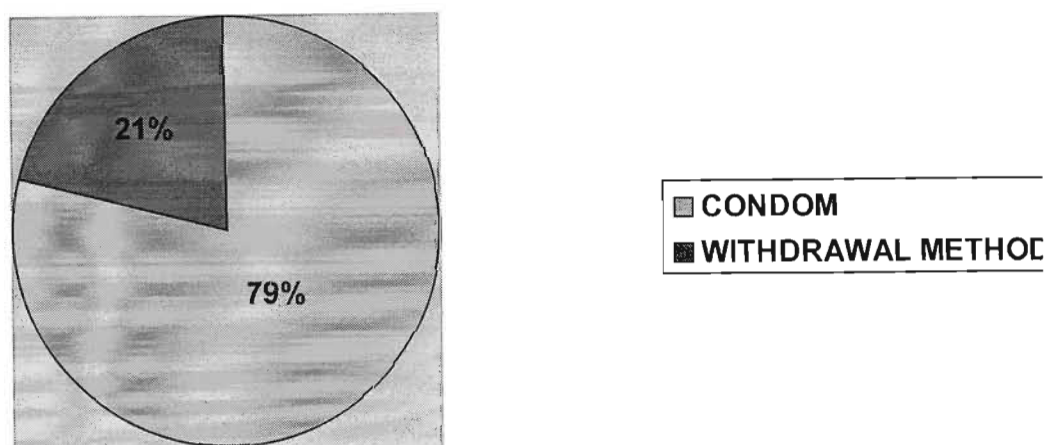
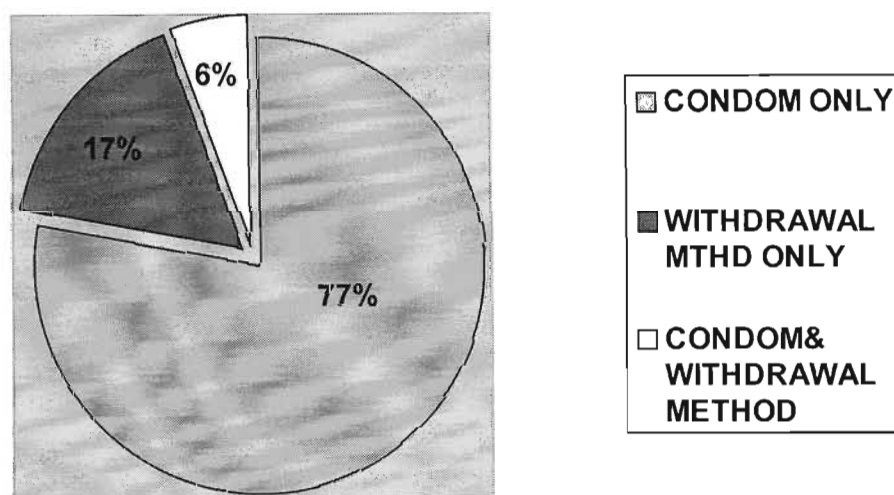


Figure 4.3 (n=20). Initial Contraceptive Use Amongst Male Students



Figures 4.4 (n=20). Use/Combination Of Methods Amongst Male Students

Figure 4.3 presents male respondents' use of contraception, ten of whom took part in the research process by filling out questionnaires while the other ten who also filled out the questionnaires were part of the interview process.

From the above, it is evident that condom use is highest among respondents at seventy-nine percent (n=15) while the use of the withdrawal method is at a low of twenty-one percent (n=4).

Figure 4.4 shows that seventy-seven percent (n=14) of the above male condom users rely solely on the condom, seventeen percent (n=3) rely singularly on the withdrawal method, while only six percent (n=1) combine the use of both methods. This results in a high of ninety-four percent among male respondents that use only one contraceptive method, and six percent that combine more than one, as opposed to the relatively high fifty-three percent of female students that combine respective contraceptive methods with the use of the condom, and a total of forty-seven percent that rely on the singular use of a method among female students. Thus, we can summarize that female respondents take more contraceptive precautions than male.

It can be observed from figure 4.3 that most of the male respondents claim to use the condom while; none of the above reports the use of irreversible form of contraception (sterilization). The reason for this is assumed to be clear, as the above respondents comprise of young adult students at the University of Natal, Pietermaritzburg, between the ages of 18 and 25. Which makes it easy for us to conclude that these respondents are just reaching their reproductive years and as a result of this, will most probably not be interested in taking permanent contraceptive measures yet.

The actual use of contraception among the respondents who claim to use the withdrawal method can be questioned, as this method is usually not referred to as a method of contraception available to the members of the male gender. (Guillebaud, 1985; Szarewski et. al, 1994; Roux, 1995).

Therefore, if the withdrawal method cannot be considered to be a contraceptive method, the seventeen percent of male respondents who relied solely on this method for contraceptive purposes will then have to be classed as non- users of contraception

at initial sexual experience. This will consequently bring down the total number of male contraceptive users to seventy-nine percent from a hundred percent.

However, the method is usually described as a natural method of contraception alongside other natural methods in books, journals, and leaflets on contraception. This therefore made it mandatory for the researcher to include this method in the list of contraceptive methods available for members of both the male and female genders respectively.

Collectively, from figures 4.1 and 4.3, we observe that initial contraceptive use among these set of respondents is quite high.

The common trend of contraceptive use among the respondents is the combination of the condom with other methods of contraception. Consequently, the condom was the most commonly used method at initial sexual experience.

The interview respondents were asked if they had ever used the female condom, to which all ten female respondents answered 'no', stating they were not available. While two of the ten responded that they would be willing to try using them if only they were available to them, for this reason, the researcher has reason to believe that condom use among all twenty female respondents refers to the male condom. This further emphasizes and confirms the issue that was afore raised, that members of the female gender are taking an active part in male-female power struggles for control of contraceptive use, and hence, their sexuality and reproductive lives. This, consequently raises the question can the use of the (male) condom be accounted for as the female respondents taking responsibility for contraceptive use, as they do not as individuals take responsibility for wearing the condom? The level of contraceptive

use among the female respondents can thus be questioned. Since twenty-six percent of female respondents report the singular use of the (male) condom at initial sexual experience, it can be assumed then that this twenty-six percent respondents did not as individuals, personally use contraception at initial sexual experience, but relied on their partner's use of the condom.

However, whether this is taken into consideration or not, the level of contraceptive use remains high among both male and female respondents.

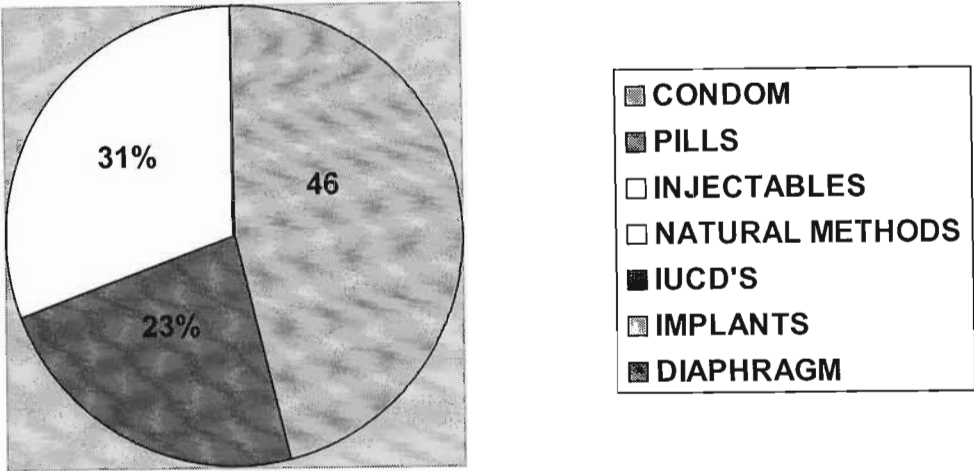


Figure 4.5 (n=20). Subsequent Contraceptive Use Amongst Female Students

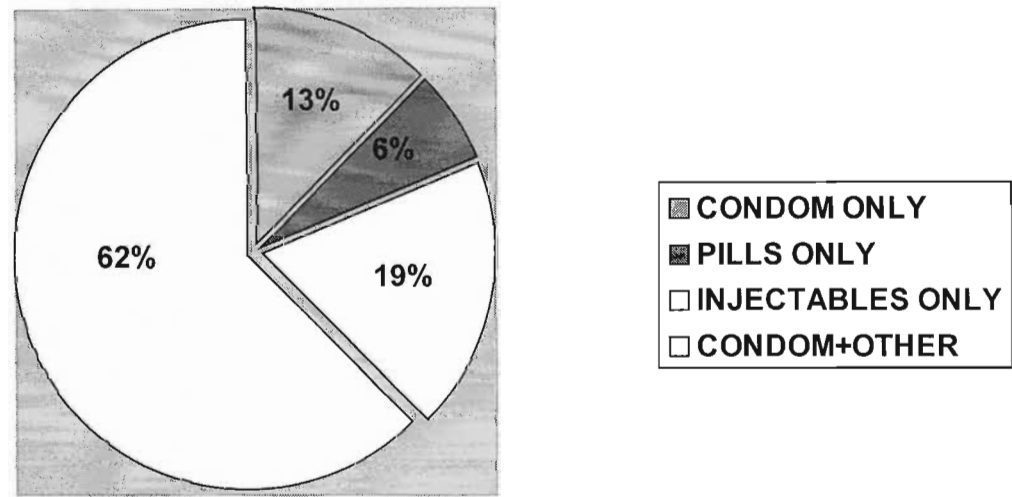


Figure 4.6 (n=20). Use/ Combinations Of Methods Amongst Female Students

Figure 4.5 presents subsequent contraceptive use among individual female students at the University of Natal, Pietermaritzburg. What is presented in this figure can be

taken as a representation of the present use of contraception among the above respondents.

It can be observed that there are slight changes in contraceptive use among the respondents. The use of condom has gone down from an initial use of fifty-two percent (n=15) to forty-six percent (n=12) subsequently, and the use of inject-able methods has also gone down from thirty-four percent (n=10) to thirty-one percent (n=8), while the use of the pill has gone up from fourteen percent (n=4) to twenty-three percent (n=6) respondents. Slight differences that led to the changes in the use of certain methods in the figures were observed while studying the questionnaires. A questionnaire respondent, who had initially used an inject-able method, subsequently stopped the use of contraceptives altogether. Another respondent, who had also used an inject-able method of contraception initially, subsequently changed from the use of this method to the use of the pill, hence the drop in the use of inject-able contraceptives, and the rise in the usage of oral contraceptives.

The above account for the rise noticed in the use of pills is further accounted for by the questionnaire & interview respondent, who initially used only the condom but subsequently made use of the pill.

As in figure 4.1, it can be observed that respondents made use of either the inject-able method or the pill. However, most respondents combine the use of the condom with either of the afore-mentioned contraceptive methods, while some only use the condom. Sixty-two percent (n=10) of female respondents, who claim to use condoms, used them alongside either the pill or an inject-able method, while thirteen percent (n=2), used the condom alone. The remaining six (n=1) and nineteen (n=3) percent used the pills and inject-able methods alone respectively.

Thus, there is a higher percentage of female students at sixty-two percent, who use more than contraceptive method, than the percentage of female respondents at thirty-eight percent, who use only one method.

The subsequent contraceptive use pattern among male respondents will be presented for examination through the following figures, figures 4.7 and 4.8. Comparison of results, of male initial and subsequent contraceptive use patterns, and male and female respondents' subsequent use of contraception will be carried out.

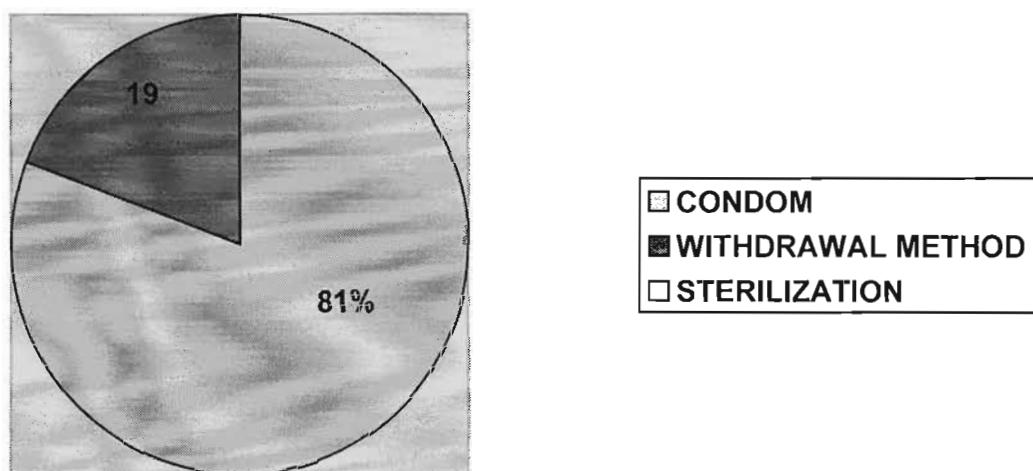


Figure 4.7 (n=20). Subsequent Contraceptive Use Amongst Male Students

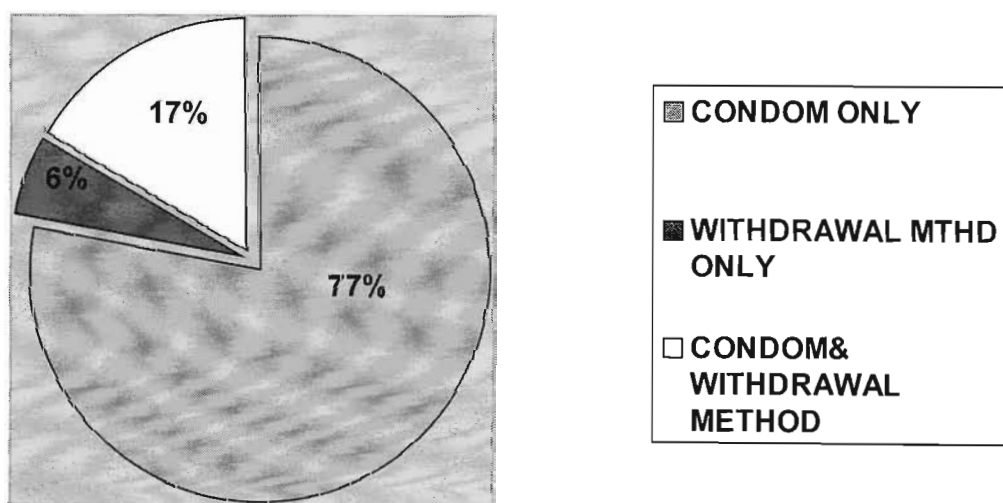


Figure 4.8 (n=20). Use/ Combinations Of Methods Amongst Male Students

It can be observed from figure 4.7, that eighty-one percent ($n=17$) of male respondents at subsequent contraceptive use made use of the condom. Nineteen percent ($n=4$) made use of the withdrawal method.

In figure 4.8, we observe that, seventeen percent ($n=3$) of male respondents who use the withdrawal method, combined the use of this method with condom use. While a very low six percent ($n=1$) of the above, used just the withdrawal method subsequently. This is a remarkable turn of events from the initial six percent ($n=1$) who used only latter method initially. However, it is noticeable that, the percentages of respondents who use the withdrawal method have decreased from twenty-one percent ($n=4$) to nineteen percent. It is observed from the questionnaires that the respondents who initially used the withdrawal method, and those who subsequently used this method are basically the same respondents.

A change can be noticed in condom use among respondents, initially seventy-nine percent ($n=15$) of male respondents used the condom; it has subsequently increased to eighty-one percent ($n=17$). Use among female respondents on the other hand, has reduced from an initial use of fifty-two percent ($n=15$) to a subsequent use of forty-six percent ($n=12$). Two male respondents do not use any method of contraception, thereby making the overall number of male respondents who use contraceptives sum up to a high eighteen, which is ninety percent of the male population. While the number of female respondents who do not use any form of contraception is higher by two, resulting in four female respondents, which makes a total of sixteen out of twenty female respondents who use contraception. This makes the number of

respondents who claim the use of contraception lower among female students at eighty percent, which however remains high.

However, this does not necessarily make actual contraceptive use among female respondents lower, as could be seen from the figures, more female respondents (than male), combined the use of more than more contraceptive method which means they took more contraceptive precaution than the male respondents. Below is a figure showing the comparative levels of initial contraceptive use among both male and female respondents.

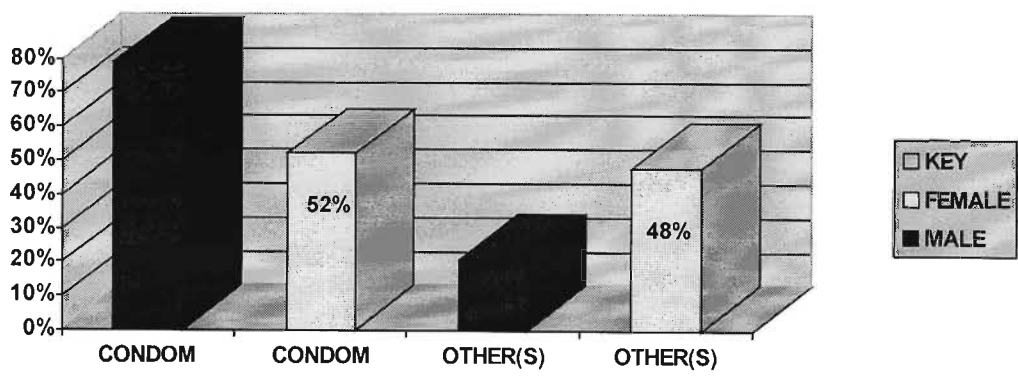


Figure 4.9 (n=40). A Synopsis Of Initial Contraceptive Use Amongst Male And Female Students

Figure 4.9 shows that initial use of the condom was higher among male students, while the use of other forms of contraception, was higher among female students. The total number of use of other methods mainly, the pill and inject-able methods, among female respondents is at fourteen (n=4), and thirty-four (n=10) percent

respectively, making a total of forty-eight percent, while the use of the withdrawal method among male respondents is at twenty-one percent (n=4).

The subsequent use shall also be presented comparatively in the next figure.

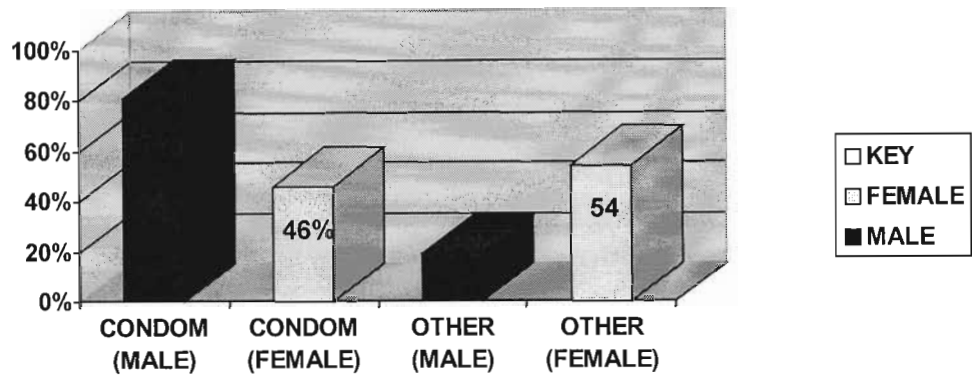


Figure 4.10 (n=40). A Synopsis Of Subsequent Contraceptive Use Amongst Male And Female Students

NOTE

- ❖ Female use of the (male) condom as a form of contraceptive is questionable in terms of individual contraceptive responsibility taking as the male and not the female wears it.
- ❖ Male use of the withdrawal method as a form of contraceptive has also been questioned.
- ❖ This note also applies to figure 4.9.

It is observable that condom use among male students has increased from a high of seventy-nine percent (n=15) to eighty-one percent (n=17), while among female students it has decreased from a high of fifty-two percent (n=15) to a low forty-six

percent (n=12). Among male students, the use of other methods (withdrawal) has also decreased from a low twenty-one percent (n=4) to a lower still nineteen percent (n=4). While female students use of other methods (pill and inject-ables), has increased from an initial low use of forty-eight percent (at fourteen (n=4)& thirty-four percent (n=10) respectively), to a subsequent high of fifty-four percent (at twenty-three (n=6)& thirty-one percent (n=8) respectively).

This result will be taken to be respondent's current use of contraception as it depicts their subsequent use, since initial use in figure 4.9.

However, the drop in condom use among female respondents does not necessarily affect female contraceptive use, as female claim to the use of the male condom was earlier questioned. Meaning that since the male and not the female gender personally takes responsibility for the use of the (male) condom, the rise or fall in female condom use will then be inconsequential. Hence, it is observed that initial and subsequent contraceptive use among both male and female respondents do not go through drastic changes, but remain quite constant with mild fluctuations, but within the same frames or boundaries.

Summarily, it can be concluded, taking the 'notes' under figure 4.10 into consideration that, contraceptive use and responsibility taking among both male and female respondents has subsequently increased. This is due to the fact that the use of the methods that have increased are those which are exclusive to each of the genders and cannot be contested in terms of personal/ individual contraceptive responsibility taking.

4.1.5.2 RESPONDENTS SATISFACTION WITH CONTRACEPTIVE CHOICE

Table 4A (n=20). Male Satisfaction With Choice

| Method | Number of Respondents | Yes | No |
|-------------------|-----------------------|-----------|----------|
| (Male) Condom | 17 | 13 | 4 |
| Withdrawal method | 4 | 3 | 1 |
| Sterilization | 0 | 0 | 0 |
| TOTAL | N/a | 16 | 5 |

NOTE

- ❖ The results represented for the overall use is taken from the subsequent use of contraceptives table for both male and female respondents respectively as that is used to represent their present use of contraception respectively.
- ❖ The first column titled 'number of respondents' shows the number of individuals that had the choice of that particular contraceptive method that the number comes after. This is due to the fact that in the questionnaires, the respondents were allowed to choose as many contraceptive options as were pertinent to them.

Meaning that each contraceptive method has an overall number of 20 respondents that could have marked it as their method of choice.

Table 4A presents the choice of all the male respondents in a condensed form and it shows how the clients feel about their chosen contraceptive method.

Out of the seventeen male (eighty-one percent) respondents that use the condom as their choice of contraception, thirteen (seventy-six percent) asserted that they were satisfied with the choice and the results while four (twenty-four percent) registered their dissatisfaction. The number of respondents that claimed to be satisfied with their choice of and the use of the condom is quite high compared with the number that claimed dissatisfaction. The reasons for their dissatisfaction varies but has to do mostly with the way by which this method is used, most of the respondents were happy with the actual working or functioning of the method. However, this will further be discoursed when the qualitative data is analysed.

Four respondents (nineteen percent) opted for the use of withdrawal method as their method for contraceptive measures. Three (seventy-five percent) out of these four respondents filled that they were satisfied with the method and results while one respondent (twenty-five percent) filled in his dissatisfaction on the questionnaire. The respondent that was not satisfied with the method and consequently the results is totally reliant on the withdrawal method as his solitary method of contraception. The other three users (seventy-five percent) of the same method on the other hand showed in the questionnaires that they do combine the use of the withdrawal method with the use of the condom. This observation therefore questions the use of or reliance on the withdrawal method as a form of contraceptive measure.

Table 4B (n=20). Female Satisfaction With Choice

| Method | Number of Respondents | Yes | No |
|-----------------|-----------------------|-----------|----------|
| (Male) condom | 12 | 10 | 2 |
| Pills | 6 | 6 | 0 |
| Inject-ables | 8 | 6 | 2 |
| Implants | 0 | 0 | 0 |
| IUCD's | 0 | 0 | 0 |
| Natural methods | 0 | 0 | 0 |
| Diaphragm | 0 | 0 | 0 |
| TOTAL | N/a | 22 | 4 |

NOTE

❖ The same rules and explanation as applies in Table 4A applies in Table 4B.

In table 4B, twelve female respondents (sixty percent) out of twenty claims the use of the male condom, which means that these sixty percent (n=12) of female respondents do not take individual or personal responsibility for contraceptive use. Out of these twelve respondents (sixty percent), ten (eighty-three) are satisfied with the results they get from condom use while the remaining two (seventeen percent) dissatisfied with

the results or use of this method. The reasons these female respondents give for their dissatisfaction with the method however differs from the reasons the male respondents give. Their (the female respondents) reasons have to do with the method of use as well as the results. This will however be discussed at length during the process of the qualitative analysis.

Six female respondents (thirty percent) use the pill out of a possible twenty that could opt for this method, and all six (thirty percent) of them showed in the tables that they were satisfied with the use of this method as a contraceptive measure. For the injectable method of contraception, eight (forty percent) out of twenty respondents filled in that they use this method of contraception. Six (seventy-five percent) out of these eight are satisfied with the use and results of this method while the remaining two (twenty-five percent) are not satisfied. The reasons given for their dissatisfaction has to do mainly with the physical and possible health effects of the method. Meaning that, respondents were concerned that particular methods made them gain weight, they were also concerned that some methods meddled with their hormones (though none of the respondents had a clear idea of how), and particularly their menstrual cycles, which were consequently taking on some of the following characteristics; becoming heavier, longer, irregular or unusually light.

The reliability and potency of the method is however not faulted or questioned.

4.1.5.3 KNOWLEDGE AND ATTITUDES TOWARDS CONTRACEPTION

Table 4C (n=20). Male Knowledge Of Contraceptive Methods For Men

| Number of methods known | Questionnaire respondents | Q& Interview respondents | Total | Percentages |
|-------------------------|---------------------------|--------------------------|-------|-------------|
| One method | 3 | 6 | 9 | 45% |
| Two methods | 4 | 3 | 7 | 35% |
| None | 3 | 1 | 4 | 20% |

From table 4C it can be observed that out of a total of twenty male respondents, nine respondents at forty- five percent know of one method of contraception that is available to men. Seven respondents at thirty – five percent know of two methods that are available, while four respondents at twenty percent are not aware of there being contraceptive options or choices for members of the male gender.

However, among those who have stated that they know no method of contraception available for men, it can be assumed that most, if not all of them simply do not view the (male) condom as or know it to be a contraceptive method. This was most obvious in the qualitative data collection process and will be fully discussed during the course of the qualitative data analysis.

Table 4D (n=20)

Female Knowledge Of Contraceptive Methods For Men.

| Number of methods known | Questionnaire respondents | Q& Interview respondents | Total | Percentages |
|-------------------------|---------------------------|--------------------------|-------|-------------|
| One method | 3 | 3 | 6 | 30% |
| Two methods | 1 | 2 | 3 | 15% |
| None | 6 | 5 | 11 | 55% |

Table 4D presents the level of knowledge of contraceptive methods for males among females.

A total of six female respondents at thirty percent know of one method of contraception available for men. Only three respondents at fifteen percent are aware of there being more than one contraceptive option available to the male gender. While eleven female respondents at fifty-five percent out of a total of twenty are not aware of the existence of any form of contraceptive method for members of the male gender. However, the same explanation that applies to the male respondents also applies here, we can safely assume that these female respondents do not view the (male) condom as a form of contraceptive measure that is available to men, as a high percentage claim the use of the condom. This implies that there are unsaid perceptions about contraception, and that the (male) condom probably has some other use for which these students allocate it (for instance, as a protective measure against sexually

transmitted infections and diseases), in the light of which a lot of them see it rather than as a contraceptive measure. Among male and female respondents, all twenty respondents respectively, indicated that they are aware of the existence of contraceptives.

The results of tables 4C and 4D show that twenty percent (n=4) male and fifty-five percent (n=11) female respondents respectively are unaware of contraceptive methods for men. However, it is clear that ignorance about contraception for men is higher among the female respondents than among the male respondents. This arouses a question in one's mind about perceptions on contraception and its use among members of both genders.

Tables 4E and 4F presents a synopsis of both male and female perceptions on contraceptive use by men and women respectively.

Table 4E (n=40)

A Synopsis Of Male And Female Perceptions On Contraceptive Use By Men.

| Perceptions | Male | Male Percentages | Female | Female Percentages |
|-----------------------------------|------|-------------------------|--------|---------------------------|
| Men should use contraceptives | 20 | 100% | 18 | 90% |
| Men should not use contraceptives | 0 | NIL | 1 | 5% |
| No comment | 0 | NIL | 1 | 5% |

Table 4F (n=40)

A Synopsis Of Male And Female Perceptions On Contraceptive Use By Women

| Perceptions | Male | Male Percentages | Female | Female Percentages |
|-------------------------------------|------|-------------------------|--------|---------------------------|
| Women should use contraceptives | 19 | 95% | 19 | 95% |
| Women should not use contraceptives | 1 | 5% | 0 | NIL |
| No comment | 0 | NIL | 1 | 5% |

Tables, 4E and 4F each present male and female thoughts on contraceptive use by men and women respectively.

The results of the tables is quite interesting though, in table 4E, all twenty male respondents (a hundred percent) were of the opinion that men should use contraceptives while eighteen female respondents (ninety percent) were of the same opinion. However, one female respondent (five percent) was of the opinion that men should not use contraceptives. While another female respondent (five percent) refused to answer the question and filled 'no comment' in instead.

In table 4F, the results are only slightly different from table 4E. Nineteen male respondents (ninety-five percent) were of the opinion that it is alright for women to use contraceptives and nineteen, an equal number of female respondents (ninety-five percent) also thought it is right for women to use contraceptives. The same female respondent who answered 'no comment' in table 4E repeated the same answer in table 4F. However, one male respondent (five percent) thought that women should not use contraceptives. The reason he gave for this was that he had heard that it affects women in some way he was not sure of, but generally thought 'it gives problems and women should not do it'. The female respondent who earlier thought that men should not use contraceptives simply thought that 'it isn't masculine, it's a woman's thing'. Here we hear undertones of specific gender roles of masculinity and femininity, and stereotypes constructed around these roles such as the role of reproduction for the female gender, and production for the male gender (Engels, F. 1985).

What is clear from the above is that a high percentage of males and females alike view contraception as something that should be used by both genders.

The following tables will be examining contraceptive decision- making. In a sexual relationship where one or both partners believe in the good of contraception and its use, how do they decide what to use or when to use it, whose decision is it?

A lot of factors affect contraceptive decision- making, some of these factors are, supportive policies, information, access, and other factors (Population Reports, 2001). However, people who represent an immediate form of authority in an individual's life such as, family members, health personnel, a partner, etc can also affect their decision- making abilities.

Tables 4G and 4H will be evaluating individual male and female contraceptive decisions- making abilities, who makes that decision for them as individuals.

4.1.5.4 CONTRACEPTIVE DECISION -MAKING

Table 4G (n=40)

A Synopsis Of Male And Female Contraceptive Decision-Making Abilities

| Variables | Male | Male Percentages | Female | Female Percentages |
|------------------|------|------------------|--------|--------------------|
| Self | 5 | 25% | 6 | 30% |
| Partner | 1 | 5% | 0 | NIL |
| Both | 14 | 70% | 14 | 70% |
| Family member | 0 | NIL | 3 | 15% |
| Health personnel | 0 | NIL | 0 | NIL |

NOTE

- ❖ Respondents were allowed to fill in multiple answers. Meaning that they were given the above variables and they could choose as many options as they thought were relevant to them. Thus resulting in the female percentile exceeding a hundred.
- ❖ Each of the variables was given a hundred percentile.

Table 4G presents a synopsis of both male and female respondents and who makes their contraceptive decisions.

As is seen in table 4G, respondents were given five variables from which they were to say who actually makes their contraceptive decisions. That is as individuals, who decides whether or not they use contraception or what method they use.

The majority, which interestingly happened to be equal numbers of both male and female respondents (seventy percent of each; n=14) claimed that both they and their partners make the decision. Twenty-five percent male (n=5) and thirty percent (n=6) female respondents claimed to make the decision by themselves respectively. One male respondent (five percent) claimed that his partner made the decision while fifteen percent (n=3) of female respondents claimed that family members made the decision for them. Health personnel or their contraceptive service givers make none of the respondent's contraceptive decisions for them.

Of the fifteen percent (n=3) who claimed that their family members make contraceptive decisions for them one of such respondents had used the inject-able method of contraception initially. In a series of questions asked the respondents, the above respondents' answers suggests that her choice of contraception was affected by the party that has the power to make contraceptive choices for her, this represented by her family members. This choice or decision obviously makes the respondent unhappy. The other respondent who claims that family members makes contraceptive decisions for them claims to have used the condom initially, to question 18 she answers 'no' and to the question *'are you happy with this choice'* she answers 'no'. The third respondent refuses to answer the question on initial contraceptive use, answers 'no' to question 16 however to question 19 *'Since you started using contraceptives has there been an increase in the number of times you have sexual intercourse?'* which implies that the respondent is or has been on contraception, the

respondent answers 'yes'. The inconsistency in the answers raises questions as to the state of mind of the respondent on her inability to make her contraceptive choices.

The respondents' refusal to answer some of the questions points to one of the issues that were raised in the limitations that is, the private nature of the research made respondents feel self-conscious about answering some of the questions.

From the above it can be assumed that a person's actual contraceptive decision-making ability and what the person would have it be may not be the same, as a result of this, the next table, table 4H will present male and female opinions on who has the right to decide what contraceptive choices to make and when to make it.

Table 4H (n=40).

A Synopsis Of Male And Female Perceptions On Who Has The Right To Make An Individual's Decisions For Contraceptive Use.

| Variables | Male | Male Percentages | Female | Female Percentages |
|------------------|------|------------------|--------|--------------------|
| Self | 4 | 20% | 6 | 30% |
| Partner | 0 | NIL | 0 | NIL |
| Both | 16 | 80% | 15 | 75% |
| Family member | 0 | NIL | 0 | NIL |
| Health personnel | 0 | NIL | 0 | NIL |

NOTE

- ❖ Respondents were allowed to fill in multiple answers. Meaning that they were given the above variables and they could choose as many options as they thought were relevant to them.
- ❖ Each variable was given an overall percentage of hundred.

Table 4H presents respondents opinion on who has the right to make an individual's contraceptive choice.

Twenty percent (n=4) male respondents were of the opinion that the decision ought to be made by the individual, while thirty percent (n=6), a greater number of female respondents were also of the opinion that the individual should make the decision for

him/herself. However, the percentages among both male and female respondents remain low. Fifty percent (half) of the above thirty percent female respondents were respondents who claimed in table 6a that their contraceptive decisions were made by their family members.

In table 4H however, each of them was of the opinion that an individual had the right to make their own contraceptive decisions. Which confirms the stipulation that a person's actual contraceptive decision- making ability and what the person would have it be may not be the same as happens to be the case for these respondents.

Eighty percent (n=16) of male respondents in table 6b were of thought that decision for contraceptive use ought to be made by both partners involved in the sexual relationship. The percentage of female respondents who were of the same opinion is seventy-five percent (n=15), which is slightly less than the male respondents. However, no respondents felt their partner, family member, or health personnel ought to make this decision for them as individuals.

When asked why they feel that the individual has the right to decide one female respondent's answer was; *"because everything will be happening in my body, not anyone's"* and a male respondent replied; *"if I'm the one deciding I won't feel like I'm pressured"*.

Although these are two (twenty percent) responses out of a total of ten but most of the female respondents' answer was of that nature. Their thinking they had the right to decide was based on the line of thought that their bodies was in question and they assumed with the phrase 'contraceptive choice' that they were and would be at the

receiving end. So that their arguments was that since they were taking the contraceptives, it was their right to decide.

The trend of response gotten from male respondents however had to do with their decision making abilities and rights as individuals and consequently as individual male beings.

Among the seventy-five percent (n=15) female and eighty percent (n=16) male respondents who were of the opinion that both partners involved in the sexual relationship had the right to make contraceptive decisions, the researcher has tried to get out two reasons for choice that represents the common trend of reasons given among each of the genders respectively. The following are the responses of two female respondents. First respondent, *“because it needs to be a mutual decision based on trust”*; second respondent, *“ we are both responsible for our happiness”*.

The above responses from the female respondents are the trends that can be noticed among the reasons given by the seventy-five percent female respondents who are of this opinion. The responses suggest the individual has a sense of belonging with the partner and we (the recipient) might that the respondent has a sort of relationship of commitment with the partner that is in question. So that it can be assumed that the female respondents think of contraceptive choice making as a function of both partners in a relationship.

Following are the responses from the male respondents. First respondent, *“because we will both get sick”*; second respondent 2, *“so that you both can enjoy sex”*.

The first response is the most recurrent. Most of the male respondents think of contraceptive use and decision –making in terms of contractible diseases. As opposed to responses derived from female respondents, male respondent's responses are quite peripheral it lacks emotion or feelings of commitment. It can be gathered from female responses that their answers are based on feelings of togetherness with their partners; their responses suggest that the relationship is not merely sexual for them but there is emotional attachment. However, male responses address the issues that arise from the questions from a simply sexual point of view and it suggests that there might just be a sexual relationship and no emotional ties between them and their respective partners. The opposite of this, is the case for female respondents as can be deduced from their responses.

4.2 QUALITATIVE DATA ANALYSIS

4.2.1 INTRODUCTION

In the following pages, an attempt will be made to present the qualitative data collected.

This will be done by taking each of the interview questions and discussing the response obtained on each from both male, and female respondents respectively.

However, as the interview respondents consist of ten male students and ten female students, the researcher will not discuss each of the interviews separately, as this substantial number has been used for the express purpose of sampling the thoughts and opinions of more respondents thoroughly.

Therefore, the researcher will collate data gotten, grouping responses and discussions into sets of similar responses among the male and female respondents respectively.

The researcher will then take representative interview schedules, typical of a set or group of responses and will commence the analysis using the chosen schedule(s) as a referral and drawing on specific instances, dialogues and responses, the researcher will carry out the data presentation and analysis.

4.2.2 THE INSTRUMENT

In the qualitative data collection process, an interview schedule was developed and, three major questions were asked.

The first question had two sub-questions then, followed two main questions. A fourth question, which was not pre-planned, was added for the male respondents. This fourth addition was made after the interviews had commenced and first male had already been interviewed, so that the researcher was not opportune to ask the first male respondent the added question. The researcher saw the need to add this question in order to get the view of male respondents concerning contraceptive (outside of the condom) use among women.

The first question that was asked is: (1). From your view, who takes responsibility for contraceptive use? The two sub-questions that were under this first one are: (1a). Are you happy with the contraceptive method you are using? And (1b). Do you think you get the service that the use of contraception should offer you?

The first question and the two sub-sections seeks to answer the second research question; who takes responsibility for contraceptive use among young adults; is it the men or the women? Do contraceptive users consider their needs as being met, and their interests adequately protected?

The second question: (2). In what way do you find the use of contraceptives liberating to you? Is directed at answering the first research question, how do men, and women view contraceptive use? As a form of reproductive technology, do they find it liberating?

Attempts however have been made at answering the first part of the above research question in the first interview question and during the course of carrying out the quantitative research.

The third question is: (3). Who keeps the condoms?

This question was asked because quite a lot of the female respondents claimed to use the (male) condom, which a lot of them referred to as '*the normal one*' when asked which one or type they used. As the condom happens to be the only type of contraceptives the male respondents use apart from the withdrawal method, and female respondents also claim to use it either in conjunction with another method or as their major form of contraceptive the researcher thought it would be helpful to examine which party takes responsibility for the keeping and provision of the condoms among these respondents.

The fourth question that was added was directed at the male respondents: (4). What would be your opinion to the use of other contraceptive methods apart from the condom by your girlfriend? This question applied only to male respondents in specific situations. The respondents that were asked this question were those who claimed that their girlfriends did not use any other method of contraception apart from the condom. The third question partly answers the second research question which has already been stated above and alongside the fourth question, it answers the fourth which is the last research question: Who in the long run benefits from contraception as a reproductive technology; who has control of the female body?

How these interview questions are answered, and how the interview questions in turn answer the research questions will be unfolded in the rest of this chapter and in the next chapter respectively.

In conclusion, the above questions were generated and have been structured by the researcher to examine and to acquire information on the above questions, which forms the basis for this research paper.

4.2.3 RESULTS AND DISSCUSSION OF QUALITATIVE DATA

In order to discuss results derived from the qualitative data, data collected were grouped into categories, and prominent/recurrent themes were found. These include:

1. Responsibility for contraceptive use
2. Issues of gender power relations
3. Relating condom with STI, HIV/AIDS prevention
4. Satisfaction with contraceptive service, under this we have:
 - a. Health effects of contraception on the individual
 - b. Societal and cultural attitudes towards contraception
5. Contraception is liberating
 - a. Pregnancy prevention
 - b. Un-liberating contraceptive effects
6. Blame shifting
7. Responsibility for condom housing (Who keeps the condoms)?
 - a. The condom, a male domain?
8. Male opinion on contraceptive use among women
9. Misconceptions about condom use

Hence, discussing data results under the above titles and sub-titles the researcher will carry out the analysis.

4.2.3.1 Responsibility for contraceptive use

The first issue addressed in each of the interviews was responsibility for contraceptive use. This question was quite straightforward and required little explanations. Each of the respondents was asked who in their opinion, took the responsibility for using contraception in a relationship scenario. The responses derived from this question were in two directions among female respondents. (Respondents will be referred to using numbers). When asked the question *'from your view, who takes responsibility for contraceptive use?'* A respondent answered, *'the girl always does'*. This was a generalization that was repeated in several ways by seven out of the eight female respondents who were of the opinion that the female gender most often does.

Another respondent answers by saying,

'The woman usually is the one to use the pills 'cause problems like pregnancy affect the woman more than the man and in a relationship the woman just has to protect herself'.

This answer was repeated by most of the other female respondents.

However, two respondents were of the opinion that both partners take the responsibility, respondent:

'You know before when we started going out, I wasn't using anything, so he had to wear condoms but now, I take contraceptive pills so you know, maybe sometimes it might happen that we don't have condoms, at least I am sure I am okay because now, I'm using the pills (laughs), accidents can happen now.'

From the above, we gather that the pill acts as a safeguard for respondent and partner against pregnancy thus, it can be inferred from her response that due to her present use of the pill, the condom is no longer relied on as their contraceptive choice, and the use of the condom (by the boyfriend) is no longer a priority. Which questions her

assertion that her boyfriend, as well as herself take responsibility for contraceptive use.

When male respondents are asked the same question, the responses gotten are quite different from those gotten from female respondents. Three male respondents are of the opinion that members of the female gender take the responsibility for contraceptive use.

According to a respondent,

'A lot of the times, like maybe most of the time, it is the woman, but some men also do, I do 'cause I have to be responsible for myself.'

Five respondents are of the opinion that the man does take the responsibility, while two respondents say that members of both genders take equal responsibility for the use of contraception. The two respondents whose response was that both men and women take responsibility were of the opinion that men and women respectively have different methods of contraceptives they can use and each makes use of the method, which is pertinent to them.

Summarily, from the female respondents perspective, the members of the female gender take this responsibility. The majority of male respondents however believe that they take the responsibility for contraceptive use.

4.2.3.2. Issues of gender power relations

One of the five respondents who were of the opinion that the man takes responsibility for contraceptive use raised the issue of power struggles between the male and the female gender.

Following is respondents' reply to the question, *from your view, who takes responsibility for contraceptive use?* Respondent:

'Me! It depends on who is more powerful because sometimes, (pauses; smiling) maybe you can persuade the lady not to want to insist on you using condoms'.

This respondent views contraception from quite a different angle, which introduces the theme of male domination. According to Rowland (1985), the demand of women for choice and freedom in reproductive and sexual matters may eventually limit their choice to male domination (Rowland, 1985). From the respondents' answer, we infer that women sometimes insist on male use of the condom, before sexual intercourse, this an attempt by the woman to control the sexual process, thus achieving sexual freedom. However, this respondent in-turn takes the gesture as a challenge of male domination/power, and thus results in his viewing the situation as an instance of power struggle, the respondent says *'...it depends on who is more powerful....'* and then goes on to say *'...you can persuade the woman....'*

When the above respondent talks about it depending on who is more powerful and then goes on to talk about persuasion, one might wonder if the respondent is not thinking in terms of coercion. Contraceptive use, especially the condom (a method which both genders lay claim to), engendering power struggles is recurrent as the study progressed.

When asked, “*who keeps the condoms?*” A female respondent replies:

‘We both do. But sometimes when I have them or suggest using them, he gets funny ideas that I am seeing someone ‘cause I’ve got condoms on me, that’s why I’m happy to take the injection ‘cause I cant be sure he’ll want to use the condom all the time’.

This reply suggests that there is a power struggle going on between the respondent and partner. The pattern we see here is one of male dominance and female subjugation. We gather from the response that the respondent is incapable of dictating her terms for sexual participation or protection. Women and girls often fail to negotiate safer sex or condom use because of a number of factors that reinforces the subordination and or subjugation of women. Given the absence of a method she can use exclusive of her partner, respondent is subject to unprotected intercourse irrespective of her personal opinion.

4.2.3.3. Relating condom with STI, HIV/AIDS prevention

During the course of giving out questionnaires to respondents, two male respondents individually asked the researcher what the word ‘contraception’ meant, and once each of these respondents were given an explanation, they seemed to understand, or realized what was being talked about. The observation was also made that not only did none of the female students need an explanation as to what the word meant all of them seemed to know what was being referred to.

As the interviews progressed, it became apparent by the time interviews with three male respondents and two female ones had been carried out that male and female

respondent's ideas of contraceptive functions were quite different. It became especially obvious as the second question was asked that most male respondents associated contraceptive use with the prevention of STD's and HIV/AIDS. Paralleling of contraception with safe sex practices was quite rampant in the male respondents interviews. All ten male respondents alike indicated that they considered themselves as receiving the service a contraceptive should offer them from the condom, since it is the method they all use. However, all the male respondents could not separate the function of the condom as a method safe sex practice apart from its function as contraception. This was very pronounced in all the interviews hence one of responses from the male respondents will be sampled.

Researcher: *do you think you get the service that the use of contraceptive should offer you?*

Respondent: *'yes, because then we (respondent and partner) are able to have safe sex'.*

Researcher: *'could you explain?'*

Respondent, *'okay...when I use condoms, then me and my girlfriend are protected from HIV and all other diseases because it's up to us to have safe sex'.*

This response is typical of most male respondents, which shows a mindset among this group. Their perspective of the question is mainly one of safe sex practice, even though the term 'contraceptive' was used, the respondent does not relate it to pregnancy or its prevention. This raises a question about male understanding of the term 'contraception' in relation to them apart from the female gender. From the interviews, it was observed that all the male respondents talked about STI's, especially, HIV (AIDS) when asked this question, out of ten respondents, contraceptive function of pregnancy prevention had to be suggested to seven of them

before they went on to include that in their response only three respondents originally mentioned it alongside the pregnancy prevention.

A female respondent takes the same format when asked, *from your view, who takes responsibility for contraceptive use?* Respondent:

'Both, I use the pills, and my boyfriend uses condoms because pills don't protect against HIV so one still has to use condoms.'

At the end of the reply, the respondent offers an explanation for her boyfriend's use of the condom, in which her reply implies that her partner uses the condom for the sole purpose of protection against HIV/AIDS. Gender is being increasingly recognized as a major factor in the spread of this virus.

"The high rates of HIV infection among women and girls often have less to do with biology and more to do with fundamental issues of power and control between women and men."(PRB; 2001:3-4).

The Joint United Nations Programme on HIV/AIDS (2000) has recently recognized that men are key players in stemming the spread of HIV therefore research on men is very crucial to designing effective HIV/AIDS prevention programmes, however, most of the previous HIV/AIDS research and programmes have been focused on women who have little or no power in sexual relations. Sub-Saharan Africa accounts for seventy percent of people living with HIV/AIDS. 24.5 percent of the population are infected in South Africa (UNAIDS, 2000).

4.2.3.4. Satisfaction with contraceptive service

The second question, which is a sub-question under the first, goes as follows; *do you think you get the service that the use of contraceptives should offer you?*

All ten female respondents (hundred percent) answered affirmative to this question.

Their responses showed that their preoccupations was with pregnancy prevention and once their contraceptive of choice could do this, most of them were satisfied. One of such responses is sampled,

‘Yes, because it should protect me from pregnancy and disease, and it all does, like now, if the condom bursts then it will affect me of course, so I must just use the pills’.

A respondent however questions the efficacy of contraceptives,

‘Yes, it prevents me from getting pregnant. But contraceptives do not give 100% protection. My best friend actually fell pregnant and it does not protect against HIV, so one still has to use the condom and do whatever else because if you don’t, you’re the one who will end up being pregnant’.

Although respondent ten considers herself as getting the service contraceptive should offer her however, she does raise the issue that her best friend got pregnant despite the use of contraceptives, which resulted in the respondent questioning the efficacy of contraceptives. A male respondent (one of three) is preoccupied with pregnancy, and not STI prevention when asked the above question.

Respondent: *‘yes, I believe in condom-ising, it protects me from STD’s and at least, my girlfriend (I have a girlfriend, we’ve been going out for about...(thinking) 6 months now), so she wont fall pregnant, if it is used the right way because some people don’t know how to use it well...and sometimes too, it breaks.’*

This respondent relies on the condom for contraceptive purposes, he explains later that his girlfriend once had to deal with an unplanned for and probably, unwanted pregnancy, hence the reason for his being conscious of the condom as a contraceptive measure.

When asked, *are you happy with the contraceptive method you are using?*

Among female respondents, six out of ten respondents were not happy with the use of contraceptives. The most recurrent answer derived was, that the respondents were not happy to have to use the pills and inject-able method for two reasons, health effects of contraception on the individual, and societal and cultural attitudes towards contraception.

Health effects of contraception on the individual: Respondents were unhappy with the effect pertinent methods had on their periods, and four of the respondents complained of weight gain. Although some of them were careful about speaking their minds on this issue, one respondent actually claimed to have never used any method other than the (male) condom but as the interview progressed, and the researcher mentioned that weight gain was quite common among some users. The respondent was quick to agree with the researcher saying,

'Yes, that's the part I hate, I was so fat last year and the nurse said it was probably because of the pills, and since I stopped them, I have lost most of it.'

This respondent's disclosure of her status as a contraceptive use is late and probably unintentional. This draws attention to the fact that sometimes during research, qualitative research especially, respondents do not make true disclosures. At times respondents say what they think should be the answer or what they think the interviewer wants to hear, irrespective of what is their actual situation.

Societal and cultural attitudes towards contraception: Another point that was mentioned quite a lot was respondents' reluctance to use other contraceptive methods

apart from the condom. This is due to some misconception among them that the use of other methods as young unmarried women was not normal or acceptable. This is a result of societal and cultural attitudes towards sexual activity among young unmarried people and hence, the use of contraception among such. This also explained the reason why a lot of the girls were reserved about discussing the issue.

During quantitative data collection, it was observed among female students that questions in the questionnaires were read quietly, and there was a permeating aura of silence and secrecy around female respondents. Those who came in with friends quietly pointed out questions they found interesting to each other. Male respondents on the other hand, had a lackadaisical attitude to the questionnaire and its theme. They referred to questions with loud laughs and a lot of comments in zulu, and to question 13, *'have you ever had sexual intercourse?'* most, who were in company of friends laughed, and made comments like *'for sure'*.

Female respondents on the other hand, pointed out the question to friends, telling them the number, on seeing it, they reacted with quiet giggles and laughs, some kept straight faces, while some of them shook their heads with disapproval or made no other comments about the question. Female participants had to be encouraged to talk, making them know that it was normal and expected of them to use contraception, as they were generally more reserved about discussing issues of such sexual nature. While male participants on the other hand, were more outspoken. Following is a response given by one of the more outspoken female participants,

'No, I am not happy to be using contraceptives now because I'm still young, maybe later when I am married then it will be okay. But now, I do it because I have to so that I can feel safe because if I don't, then I fall pregnant....'

There is increasing evidence that gender differences, which exists in sexual behavior, are perpetuated by social cultural and gender norms that (Dolcini et al, 1993).

This is found to be true from the observations made above, societal attitudes and values does confine the above individuals, within gender roles and stereotypes, such that female respondents exhibit roles that can be interpreted as non-vocal and recessive about contraception, while males are vocal and are dominant in their discussions and reaction to contraceptive issues.

Out of ten female respondents, four were happy to use contraception. Two of them are on pills while one uses inject-able contraceptives. The remaining one of the four uses the condom and claims to be satisfied with the method:

'I use condoms and I am 100% happy with it because I don't think the other ones (contraceptive methods) are safe, they change hormones and stuff like that.'

The above respondent clearly is not happy with other methods and has her mind made up not to use them.

Three of the above forty percent are happy to use contraceptives if it protects them, which does not necessarily mean they are totally satisfied with the method itself. The following is an example of such:

'Yes, because as a woman you have to protect yourself from getting pregnant when you are a student and you are obviously not ready to have a baby so, I'm happy to use them as long as I'm protected'.

When asked the same question three male respondents reply that they are unhappy with the use of the condom. The reasons two of them gave were about discomfort caused by condom use during intercourse by diminishing sexual feeling

'Using condom is not nice sometimes you just have to use it because you don't know maybe the other person is HIV positive or maybe she (the partner) has another disease and you can just die.'

Researcher, *"can you explain what you mean when you say the 'condom is not nice sometimes'?"*

Respondent, *'(smiling) okay...maybe when somebody use the condom, the feeling is not nice like when you are not using it'*

Researcher, *'do you mean during sex?'*

Respondent, *'yes, during sex'.*

Seven of ten male respondents claimed to be happy with their use of the condom.

Respondent, *'I am happy to use it, I have to because it's our responsibility because she doesn't get pregnant and we reduce the risk of infections.'*

Another respondent says,

'I am happy with it. Sometimes a girl will say that she can't have sex with a man if you don't wear it. Its about life, life can't be reimbursed, it might happen that my partner had HIV/AIDS or other disease.'

This respondent sees the question purely from a perspective of safe sex practice and contractible diseases he does not consider the option of pregnancy prevention.

Summarily, it can be said that the male respondents were happy to use contraceptives as they thought about condom use mostly in terms of safety against likely contractible diseases and especially HIV/AIDS. The female respondents however, thought about contraceptive use mostly in terms of pregnancy prevention or avoidance, and this was their incentive for using whichever methods each of them used.

4.2.3.5. Contraceptive use is liberating

There are three main trends of response among female respondents who feel they find the use of contraceptives liberating. Nine female respondents answer in the affirmative while the remaining one is of the opinion that contraception or its use does not liberate. However, the variety of responses derived from female respondents that answer in the affirmative will be considered first. Among respondents who view contraception as liberating, answers/ reasons given are in two varieties. Following is the first:

Pregnancy prevention: This theme has been recurrent throughout the course of this study, especially among the female gender. Respondents who find contraception to be liberating are especially conscious of the function of prevention of pregnancy, which is what contraception is all about.

Respondent, *'I find it (the condom) liberating because it prevents me from falling pregnant. A lot of people think it is not good enough, I think you just need to know how to use it properly, and people can still get diseases with pills and other contraceptives, so I think the condom is better for me personally.'*

This respondent relies on the (male) condom for contraceptive purposes. She confided earlier on, that she believes that other methods of contraception are unsafe due to their hormonal compositions hence, her choice of the condom as a contraceptive.

The contraceptive advantage of pregnancy prevention also includes an unperturbed attitude towards unplanned for or unexpected sexual relations.

Second respondent, *'okay... like sometimes maybe your boyfriend doesn't want to use condoms then if you're not on pills or anything then you can fall pregnant, but when you are on pills then you can feel more comfortable to have sex anytime. (As an afterthought), of course its got to be someone you trust you know, like your boyfriend if you don't use condoms.'*

This respondent acknowledges that contraceptive use enables her to be more comfortable about or positive towards sexual intercourse. She also raises the issue of contraceptive use resulting in unprotected sex and probably more frequent sex. This respondent however, seems not to think or speak of it from a negative or dissatisfied perspective. Nevertheless, the issue of contraceptive use causing undesirable effects has been raised.

Un-liberating contraceptive effects:

'I find it liberating because I know I cannot fall pregnant when I sleep with my boyfriend. But sometimes it can have a bad effect, because you now don't have an excuse why not to because he (boyfriend) now knows u won't fall pregnant. Before maybe you'll just say you're not safe but now if I say (lying to boyfriend) I missed my injection, he gets upset because now I'm not safe and sometimes the condom is uncomfortable.'

Even though the above respondent answered in the affirmative to the question, through the response, the respondent confirms that the use of contraceptives might have negative, un-liberating consequences for some women, and the respondent as an individual. Although she tries to lighten the tone of her response at the end by adding that the condom gives discomfort as a way of lighting her comments about her partner and their sexual relationship.

The following respondent is happy to use contraceptives though she is not totally satisfied with the effects,

'I am happy with it (inject-able) because it works for me, but condoms are sometimes uncomfortable...basically...yes.' researcher: *do you rely on the condom for contraceptive purposes also?'* Respondent, *'no the injection does that, but before I started taking the injections, my boyfriend had to use condoms it was actually easier then because now, you know how guys can be...he now knows I use the injection so he doesn't use condoms all the time now (meaning sometimes) 'cause I cant fall pregnant anyway.'*

This respondent raises the issue of discomfort from condom use but the more important issue, which the respondent raised, is the inability to control sexual initiatives and probably the frequency of sexual intercourse. In a study of adolescent boys and girls in Kwazulu/Natal province of South Africa (1998), indicated that girls said it would be easier to try to refuse sex than negotiate condom use, underscoring how difficult it is to convince a man to use condoms. Many other studies have also shown that women and girls were usually unsuccessful in refusing sex. Attempts to refuse might lead to partner's objection, (Varga, 1997) forced intercourse or rape (Varga, 1997; Ajuwon et. al, 2001),

The above respondent used the fear of pregnancy as an excuse for her partner to control condom use and frequency of intercourse in the relationship. A lack of control, by women, over the circumstances in which intercourse occurs may increase the frequency of intercourse and lower the age at which sexual activity begins (UNDP, 1992:4 UNAIDS, 2000c). But since the possibility of pregnancy has been eliminated by the respondent's use of contraception, her tool of control has been forfeited.

Through the course of the study, the assertion that condoms alone do not give hundred percent protection against pregnancy, and that other contraceptive methods do not protect from STI'S have been made. We have seen this resulting in respondents (female) combining respective methods with condom use. A few respondents have referred to this as a disadvantage therefore this can be seen as another in which contraceptive use is not liberating. The user could easily begin to feel the need to be emancipated from the encumbrances of always having to worry about having a

condom, or diaphragm available, and this could lead to a feeling of enslavement.

Another respondent who holds the view that contraception does not liberate explains,

'It is not liberating because even when you use the pill, or any other thing, then you still have to use the condom. Because those other ones do not give protection against disease and they don't even give 100% protection against pregnancy that's why the condom is good enough, if you use it well.'

Researcher, *'if you use it well?'*

Respondent, *'yes, because lots of times people don't use it well or it busts that is why sometimes it is possible to still fall pregnant with it.'*

The above respondent states clearly why she does not believe in the possibility of a woman being sexually or reproductively liberated through the use of contraceptives.

Among male respondents, three were of the opinion that contraceptives do not liberate, sampled below are two of such.

First respondent, *'no, because condoms do not mean 100% protection, it can break and your partner can still get pregnant and two of you can get disease.'*

Second respondent,

'Using contraceptives or condoms, does not liberate me, it only gives protection. It all depends on trust, when you trust your partner you can have sex without using condoms.'

Seven thought contraceptive use does have a liberating capability on the user. As was noticed earlier on, male respondents' affirm that contraception liberates. However, this had to do with the condom doubling as a means of protection from contractible diseases and infections. Only two of the above seventy percent mentioned the prevention of pregnancy as a major reason why they see contraception as liberating. From the responses derived to the above question, it can safely be concluded that majority of the respondents, both male and female, view contraception as a tool of liberation. However, the respondents who do not hold this view bring up issues that cannot be ignored or swept aside. Also, among the male respondents that believe in the liberating capabilities of contraceptive use, most of their responses mostly do not support the answer they have given to the particular question. Instead, most of them

make arguments for condom as an effective means of ensuring protection against STI's and especially, HIV (AIDS).

4.2.3.6 Blame shifting

Recent surveys have shown that clear gender differences exist in sexual behaviour. Compared to women, men often report having multiple sexual partners (Catania et al., 1993). In the next extract, we will witness a role reversal as male respondents shift blames of promiscuity on the female gender.

Respondent 1, *'Zulu women have more than one boyfriend. The women don't care if their men use condoms. They say 'I love him, I can die for him'. So when my girlfriend is not using condoms with me, I don't know if they have another boyfriend so I have to protect myself because I don't know if the other man can have AIDS.'*

Researcher, *'so do you feel liberated that is, you feel more confident thereby freer, when you use condoms?'*

Respondent, *'yes, so when I use condoms, I know I can't get any disease, so I'm not worried.'*

The third respondent however, makes pregnancy prevention his major preoccupation.

Respondent 7,

'It liberates because it protects from diseases and sometimes some women are very loose. They will lie that they are using pills so that you won't use the condom then they will get pregnant for you. But if you are lucky, and your girlfriend is using pills then she won't get pregnant and a lot of girls don't want to fall pregnant, only the loose ones.'

This respondent views contraception as sexually liberating tool in an unusual way. He sees the possibility of a woman getting pregnant as a means of entrapment to men by the woman, however, he views contraceptive use (the use of the condom by males and

other methods by women), as being able to liberate himself and probably other men from the impending entrapment.

4.2.3.7. Responsibility for Condom Housing (Who keeps the condoms)?

This is an attempt to evaluate who it is that keeps the condoms in male/female relationships as almost all respondents, both male and female claim to use the condom, either solely or alongside any other method they might be using.

When asked this question, one female responds that she keeps them, two respond that both they and their partners do, while the remaining seven say their (male) partners keep them.

Respondent 9 who keeps them herself says,

'I do because it's my life too and we both should be responsible.'

The condom, a male domain?

The male gender view the condom as theirs and view women's possession of condoms as a threat to their manhood, an attempt by women to usurp their power; male control and domination of the sexual arena, from them thus creating issues of mistrust caused by the female partner holding on to condoms, which arise here, we will sample one of such.

Respondent, 'we both do. But sometimes when I have them, or suggest using them, he gets funny ideas that I may be seeing someone else 'cause I've got condoms on me, that's why I'm happy to take the injection 'cause I cant be sure he will want to use the condom all the time.'

For some women asking their partner to use a condom may signify mistrust or promiscuity. (Pivnick 1993; Varga 1997; Gupta et. Al, 1993). The opposite is the case

here the respondent's partner does not expect her as the female in the relationship to keep condoms. This tone is recurrent in the rest of the respondent's views.

Three responses from the respondents who claim that their partners keep the condoms will be sampled. These three responses are quite similar and they echo the voices of most of the other female respondents.

Respondent 3, '*both should but the guys keep them most of the time.*'

Respondent 10, '*the boys do, sometimes they are suspicious when we (females) keep them. Some of them even accuse their girlfriends of sleeping around.*'

Respondent 6, '*the man, he keeps the condoms because he wears them, that's why both of you must take responsibility. Like maybe the woman can use the pills or something to protect herself.*'

The above responses border on a range of issues. The condom being a male thing, or domain, while the pills and injections are the woman's thing, the female domain. It also borders on suspicions and accusations, stemming from female possession of something the male considers his and therefore should be found on him. When asked the same question, answers obtained from male respondents can be divided into two different groups. One male respondent simply claimed his girlfriend keeps them. The most common answer obtained from male respondents however was that they keep them for different reasons. Six out of ten male respondents view condom housing as the man's responsibility for various reasons, ranging from, Respondent 7,

'It's a man's thing, I think I've heard that there is one type that women can use, maybe the women can keep those ones for them.' And, Respondent 4, '*I do, as a man, you have to be responsible and I use it so I keep it.*' To respondent 8, '*the man must keep it. I won't like it if my girlfriend kept it that would be like her telling me what to do. It's a man's responsibility and decision.*'

While three respondents stated that they oppose the idea of the female partner holding on to condoms. The remaining respondent as was noted earlier, claims his (female) partner keeps the condoms.

From the above, “...*I use it, so I keep it*” we can conclude that the condom is mostly regarded, by both members of the male and female genders, as something that belongs to the male, and should be found on him, as he uses it. This is discovered to be the case even among female respondents that claim the use of the (male) condom for themselves as individuals, as a method of contraception they use. As it can be observed that with the exception of three female respondents, one who claims the condoms are kept by her, and the other two who claim it is kept by themselves and partners, all others claim not to keep them. Harrison, Xaba and Kunene (2001) have noted that condoms, which has been variously acclaimed as a veritable means of preventing the sexual transmission of HIV/AIDS, have become a powerful manifestation of how little control women have over their prevention needs (Harrison et. al, 2001; Pivnick, 1993; Gupta & Weiss, 1993). This observation does tally with the observations made by the researcher during the data collection. The researcher observed that at the site of the research, the campus clinic where condoms are kept in dispensers, out of the three weeks that the researcher sat at the clinic from (8am to 12pm; 2 to 3pm, on an average of three days each week), only once did two female students get condoms together. While on three different days, the researcher noticed a total of seven male students get condoms from the dispenser. None of these students took part in the qualitative (interviews), and quantitative (questionnaire answering) data collection process, they were separate from the forty students that were used. This observation supports the findings made from the above data.

4.2.3.8. Male opinion on contraceptive use among women

When asked, *'what would be your opinion to the use of other contraceptive methods apart from the condom by your girlfriend?'*

Two male respondents said their girlfriends already use. Following is one of such,

Respondent 6, *'I think its okay, my girlfriend uses'*.
And three respondents said they would support her, one such response is sampled; respondent 5,

'I will support her, it's her life, if she wants to then it's her life'.

4.2.3.9. Misconceptions about contraceptive use

Misconceptions about contraceptive use and effects were revealed here as three respondents said they wont advise it. Sampled here are two of such responses,

Respondent 2, *'you mean like using pills?'*

Researcher: *'yes.'*

Respondent, *'I wouldn't encourage her, it can cause infertility';*

Respondent 3, *'no, I don't think it's good, they can affect the persons' health.'*

While respondent 1's response was: *'I don't like it, the good old way is good enough (the condom) but if she wants to, it's her business'*.

Based on the data presented above, a total of five respondents could be said to be at peace with the use of contraceptive methods other than the condom by their partners.

While a total of four respondents can be said to be against their partner's use of other contraceptive methods apart from the condom. The results obtained from this last question, however is based on and only seeks to sample the opinions of respondents.

Hence unlike previous questions, is not based on facts or actual situations.

A total of 9 male respondents were asked this last question. As was afore mentioned, one male respondent had already been interviewed before this last question was added.

A male respondent voiced a different view of contraception from other respondents when he was asked, *do you think you get the service that the use of contraceptives should offer you?*

Respondent: *'its a woman's thing, men don't have problems, we don't have to worry about all those things women worry about (researcher interrupts)... can you give an example, things like what? (Respondent commences), you know, like getting pregnant. Researcher: 'so you don't use anything during sex to prevent your partner from falling pregnant?' respondent, 'oh I use the condom, but condom is most important for HIV (prevention) ...I think so some women take medicine so that they wont fall pregnant...'*

Respondent asks to be reminded of the initial question, after he is told, he then says,

'I think I get the service because I don't have HIV (laughs)'.

This respondent views contraception as a 'female domain', respondent appears to be totally oblivious of the contraceptive functions of the condom. Other male respondents however are conscious of it, in most cases, respondents just find it difficult to conceptualise the condom and its use as a contraceptive method apart from its functioning as a safe sex method. Once again, we experience paralleling of the condom solely with HIV (AIDS), and 'contraceptives' as a 'female thing' this is a misconception. This finding is related to, and affects all the research questions as will be further seen in chapter five. If members of the male gender see condom use from the light of safe sex practice, then their overall view of contraception and its use, in relation to them is questioned? The question may then be asked that, since their basic understanding of the term contraception and its relation to them is questionable, can they then as individuals claim to benefit from contraceptive use, as a means of

pregnancy prevention, since the individuals themselves do not identify with it in that light? However, for the purpose of this study, the research questions will simply be answered using the results derived from the data collected, viewing contraception as a means for prevention or regulation of pregnancy for both genders, and disregarding the safe sex issues that were raised apart from the research questions. However, the issue will not be totally ignored in the findings, as it will still be discussed as an issue, which arose separate to the research questions.

CHAPTER FIVE

SUMMARY OF FINDINGS AND CONCLUSION

In this chapter, the summary of findings made in the previous chapter (chapter four) will be used to answer the four research questions by way of discussion, accordingly.

In order to do this, each of the research questions will be taken one after the other, and drawing on research findings made in both the qualitative and quantitative respectively, each of the questions will be answered.

Who takes responsibility for contraceptive use among young adults; is it the men or the women? Do contraceptive users consider their needs as being met, and are their interests adequately protected?

Condom use among male students is eighty-one percent (n=17), while among female students it is forty-six percent (n=12). Among male students, the use of other methods (withdrawal) is nineteen percent (n=4). While female students use of other methods (pill and inject-ables), is at fifty-four percent (at twenty-three (n=6) and thirty-one (n=8) percent respectively). However, the drop in condom use among female respondents does not necessarily affect female contraceptive use, as female claim to the use of the male condom was earlier questioned. Meaning that since the male and not the female gender personally takes responsibility for the use of the (male) condom, and the use of the methods for which responsibility is taken by the female gender falls above fifty percent further makes the rise or fall in female condom use

inconsequential. Both male and female contraceptive use (of methods that pertain to them) fall above fifty percent, it can be concluded that both take responsibility for contraceptive use. However, female respondents take more contraceptive initiative as is obvious from chapter four that most of them combine more than one method, while male respondents mostly claim to use the condom.

From the qualitative research however, among female respondents the belief is that women take the responsibility while male respondents were of the opinion that men take responsibility for the use of contraception. The latter may be true as this belief is based on the fact that men use the condom, a method that the higher percentage among female respondents, claim to use meaning that, as women as well as men, personally take responsibility for condom use, condom use by men could actually have higher percentage than other female methods, which actually is the case. However, an attempt could be made at explaining this results away by concluding that the high use of the condom among the male population is by virtue of its functioning as a safe sex method, and not necessarily because of its capacity as a male contraceptive. Eighty-two percent of South African men who participated in a survey said that they would prefer to use a vaginal microbicide rather than condoms for preventing sexually transmitted diseases (STDs). Also, most would like a product that prevents STD infection only rather than one that acts only as a contraceptive (Ramjee, 2001).

In the above, Mfono's assertion that most South African males consider contraceptive use to be the responsibility of their partner, is re-emphasized. Also, we can join her in concluding that among South African youth, an attitude of joint responsibility for contraceptive use is not present (Mfono, 1998).

However, in order to find out more exact statistics on who takes the most responsibility for contraceptive use, more in-dept research would need to be carried out.

Do contraceptive users consider their needs as being met, and are their interests adequately protected?

In the quantitative research, when respondents are asked whether or not they are satisfied with the method of contraception they used, seventy-six percent (n=16) of male respondents reported that they were satisfied, while eighty-five percent (n=22) female respondents also reported satisfaction. Twenty-four percent (n=5) and fifteen percent (n=4) of male and female respondents respectively, however divulged that they were dissatisfied.

Hence, from the considerably higher numbers of satisfied clients, the conclusion can be drawn that, both genders are happy with the service they get and consider their needs as being met, and their interests protected.

From the interviews conducted, it can be assumed that the research population consider that their needs are being met and interests well protected.

From the responses given, the needs and interests of both male and female contraceptive users revolve around safety and protection against unwanted or unplanned for pregnancy and STI's especially, HIV/AIDS.

Given that the condom serves dual purposes, some females but especially male respondents could not or did not see a need to separate the function of the condom as

a form of contraceptive, from its function as a safe sex method. Most male respondents thought of the duality of the condom in terms of setting it aside as a contraceptive method for females, and a safe sex method for themselves, and partners. Only a few of them thought of its contraceptive functions in regard to themselves. The most obvious reason for this is because the female gender carries the pregnancy.

Based on the above male and female understanding of their biological reproductive functioning, hence, their contraceptive needs, and interpretation of contraception in relation to their respective needs, both male and female users consider their needs as being met, and their interests adequately looked after. However, if despite male respondents understanding of their needs, they have condoms made available to them solely for contraceptive purposes or, other method(s) of contraception, perhaps then, male respondents might be less satisfied with service provided by the condom as there would have been a remarkable change in their perspective.

How do men, and women view contraceptive use? As a form of reproductive technology, do they find it liberating?

Among research respondents, it was observed that female respondents identified themselves most frequently and easily with contraception and its use. Few male respondents also did this, but the higher number of male respondents identified it with the female gender, they talked about it in relation to members of the female gender getting pregnant. And not in relation to themselves causing, or bringing about pregnancy in a member of the female gender. Hence, it could be said that members of the male gender designate contraception and its use to be a female arena.

Quantitative research results show that both male and female respondents equally view the use of contraception by males and females respectively, as acceptable. However, this assertion derived from the quantitative sample is disputed through the course of the qualitative research process and observations, which pass across that male respondents find it hard to identify contraception as a reproductive technology which serves or is meant to serve them. Female respondents however, easily recognise the contraception as such.

We can therefore conclude that males identify with contraception as an organisation, and as reproductive technology that pertains most actively to members of the female gender while females identify with it as such.

Is Contraceptive Use Liberating?

From conclusions arrived at in the qualitative study, both male and female respondents, affirm that they find the use of contraception liberating to them. However, despite the fact that the majority of male and female contraceptive users alike view the use of contraception as liberating to them, an issue, raised by some of the above female respondents may contest this assertion. This issue will be considered while answering the fourth research question.

What Contraceptive choices are there for men, in comparison to those available for women and which ones are the recipients familiar with?

The results of the quantitative study shows that all the respondents were aware of contraception for women. Forty-five percent (n=9) of male and thirty percent (n=6) of female respondents claimed to know of only one method of contraception available to men. While among male respondents thirty-five percent (n=7) and fifteen percent (n=3) female respondents claimed to know of two methods. Also, twenty percent (n=4) and fifty-five percent (n=11) of male and female respondents respectively, claimed no knowledge of contraception available to men.

From the above it is apparent that male respondents have more knowledge of male contraception than female respondents. The highest percentages found are among female respondents who do not know of male contraception, and male respondents,

who know of one method of contraception. Thus, it can be concluded that female male contraceptive knowledge among these set of students is quite low.

Who in the long run benefits from contraception as a form of reproductive technology; who has control of the female body?

From the above, the answer to this question would be the individual who uses contraceptives and considers it to be of benefit to them as a form of reproductive technology. However, we may want to refer back to the issue raised by female respondents, as mentioned earlier under research question 1. This is the possibility of contraceptive use resulting in unprotected sex and probably more frequent sex. It may also lead to inability of a female partner to say no to unwanted sex especially in sexual relationships. This response that was generated among some of the female respondents thus, questions the ability for an individual to be sexually and reproductively liberated due to the use of contraception. However, as we must depend on the data collected, it can be said then that contraception as reproductive technology does benefit the individual who makes use of it.

CONCLUSION

Most of the results derived from this study, imply that male and female respondents are willing to take responsibility for contraceptive use, if they are enlightened and given proper and adequate information about contraception, its functioning, usage and methods. Levelling answers derived to the second research question and part of the first question with the knowledge that the contraceptive industry serves the female population more than it does the male, makes it possible for us to conclude that contraception, as a form of reproductive technology serves the female population.

Also, from the above, we can conclude that the male population of young adults represented by the research respondents, who are made up of University of Natal, Pietermaritzburg campus students need to have an understanding of contraception in general, and how it affects them as individual males, and also in relation to how it affects women.

There is also a need to eradicate stereotypes and to break down negative attitudes towards young women's use of contraception. As was observed in chapters 4, and 5, there exist attitudes of secrecy towards discourse about issues and topics that are of a sexual nature among young women, represented by the research population. While among young men of the same age group, signals and responses given off when issues of such sexual nature are broached, are quite the opposite. This is a function of cultural beliefs, societal norms and stereotypes of gender roles and expectations in societies. This more often than not stems from gender dichotomy and patriarchal systems that exists within patricentric societies.

Certain beliefs about and attitudes towards the use of contraception among young adult women results in breeding secrecy, and lack of use among this population while its use may result in bringing down mortality and morbidity rates among young adults. Presently, members of society, both male and female, view the contraceptive industry as a female institution. This could be seen, as an advantage as it suggests that the female population are taking responsibility for themselves, and the male population are admitting that contraception as a form of reproductive technology is something that is essential and needful for the female gender. It also suggests that the male population is willing to relinquish the power to the female gender, to take charge of their sexual and reproductive health. However, despite the fact that women personally suffer for irresponsible sexual behaviour, in terms of pregnancies, health and reproductive issues nevertheless affect all people and should be treated accordingly, and accompanied by a sense of responsibility by members of both genders.

Thus, in conclusion, contraceptive use is very much gendered, and this is a product of society. Therefore, changes must be made in societies towards the elimination of negative attitudes towards contraceptive use among young men and women in societies. Efforts could be made at involving the male population in contraceptive practice through enlightenment programs, and the provision of more methods pertinent to them. Gender stereotypes and patriarchal beliefs and systems in societies that relegate the female gender, confining them to, and prescribing roles of silence, unassertiveness, dependency and subordination to them must be deconstructed.

Finally, contraceptive practice must be de-gendered, and both men and women, must be encouraged to take responsibility for themselves, their sexual and reproductive lives.

5.1 RECOMMENDATIONS FOR FURTHER RESEARCH

While the study has suggested certain possible answers, it also raises questions requiring further research. The study of contraceptive use among respondents, and the results derived brings to mind issues and opportunities for research such as, attitudes to contraceptive use among young adults within the family, institutions. There is also the need for research to be conducted into contraceptive use among the male gender on perceptions and opinions about methods presently available to them and do they find this adequate? And for the future; a comparative study among the male population on the use of methods which singularly serves contraceptive purposes and are safe and effective, and on a method such as the condom which doubles as both a contraceptive and safe sex method.

There is also the need for research to be conducted on gender role distribution on sexual and contraceptive issues in specific cultures and societies in order to be able to get to the root of societal attitudes, both gendered and colossal, (like female roles of silence, and male roles of vocalicity; women are to be seen, and not heard) that ultimately affect contraceptive use among young people and consequently, mortality, childbirth, and abortion rates and even increase and decrease in populations, not only in South Africa, but in the entire world.

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Paper presented at the WHO Afro Regional Meeting in Pretoria, South Africa

APPENDIX 1:QUESTIONNAIRE

Thank you for assisting me in this research. Please mark an X in the appropriate box as you answer the questions below. Your confidentiality is guaranteed.

1. Gender: Male ☐ Female ☐ Transgender ☐
2. Age (years): < 18 ☐ 18-25 ☐ >25 ☐
3. Marital status: (select more than one if appropriate)
Single (never married) ☐ Living together ☐ Married ☐
Divorced/separated ☐ Widowed ☐
4. Nationality: South African ☐ Non-South African ☐
5. Highest level of education received?
Matric ☐ Degree Honours ☐ Other (specify)
6. Are you aware of any method(s) of contraception?
Yes ☐ No ☐
7. If yes, where did you get to hear about it? (you can mark more than one box)
Friend ☐ Partner ☐ Media (e.g television) ☐ Family ☐
Hospital/ health clinics ☐ Workplace ☐ Other(specify).....
8. Do you know the different types of contraceptive methods there are?
Yes ☐ No ☐
9. Are you aware of any form of contraceptive method(s) for men?
Yes ☐ No ☐
10. If yes, how many methods do you know?
One ☐ two ☐
11. Do you think it is okay for men to use contraceptives?
Yes ☐ No ☐
12. Do you think it is okay for women to use contraceptives?

Yes ☐ No ☐

13. Have you ever had sexual intercourse?

Yes ☐ No ☐

14. Did you use any kind of contraceptive method?

Yes ☐ No ☐

15. If yes, what kind?

Withdrawal method ☐ Condom ☐ Implants ☐

Oral contraceptives (Pills) ☐ Injectables (Depo-Vera, Nur-Isterate) ☐

Intra-uterine contraceptive devices ☐ Rhythm/billings method ☐

Diaphragm ☐

16. Do you use any presently?

Yes ☐ No ☐

17. If yes, what kind?

Withdrawal method ☐ Condom ☐ Implants ☐

Oral contraceptives (Pills) ☐ Injectables (Depo-Vera, Nur-Isterate) ☐

Intra-uterine contraceptive device ☐ Rhythm/billings method ☐

Diaphragm ☐

18. Are you happy with this choice?

Yes ☐ No ☐

19. Since you started using contraceptives has there been an increase in the
number of times you have sexual intercourse?

Yes ☐ No ☐

20. If yes, are you happy with this behavioural change?

Yes ☐ No ☐

21. Has the use of contraceptives made you feel more comfortable about having sex?

Yes ☐ No ☐

22. Who decides whether or not you use contraceptives?

Yourself ☐ Partner ☐ Both of you ☐

Family member(s) ☐ Health practitioner ☐

23. Who do you think has the right to decide?

Yourself ☐ Partner ☐ Both of you ☐

Family member(s) ☐ Health practitioner ☐

24. Why?.....

25. Do you think the use of contraceptives affect you in anyway?

Yes ☐ No ☐ Not really ☐ I don't know ☐ I'm not sure ☐

26. How do you think it affects you?.....

27. Who in your opinion benefits more from your use of contraceptives?

Yourself ☐ Your Partner ☐

28. In what way?.....

APPENDIX 2: INTERVIEW SCHEDULE

GENDER:

AGE:

VENUE:

DATE

TIME

QUESTION 1

From your view, who takes responsibility for contraceptive use?

1a). Are you happy with the contraceptive method you are using?

1b). Do you think you get the service that the use of contraception should offer you?

QUESTION 2

In what way do you find the use of contraceptives liberating to you?

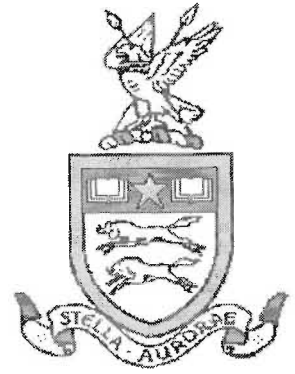
QUESTION 3

Who keeps the condoms?

QUESTION 4----- (male respondents only)

What would be your opinion to the use of other contraceptive methods apart from the condom by your girlfriend?

APPENDIX 3: REQUEST LETTER FOR PERMISSION



**University of Natal
Gender Studies
DURBAN
4041**

**genders@nu.ac.za
Telephone: (031) 2602915**

Fax: (031) 2601413

The Administrator

REQUEST TO USE CLINIC FOR A MASTERS DEGREE STUDY

I am writing to seek permission on behalf of Ms Adeola Oyedeji, a Masters student at the Centre for Gender Studies. As part of the requirements towards the degree the student is expected to do an empirical research project. Ms Adeola Oyedeji's MA project is entitled 'A gendered study of contraceptive use among students at the UNP campus'. The study entails observations, gathering statistical information and conducting interviews. We will appreciate your assistance in enabling the student to conduct the study.

Please refer any queries that you may have to the centre.

Thank you

Dr Thenjiwe Magwaza
Programme Director

APPENDIX 4: COVER LETTER FOR QUESTIONNAIRE



**University of Natal
Gender Studies
DURBAN
4041**

**genders@nu.ac.za
Telephone: (031) 2602915**

Fax: (031) 2601519

28 May 2003

Dear Fellow Student,

Research project: A gendered study of contraceptive use among students at the UNP campus.

I am a Masters student from the department of Gender Studies, from the Faculty of Human Sciences at the University of Natal, Durban campus. I am doing a research on the use of contraceptives among students like myself. Contraceptive use among members of both genders has come to be of importance in the study of relationships between members of the male and female genders.

You have been randomly selected to take part in this study. I am trying to involve both male and female university students between the ages of 18 to 25. Your name will not appear on the questionnaire, and the information you give will therefore be anonymous.

If you are willing to take part in the study, please complete the attached questionnaire. I will be sitting at the clinic from the 28th of May to the 19th of June. Please note that the time for this study is quite short. If you have any questions about the research, please don't hesitate to contact me at the following address Gender Studies Programme, University of Natal, Durban, 4041 Durban (031-260-2917) or phone 033-3949464.

I can also be contacted via e-mail: adeolaoyedeji@yahoo.com

Your participation will be greatly appreciated.

Thank you kindly.

Yours sincerely,

O.A Oyedeji
Department of Gender Studies.