FACTORS FACILITATING AND INHIBITING CONTRACEPTIVE USE AMONG WHITE UNIVERSITY STUDENTS IN DURBAN SOUTH AFRICA

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ABSTRACT

Worldwide, governments have made an increasing effort in providing contraceptives and ensuring greater access and availability of a range of contraceptive methods. According to the World Health Organization the promotion of family planning to essential for improving maternal health and achieving the Sustainable Development Goals. The low contraceptive rate among sub-Saharan countries is concerning especially for young women. In South Africa research suggests that fertility has been declining steadily over the past few decades and contraception is a major factor contributing to this decline. National surveys suggest that among White South Africans contraceptive use is high. However, there has been limited focus on the contraceptive use of Whites. Various studies give us a picture of the attitudes of Africans towards contraceptives. The aim of this study is to shed insights into contraceptive use of young white, university students in Durban. For this study, semi-structured interviews were conducted to obtain data. The semi-structured interviews were held with 10 White, female students at the University of KwaZulu-Natal, Durban. The findings of this study indicated that high level of awareness about contraceptives facilitates contraceptive use. Young women stated they obtained information about contraceptives from their doctors. Health benefits was the main reason for contraceptive use. Although doctors were an important source of information, communication with their parents also influenced their contraceptive use. The women also reported partner communication about contraception. The study suggests the need for early parent-child communication in facilitating contraceptive use. Furthermore, the study suggests improved interpersonal communication between health workers and young people about a range of contraceptives. Male involvement is essential in ensuring good reproductive health outcomes and partner communication is also likely to influence contraceptive use

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ACRONYMS AND ABBREVIATIOS

CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
DMPA	Depot Medroxyprogesterone Acetate
FDA	Food and Drug Administration
GP	General Practioner
HEAIDS	Higher Education HIV and AIDS program
HIV	Human Immune-deficiency Virus
IEC	Information Education and Communication
IUD	Intrauterine Device
KZN	KwaZulu Natal
LO	Life Orientation
NET-EN	Norethisterone Enanthate
PMDD	Premenstrual Dysphonic Disorder
SA	South Africa
SADHS	South African Demographic Health Survey
SRH	Sexual and Reproductive Health
Stats SA	Statistics South Africa
SSA	Sub-Saharan Africa
TFR	Total Fertility Rate
UK	United Kingdom
UKZN	University of Kwa-Zulu Natal
USB	Universal Serial Bus
UN	United Nations
UNDESA	United Nation Department of Economic and Social Affairs
US	United States
USAID	United States Agency International Development
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

1.1 Background on contraceptive use

Family planning enables people to have their desired number of children and allows spacing between pregnancies (WHO, 2018). It is achieved through use of contraceptive methods and the treatment of infertility (WHO, 2013). There are two types of contraceptive methods: traditional and modern contraceptives. Hubacher and Trussel (2015) defines a modern contraceptive method as a product or medical procedure such as, injection, intrauterine device (IUD), oral contraceptive pill, vasectomy, sterilization, that interferes with reproduction from acts of sexual intercourse. Traditional methods include withdrawal, abstinence and periodic abstinence.

Oral contraceptives also known as the "pill" are contraceptives taken every day to reduce the chances of getting pregnant. There is also an emergency pill which is commonly taken after sexual intercourse and they must be taken within 72 hours to work effectively. The injectable is the contraception injected after every three or six months. It is commonly used in South Africa (SA) because it is deemed convenient and easily taken by women who are hiding it from their partners or parents. The vaginal ring, implantable rod and the IUD are hormonal and are not easily reversible, however, a person can conceive after they stop using this method (WHO, 2018). Traditional methods are used to achieve pregnancy by timing intercourse for fertile times, or to avoid pregnancy by remaining abstinent during fertile periods. The main disadvantage of this method of birth control is that it requires couples to remain abstinent during the time when women are most fertile and have a heightened interest in sexual activity. The other type is withdrawal, where by a male partner withdraws his penis when he is about to ejaculate (WHO, 2018).

Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49. Modern contraceptive methods account for most of the contraceptive use worldwide. Globally in 2017, 58 per cent of married or in-union women of reproductive age were using a modern method of family

planning, including 92 per cent of all contraceptive users (United Nations, 2017). Also in 2017, among married or in-union women of reproductive age, the proportion of the demand for family planning that was satisfied by modern contraceptive methods (the proportion of women currently using a modern method among all women who have a need for family planning) was 78 per cent worldwide. Across regions in 2017, this proportion was lowest in Africa, at 56 per cent, and above 75 per cent in all other regions. (United Nations, 2017).

Women with an unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of an unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour. About 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method (WHO, 2018). There are many reasons behind such trends including the lack of a variety of contraceptive methods, hindrance in accessing contraceptives, particularly among young people, in rural areas. Also, the fear and experience of side-effects, cultural or religious background, and poor quality of available services, user and provider bias as well as gender-based barriers (Kassa, Abajobir and Gedefaw, 2014). The unmet need for contraception remains too high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 24.2% of women of reproductive age have an unmet need for modern contraception. (UNDESA, 2015).

The promotion of family planning and the provision of a preferred contraceptive method is important for the health and well-being of women, children and communities (WHO, 2018). Contraception (birth control) prevents pregnancy by interfering with the normal process of ovulation, fertilization, and implantation. There are different kinds of birth control that act at different points in the process. Family planning enables people to have their desired number of children and how they want to space child bearing (WHO, 2018). This helps in reducing unintended pregnancies. Family planning decreases levels of unsafe abortion which leads to high mortality rates amongst women ages 15-24. Unintended pregnancies leads to infant mortality because mothers are either unaware that they are pregnant and do not take the necessary precautions or they are too young to carry a baby. Therefore, contraception reduces infant mortality caused by unintended pregnancies (WHO, 2018).

Family planning enables people to decide on when they want to conceive and spacing. Therefore, this enables women empowerment, which allows women to further their education and pursue career advancement (Sedgh and Hussain, 2014). Women empowerment is very important as the number of girls who drop out of school due to unintended pregnancies is still high. Also, a number of women are said to be leaving the place of work frequently to take care of their children. To have smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (WHO, 2018).

According to WHO (2013) globally, the contraceptive prevalence rates has increased from 54% in 1990 to 57% in 2015. In all regions of the world, contraceptive use has gone up but still remains low in sub-Saharan Africa (SSA). SSA has a low contraceptive prevalence rate of 25%, however the use of modern contraceptive has risen slightly from 23.6% to 28.5% between 2008 and 2015 (WHO, 2018). An estimated 19.7% of women in the reproductive age (15-49) use modern contraceptive methods compared to 5.4% who use traditional methods (UN, 2013). The injectable method is the most prevalent form of contraception used across SSA (Howse and Nanitashvili, 2014; Pacque-Margolis et al. 2013). Contraceptive use by men is lower compared to women, due to limited male contraceptive methods, mainly condoms and vasectomy (WHO, 2013).

The low prevalence rate of contraceptives is caused by the unmet need amongst women of reproductive ages. Globally, 143 million women of reproductive ages had an unmet need for family planning in 2011. In Africa, 26 of the 39 countries have the highest unmet need levels, ranging from 21% to 38% of all women of reproductive age (USAID, 2014). The ratio of women with an unmet need for modern contraceptive is 4:5 of every women living in developing countries. South Africa introduced and promoted family planning in 1970, with the purpose to reduce birth rate amongst blacks (Burgad, 2004). According to the most recent Demographic and Health Survey 58 % of women were using modern contraceptive and less than 1% used traditional methods. The Western Cape Province which is dominated by the White population has the highest contraceptive prevalence rate (CPR) of 58.3% compared to other South African provinces. In terms of race groups, black women have the lowest contraceptive prevalence rate (62.2%) whereas White women the highest (80.9%) (Peer et al., 2013). Thus, the unmet need amongst blacks remains high, resulting in high teenage pregnancies and high prevalence of HIV.

According to Cleland et al. (2006) most young women give birth before age of 20, resulting in high pregnancy related morbidity and mortality amongst this group. In SSA, it was estimated that 101 births per 1000 occur amongst women aged 15-19 years (UN, 2015). Adolescent pregnancy rates declined since the mid-1990s in most countries with reliable trend data, but the rate still remains exceptionally high in South Africa. The SADHS 2016 reported that 16 % of women between ages 15-19 years have begun childbearing, 12% have given birth, and another 3% were pregnant with their first child at the time of the survey (Stats SA, 2018).

1.2 Why focus on white students

South Africa is a multi-racial country consisting of 4 main racial groups namely Black, Coloured, Indian and White. The central focus for this research is on the White population. South Africa introduced and promoted family planning in 1970, with the purpose to reduce birth rate amongst blacks (Burgad, 2004). The white population has high levels of contraceptive prevalence rate because of their higher socio-economic status. In terms of race groups, black women had the lowest contraceptive prevalence rate (47.2 %) and White women the highest (61.9%) (Chersich et al., 2017). Oral contraceptive is more likely to be reported by White women (Chersich et al., 2017). According to Chersich et al. (2017) wealthier women were less likely to use injectable compared to poor women. Also, White respondents reported more consistent condom use compared to black respondents (Chersich et al., 2017).

A study conducted by the World Health Organization to assess the reproductive needs of the population found unexpected discrepancy between the young people's familiarity with modern contraception (Appiah-Agyekum and Kayi, 2013). It was also found that most young people experienced high levels of unwanted pregnancy and unsafe abortion (Nasir and Pharm, 2010). The lack of contraceptive use, familiarity and knowledge of contraceptives among young female adults may lead to several unwanted pregnancies, abortions, contracting Sexually Transmitted Infections (STIs), societal and family rejection (Ameha and Nebreed, 2006)

A review of current studies suggests that young people in South Africa are sexually active at age 16 and 80% are sexually active by the age of 18 (Eaton et al., 2003). Teenage pregnancy is common in South Africa this is caused by girls who are not using contraceptives but are sexually active even though contraceptives are provided for free in public health facilities.

Jonas et al. (2016) stated that contraceptives that are provided in health care facilities such as oral contraceptive and injectable are the least commonly used contraceptive methods by adolescents' girls. According to SADHS 2016 teenage pregnancy rate was 71 births per 1000 for women aged 15-19 (Statistic South Africa (Stats SA, 2017). Teenage pregnancy rates are significantly higher among the black population and low amongst White. According to Stats SA (2018) 12.5 % of black African women aged 15-19 have given birth compared to 1.8% of White women. Teenagers who become pregnant are more likely to be from poor backgrounds compared to teenagers from wealthier backgrounds (Stats SA, 2017). Also, 12.9 % of pregnant women between the ages 15-19 are HIV positive and from age 17 onwards, every second women who has been pregnant is infected with HIV (Panday et al., 2009). In addition, Jonas et al. (2016:9) argued that the lack of data on teenage pregnancy trends among South African adolescents poses a serious public health threat, as the magnitude of the problem is relatively hidden for consideration in intervention programs that aim to reduce teenage pregnancy, and improve maternal and child health outcomes.

The highest levels of new HIV infections occur among young people, with more than half of all adults acquiring HIV before they reach 25 years (UNICEF, 2016). Young people in the age group 15-24 years, a majority of whom are currently in schools, colleges and universities, have been identified as particularly vulnerable to the spread of HIV/AIDS (UNAIDS, 2005). In Africa, research suggests that the university in Africa is a high-risk institution for the transmission of HIV because of high-risk activities such as 'sugar-daddy' practices and unprotected casual sex with multiple partners (World Bank, 2001). The vulnerability of young people makes it imperative that they are an important focus for targeted pregnancy and HIV/AIDS interventions. South Africa has one of the highest number of young people living with HIV/AIDS in the world (Shisana, et al, 2014). The national HIV prevalence among women in reproductive ages 15-49 years in the country is 19 percent (Statistics South Africa, 2017). The high level of unwanted pregnancy and HIV/AIDS in South Africa suggests that a number of men and women are not using a contraceptive method consistently, correctly or even at all.

Knowledge of contraceptives is vital in contraceptive decision making especially for first time users. Young people's low levels of usage of hormonal contraceptives can be justified by low levels of contraceptive knowledge among adolescents in SA (Troped et al., 2007). The 2016 SADHS indicated that about 97% of sexually active women in South Africa have knowledge

of at least one contraceptive method. However, it was reported that 61% of women aged 15-24 were using and the mostly used contraceptive method among this group was a male condom (Department of Health (DoH), 2017). Western Cape was reported to have a high modern contraceptive rate of 62.7% compared to other eight provinces. However, the use of male condoms was high in Kwa-Zulu Natal compared to Gauteng and Western Cape which are provinces with a high economic status in South Africa (DoH, 2017). South African studies have shown that young people prefer to use condoms because they are the most accessible form of contraceptive and they are provided for free in clinics (Maharaj and Cleland, 2006; Mda et al., 2013)

The unmet need for contraception is not using contraception despite wanting to avoid pregnancy. DHD survey that were conducted between 2005 and 2014 in developing countries reported that the unmet need of contraception was between 8% and 38% of married women aged 15–49. About 25% of married women had an unmet need in African countries (Sedgh et al., 2016). Unmet need tends to be higher among women who have less education, live in rural areas or are from poorer households than among those who are more educated, urban and better off. In South Africa, 18% of women have unmet need of family planning services (DoH, 2017). Young women aged 15-19 and 20-24 have high levels of unmet need for family planning services with 31% and 28% respectively (DoH, 2017). This shows that there should be more focus on young women in order to implement policies and programs focusing on this group.

Various studies give us a picture of the reasons for the high pregnancy rate among African women. In fact, there is an abundance of literature that focus on this sector of the population. It also shows us the factors inhibiting and facilitating use, choice and consistency of contraception. There has been few, if any studies on the contraceptive use among young, white women. There is inadequate literature on teenage pregnancy among White South African, however understanding protective factors in this group could offer important lessons in preventing this issue (Panday et al., 2009). Thus, this study aims to shed insight into contraceptive decision-making among young White students.

Most of the studies focus on young black people because of the high levels of unwanted pregnancy, and their lack of knowledge. The total fertility rate in South Africa is 2.4 in 2018 (Stats SA, 2018). The total fertility rate (TFR) is high in the black population compared to the White population. According to the 2011 census in South Africa, the black African

population had a TFR of 2.82 while the White population had a TFR of 1.72 (Stats SA, 2015). In order to fill in the gap, this study will help to understand the dynamics of contraceptive use among the White population. The hope is that there are important lessons that can be learnt from this group that can be applied to the other groups. This study will focus on white, students so as to get insight into their attitudes towards contraceptives. Students are far from typical of young people but they are of special importance because they are often agents of social change, and can serve as an indicator as to whether or not there will be a demand for contraception (Gresh and Maharaj, 2014). This study hopes to find different factors, so that maybe those factors can be implemented in order to decrease unwanted pregnancies amongst other populations.

1.3 Objectives of the study

The overall aim is to shed insights into the contraceptive use of young White university students in Durban.
The specific aims are to determine:

- Factors facilitating contraceptive use
- Factors inhibiting contraceptive use
- Opportunities and constraints in changing contraceptive method

In this study, semi-structured, in-depth interviews were administered in order to understand the contraceptive use.

1.4 Theoretical framework

This study draws on the Diffusion-Innovation theory developed by Cleland and Wilson in 1987. The theory attributes the timing of fertility transition to the diffusion of information and new social norms about birth control (Hirchman, 1994). Diffusion of information is very vital in distribution of contraceptives. Lack of knowledge is one of the inhibiting factors of contraceptive use. It is also the one of the contributors of high levels of unmet need.

According to the early theorist, the decline in fertility was related to social and economic changes, particularly large scale economic transformation brought about by the process of industrialization and the move towards a greater concentration of populations in towns and

large urban areas. However, Cleland and Wilson (1987) argue that the central assumptions of economic theory alone is not sufficient to explain the fertility decline and the increase in contraceptive use. They agree that urbanization increased the costs of childrearing and resulted in a decrease in the benefits of children. However, certain attitudes and behaviours become more influential in a population through their spread from one segment to another, through informal direct social interaction (face to face) or at a distance through the mass media. Cleland and Wilson (1987) argue that ideational rather than structural change has led to the transition in fertility and greater acceptance of contraception.

Diffusion-Innovation theory also argues that the fertility decline is produced by the diffusion of new ideas and knowledge about fertility regulators rather than by changes in socio-economic factors (Cleland, 2001), as studies conducted mostly in Africa suggest. In South Africa, traditional values are still high valued and religion is widely practiced. Thus, the theory suggests that in countries such as South Africa the diffusion of knowledge contributes to contraceptives decision making and change. Meaning, there is a need for a change in how contraceptives are distributed. This can be achieved by training health care providers, especially the one in public health care where contraceptives are mostly distributed. Also, by providing spaces where teenagers can feel free to express themselves and ask questions freely (Mda et al., 2013). By doing so, teenagers will be able to choose methods that suit them best in order to be part of the decision making process.

Cleland (2001) also argued that diffusion is the process by which an innovation is communicated through certain channels over time among members of a social system. The importance of interpersonal communication is emphasized as the most powerful channel of influence. Interpersonal communication is whereby people passes information from one to another, it can be verbal or nonverbal. These conversations occur mostly amongst peers, especially when it comes to sexually related matters. Studies suggest that young people in South Africa find it easier to talk to their peers rather than parents about sexually related matters (Mkhwanazi, 2010; Mchunu et al., 2012). In fact, seeing a peer using contraceptives is a facilitating factor for most young people (Mchunu et al., 2012). Studies suggest that most young people got information about contraceptives from their friends (Mkhwanazi, 2010; Mchunu et al., 2012).

Also, conveying of information depends to some extent on interpersonal links between people of high social status who are more advantaged and those of lower social status who are less advantaged (Cleland, 2001). According to diffusion model, the advantaged population tends to be more cosmopolitan, and urban. The adoption of contraception spreads to other sectors largely through interpersonal communication networks. Therefore, if conveying of knowledge can be the main emphasis, contraception will spread rapidly throughout socially and linguistically homogenous systems, regardless of the position of groups within the economic structure (Cleland, 2001).

1.5 Structure of the dissertation

This dissertation consists of five chapters. Chapter one provides the background of the study. It also explains the focus of the study. It also provides the objectives of the study, and describes the theoretical framework of the study. Chapter two reviews relevant literature on obstacles faced by young women in accessing contraceptives nationally and internationally. It also provides literature on reasons for using contraceptives. The literature has shown that although contraceptive uptake has increased by providing free contraceptives, low uptake and discontinuation of contraceptive method is a major concern globally. Chapter three gives a detailed account of the research methodology of this study. It outlines the target population and study sample; the selection process; data collection process and analysis; ethical considerations and limitations of the study. Chapter four present the main findings of the semi-structured interviews that were conducted with White female students. Chapter five provides the discussion of the main findings, the implications of the findings and gives recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Contraceptive prevalence rate has increased worldwide over the years. However, Sub-Saharan Africa is lagging behind due to various factors. On the other hand, South Africa has performed remarkably in its provision of contraceptives. In South Africa contraception is provided for free in public health care facilities, with the latest Demographic and Health Survey reporting a contraceptive prevalence rate of 58 % (Department of Health, 2016). Even though South Africa has strong contraceptive policies and coverage, high levels of unintended pregnancy, HIV/AIDS still prevails. The literature review will trace the history of contraceptive use referring to international and South African literature. The chapter examines current contraceptive use globally and in South Africa. The review also discusses factors facilitating and inhibiting contraceptive use.

2.2 Current trends of contraceptive use

Current trends and levels of contraceptive use is crucial in order to inform the decisions of health care practitioners, program organizers, and for distribution of resources (Darroch and Singh, 2013). The global community has been dedicated to enforce access to sexual and reproductive health, mainly family planning and providing for the reproductive rights for all people. Globally, contraceptives are used mostly by sexually active women in unions. In 2015, 64 percent of women in reproductive age were on some form of contraception (United Nations, 2015). Modern contraceptive methods are the most commonly used methods for family planning purposes. In 2015, 57 percent of reproductive women were using modern contraceptive methods, however usage differs by region (United Nations, 2015). The modern contraceptive methods that are commonly used are female sterilization and the IUD (United Nations, 2015). Although contraceptive prevalence has been increasing throughout the decades, there are still high levels of an unmet need. The projection of the unmet need globally is expected to be more than 10 percent between 2017 and 2030 (WHO, 2017). According to WHO (2017), less than half of contraceptive demand were met in 45 countries with 32 countries being in Africa.

The developed countries have high levels of contraceptive prevalence because of better access and availability of range of methods. In comparison, Africa has a contraceptive prevalence rate of 36 percent, compared with 75 percent in North America and Latin America (WHO, 2017). However, contraceptive choice may change over time due to various reasons such as: side effects and effectiveness of the method.

In developing countries, contraceptive prevalence remains low compared to global and developed countries. Therefore, commitments and more resources should be provided to meet the Sustainable Development Goal number 5, which emphasizes global access to contraceptive services, needed by women and couples to have the number of children they desire (Darroch and Singh, 2013). The analysis of national surveys done by Darroch and Singh (2013) of 69 poorest countries in Africa, Asia. Latin America and Caribbean showed that 76 percent of women who were in the reproductive age in 2012 were using modern contraceptives. It also illustrated that traditional methods were used by 8 percent of women in the reproductive age group. This is due to women perceiving other choices as not being available or there is lack of knowledge about contraceptive options (Darroch and Singh, 2013).

Although contraceptive use had been increasing in developing countries, the issue of the unmet need still prevails and it is a hindrance in improving mainly the sexual and reproductive health of women. According to Sedgh and Hussain (2014), 225 million married women had an unmet need of modern contraception. However, a more recent report by WHO (2018), observed that in developing countries, 214 million of women in reproductive age had an unmet need for contraception. Among the developing countries with an unmet need, Africa has the highest level with 24.2 percent, compared with Latin America that has an unmet need of 10.7 percent and the Caribbean an unmet need of 10.2 percent (WHO, 2018). The main reasons for the unmet need are growing populations and poor quality family planning services. In addition, Westoff (2012) stated that in Sub-Saharan Africa the majority of unmet need had resulted from women who wish to space their children whereas in Latin America and Asia unmet need results from women who desire to stop childbearing altogether. Countries such as Niger and Nigeria have low use of contraceptives and a low unmet need because the desired family size is still high (Sedgh et al., 2016).

Furthermore, other reasons for not using contraceptives but not wanting to be pregnant include not having sex or having it infrequently. Women feel they are not at risk of falling pregnant if

they are not sexually active, thus there is no need for using contraceptives. This was reported in a number of countries in Latin America and Asia (Sedgh et al., 2016). Also concerns about side effects and other health risks were issues raised by women who were not on contraceptives. These concerns were not influenced by cultural beliefs or practices but they were influenced by the contraceptives themselves and their own experiences with these methods. Women reported a change in bleeding patterns and being afraid that the method can make them sterile or cause other health risks (Williamson et al., 2009). Lastly, someone close to them opposes family planning which results in some women not using contraceptives, this is more prevalent in married women than unmarried (Sedgh et al., 2009).

In South Africa, international events changed the background of sexual and reproductive health in the 1990s (Department of Health (DoH), 2012). South Africa has implemented a number of policies supportive of gender equity and protecting sexual and reproductive health. South Africa was represented at a number of conferences including the Conference on Human Rights (Vienna 1993); the Convention on the Elimination of all Forms of Discrimination against Women (adopted by the United Nations General Assembly in 1993) (DoH, 2012). Contraceptive prevalence is high in South Africa compared to other African countries. Almost 58 percent of women between ages 15-49 were using contraceptives (DoH, 2017). The dominant contraceptive method used is injectable progestogen. There are two types of injectable contraception offered in SA; the two-month (NET-EN) and the three-month (DMPA) hormonal injections. As much as these two injectable constitute substantial part of contraceptive use, a study by Baumgartner et al. (2007) reported discontinuation of use by choosing to stop or by returning late for reinjection. Some health care providers refuse provision for patients if they missed their appointments (Baumgartner et al., 2007).

The South African government introduced a dual method policy since 2001, which is a combination of condom use and non-barrier method. Morroni et al. (2006) and Ngubane et al. (2008), reported low levels (10%) of dual methods amongst sexually active women. This may result from women trusting their husbands or partners and seeing themselves not at risk of contracting STIs or HIV or husband refusing to use condoms (Osuafor and Maputle, 2017). However, acceptance of condom use have gained momentum in relationships with studies suggesting more than 75% of males and females aged 15 to 24 years reporting using a method of contraception at last sex (HEAIDS, 2010: Osuafor and Maputle, 2017).

Unmet need of contraception data is limited in South Africa with 2003 SADHS showing that 14 percent of women in union has an unmet need (DoH, 2012). Provinces such as the Eastern Cape, Limpopo and Free State has higher levels of an unmet need than the national average (DoH, 2012). Statistic SA (Stats SA) (2011) reported that White and Indian/Asian women age 15-19 and 20-24 were least likely to have children compared with African and Coloured women. Culture plays a massive role in inhibiting contraceptive use, a study by Osuafor and Maputle (2017) found that IsiZulu and IsiXhosa women were less likely to use dual methods. Moreover, IsiZulu women reported low levels of non-barrier method use, this suggest that culture may influence women's choice of contraceptive method.

2.3 Knowledge of Contraceptives

Knowledge of family planning is crucial in order to initiate the usage of contraceptive methods (Khan et al., 2007). Research studies had shown knowledge of at least one contraceptive method whether modern or traditional is universal (Nsubunga et al., 2016). Nsubunga et al. (2016:2) define knowledge as "the state of awareness of contraceptive methods, any specific types and the source of contraceptives". In sub-Saharan Africa, contraceptive knowledge was mostly 85 percent (Khan et al., 2007).

In the developed countries, knowledge of modern contraceptive methods is high with less difference in knowledge by age, number of children, urban-rural residence, regular exposure to mass media, and household wealth status. In addition, in most countries in sub-Saharan Africa differentials in knowledge of any modern method are generally small, except in a few countries, such as Mali, Mauritania, and Nigeria, where overall knowledge levels are lower (Khan et al., 2017). In these countries, urban women, more-educated women, women living in wealthier households, and those regularly exposed to mass media are more likely to know of a modern contraceptive method (Khan et al., 2017).

In the 2003 South African Demographic and Health Survey (SADHS) it was indicated that 97 percent of women in South Africa who were sexually active had knowledge of at least one contraceptive method (Seutlwadi et al., 2012). According to Seutlwadi et al. (2012), given the high level of awareness of different contraceptive methods this was not a strong determinant of contraceptive use. About 92 percent of women were aware of injectable contraception, with 89 percent reporting having heard of oral contraception and 73 percent of women of female

sterilization (Cherish et al., 2017). According to Cherish et al. (2017), women aged 15-19 had lower levels of knowledge compared to older women for each contraceptive method.

As mentioned, knowledge is not a strong facilitating factor of contraceptive use. A study in the United States of America by Frost et al. (2012) found that women perceived to be knowledgeable about contraceptives were more likely to use contraceptives, however there were more like to use methods inconsistently. The reason for more knowledgeable women to be more likely to use contraceptive in United States might be a direct result of the U.S. Medical Eligibility Criteria for Contraceptive Use. This report is made to assist health care providers to refer to when counselling women, men and couples about contraceptive method choice (Curtis, 2016). A study in the United Kingdom by Bracken and Graham (2014) showed that 95 percent of women reported effectiveness as the most important factor when choosing a method of contraception.

In some African countries there is a lack of adequate information about contraception. In Ethiopia women mentioned that if they had knowledge about contraceptives before having children, they would have reduced the number of children born and they would have given birth to stronger children (Bogale et al., 2011). According to Bogale et al. (2011) this phenomena is most likely caused by low education attainment, economic status and being deeply rooted in culture.

Studies among young women in South Africa show that they have high levels of awareness about contraceptive methods. Although the majority of young women know about contraceptives only a few know how to use contraceptive methods effectively (Mudau, 2017). This indicates that some young people do not have adequate knowledge about contraceptives. A study by Mudau (2017) showed that there were a range of barriers to contraceptive use among young people including inadequate accessibility of contraception, limited parent child communication and perceived lack of support from culture and churches. Most studies in South Africa had shown that shortage of family planning services in the country and the fact that the promotion of contraception is not a priority in primary health care services could be a reason for patients lack of knowledge about a range of contraceptive options (Somera and Ross, 2013; Stephenson et al., 2010). Thus, these barriers can be addressed by giving adequate information and counselling to both men and women (Smith, 2009). Levels of awareness of contraception are lower in rural areas than urban areas. A study in rural Taung, South Africa by Kangu and

Mash (2010) showed that teenagers in the area had poor contraceptives knowledge. In the study, a pregnant 17 year old who was asked to mention contraceptive methods said she was not aware of any contraceptive method (Kangu and Mash, 2010).

Teenage pregnancy has been suggested to be caused by factors such as low socio-economic status, young women engaging in risky sexual behaviour and low education attainment. However, the study by Mchunu et al., (2012) showed that more than half of female respondents (74.1%) fell pregnant due to lack of knowledge. A study in rural KwaZulu-Natal by Ndinda et al., (2017) found that awareness of contraceptives did not match the prevention of unwanted pregnancies, suggesting knowledge does not translate into behaviour change.

Sex education is fundamental in most HIV and AIDS prevention programs and with the high levels of HIV and AIDS amongst 14-24 years old in South Africa, sex education issue should be revised (Pettifor et al., 2004). In terms of policy, Life orientation (LO) program was introduced as a subject to be taught in South African schools in the late 1990s (Department of Education, 2002). This subject focused on HIV and AIDS and sexuality (Rooth, 2005). However, more focus has been on what young people know rather than understanding the context in which decision-making takes place. According to Population Reference Bureau (2017) youth centers have not been effective in promoting sexual and reproductive health (SRH) and contraception amongst young people because they are mostly coordinated by older people. However, peer education is said to be a promising intervention as it has been promoting SRH but the intervention still needs support as it cannot be a stand-alone program (Population Reference Bureau, 2017). Mitchell et al. (2004) state that young people are not necessarily unaware about sexual related matters, but they may lack practical and social knowledge, which makes them more vulnerable to HIV and AIDS.

2.4 Availability

According to Luaria, Donati and Spinelli (2014) awareness of the availability of contraceptives and family planning services has an impact on contraceptive use. Although some young people are aware of the availability of contraceptives, inadequate information about a range of contraceptive methods still prevails (Bhattathiry and Ethirajan, 2014). A study in the United States reported in the Morbidity and Mortality Weekly Report (2011) looked at availability of different range of contraceptive methods between public clinics and office based providers

such as gynaecologists, general practitioners and pharmacists. The results of this survey indicated a distinction in the availability of specific contraceptive methods by method type and clinical setting (Morbidity and Mortality Weekly Report, 2011). The study found that public clinics offered a greater range of contraceptives methods than office based physicians. Therefore, improving contraceptive delivery by increasing availability in physicians' offices and public clinics, is more likely to increase contraceptive use.

According to Frost et al. (2015) 6.2 million women were receiving contraceptives from public clinics in the US. About 10,700 clinics in US in 2015 were providing family planning services and clinics funded by Title X program serving 3.8 million women (Frost et al., 2015) It was also estimated that 2.4 million women received Medicaid-funded contraceptive services from private doctors (Frost et al., 2015). It was stated that "without publicly funded contraceptive services, the rates of unintended pregnancies, unplanned births and abortions in the United States would have been 67% higher; the rates for teens would have been 102% higher" (Frost et al., 2015:1).

Governments in Sub-Saharan African countries showed no interest in international offers of family planning assistance in 1980s to 1990s (May, 2016). However, massive interest rose after the 2012 London summit which was co-sponsored by the Bill & Melinda Gates foundation and others donors (Tsui et al., 2017). In the summit, global and national governments were urged to commit to enabling 120 million women and girls to use contraceptives by 2020 (Tsui et al., 2017). Ghana is one of the first countries to implement a National Population Policy in 1969 which was revised in 1994 (Adjei et al., 2015) The policy aimed to provide information to individuals and making available a full range of safe and effective contraceptive methods (National Population Council, 1994). A study in Ghana by Adjei et al. (2015) reported that in private health facilities, combined oral contraceptives, emergency contraceptives and male condoms were the most available contraceptives methods. However, in public health facilities the injectable contraception was the only method available in all public hospitals and municipal clinics (Adjei et al., 2015). A range of contraceptive options are likely to influence use of contraception. A study by Creanga et al., (2011) found that among 11 African countries that was studied, Mozambique showed an increase in use of traditional contraceptive methods because of lack of availability and limited acceptance of modern contraceptives.

In South Africa, it was reported that 88 percent of public sectors offering family planning services operate five days a week (Department of Health, 2012). According to the 2012 Department of Health annual report 30.3 percent of public facilities provided dual contraceptive methods, which includes condom and hormonal contraceptive method (Department of Health, 2012). In all South African provinces, injectable progestogen is mostly used more than oral contraceptives (Baumgartner et al., 2007). About 49 percent of progestogen injectable contraceptives is used nationally and up to 90 percent in some areas (Department of Health, 2012). The study by Weinrib et al. (2017) stated the majority of women in Kisumu, Kenya and Soshanguve, South Africa indicated choosing injectable contraception to prevent pregnancy. The decision was based on familiarity of the method, low frequency use and low user burden and correct administration (Weinrib et al., 2017). However, the study by Seutlwadi et al. (2012) among South African youth (18-24 years) found that male condoms was the mostly used contraception. The reason for male condoms being mostly used was ease of getting condoms. Also, teenagers reported condoms to be the most frequently used contraceptive methods compared to other contraceptive methods (Jonas et al., 2016).

2.5 Accessibility

There has been an increase in contraceptives use among young people in the world but there are still those with limited access. Access to contraceptives has a great impact on fertility decline and have improved equality for both males and females in terms of educational, domestic and work environments (Gill and Taylor, 2017). A study that was conducted in UK found that all the women in the study had sufficient access to information they needed from their GP to make an informed decision about contraception choice (Gill and Taylor, 2017). Meaning accessing health care facilities offering family planning services and having good interpersonal relationship with health care providers is essential in facilitating contraceptive use. In the United States, sexually active young people are accessing and making use of contraceptives to prevent unplanned pregnancies, 83.5% of young people who are high school students that do not want themselves and their partners to become pregnant use contraceptive methods (Finer and Zolana, 2011).

2.5.1 Type of Residential Area

Urbanization has a direct impact on fertility behaviour and has an influence on social and economic determinants (Martine and McGranahan, 2013). According to the U.S Census Bureau (2016), in 2010, about one third of Americans were living in rural areas. Among women aged 18-49, 52.2 percent of women living in rural areas have had their first sexual intercourse at the age of sixteen compared to 41.7 percent of women living in urban areas (Daniels et al., 2018). Number of births were higher among women from rural areas than urban areas.

Previous research suggested that people residing in rural areas have low levels of contraceptive use compared to people from urban areas because of distinctive barriers. However, Daniels et al., (2018) found that both rural and urban women were using some sort of contraceptive method with the same amount not using any contraceptive method. Surprisingly, women from rural areas were more likely to use most effective methods of contraception such as contraceptive implants compared to women from urban areas who were using moderately effective methods such as oral contraceptives (Daniels et al., 2018). In addition, a study by Geske et al., (2016:38) in South Dakota, U.S showed that although rural participants encountered greater barriers in accessing contraceptives, there were no differences in their actual contraception use compared with urban students.

However, lack of accessibility to contraceptives due to distance, transportation and lack of awareness of availability of family planning services prevails in rural areas. According to Geske et al., (2016) rural participants mentioned difficulties in travelling to a hospital or clinic and also the distance required to travel to a hospital or clinic (Geske et al., 2016). Also, a study by Yarger et al., (2016) in California found that rural participants were more likely to report that they were not aware of locations where they can access family planning services compared to urban participants.

By contrast, a study in Ethiopia showed that women who resided nearby health facilities that offered a wider range of contraceptive methods had a higher odds of using contraceptives than women who resided far from health facilities (Shiferaw et al., 2017). According to Nwallanda et al. (2010) clinics without stock of contraceptives and limited choices of methods, makes it difficult to use contraceptive methods consistently. Also, high costs in rural areas were the obstacle for both young men and women making contraceptive use dependent on disposable

income. Access was further restricted by cost implications in terms of transport, and distance to health facilities (Nwallada et al., 2010).

In South Africa, modern contraceptive prevalence in urban areas was 66 percent and in rural areas was 53 percent. Stephenson, Beke and Tshibangu (2008) in their study in the Eastern Cape, South Africa found that most women who reside in urban areas were using the pill compared to the injection. They also stated that women in wealthier communities and higher income were more likely to be using the pill or permanent method such as sterilization (Stephnson et al., 2008).

2.5.2 Health Providers

Research has shown that health providers have an influence on women's choice of contraceptive methods. In countries such as Sweden and South Africa, nurses are the primary providers of contraceptive method (Skogsdal et al., 2018; Lince-Deroch et al., 2016). Therefore, health care providers have a responsibility to counsel and offer their patients information on all forms of contraception (Skogsdal et al., 2018). According to Ramirez et al. (2018: 3) health workers believe that part of the reason why adolescents rarely come to health facilities involves the absence of family networks, as well as cultural contexts far removed from the health system and its institutions. In their study, Nwallada et al. (2010) found that the influence of health care providers over women's use of contraceptive methods was high with half of women reporting getting information about contraceptive methods from the provider.

However, health care providers serve as a barrier in accessing contraceptive methods amongst young women. A study by Nwallada et al. (2010) noted that paternalistic and judgmental views by health providers issuing contraceptive, lack of privacy and confidentiality were some of the barriers facing young men and women seeking to access family planning services. It was also mentioned that health providers would report to parents or husbands if young men or women came to seek family planning services (Nwallanda et al., 2010). Fear of stigma at the health care facility drove some women to obtain contraceptives from private hospitals due to privacy and confidentiality (Nwallada et al., 2010).

According to Chilinda et al. (2014) healthcare providers generally stigmatize teenage sex and they feel uncomfortable giving contraception to teenage girls. Young people are often

influenced to not have sex when consulting with health care providers. Most health care providers feel that the availability of contraceptives in health facilities leads to early sexual debut of young people. Therefore, young people opt not to use contraceptives to avoid difficulties in obtaining contraception in health facilities (Chilinda et al., 2014). Also, clinics' opening hours and the long time spent by health providers with patients are an obstacle to young people seeking family planning services (Ramirez et al., 2017).

The lack of knowledge about a range contraceptives by health care providers causes difficulty in administering contraceptive methods. According to Sibanda and Titus (2017) health care providers lack adequate information of contraceptives including emergency contraceptives. A study in Pietermaritzburg, South Africa showed that public health care providers mentioned that emergency contraceptives could lead to high risk sexual behaviour, transmission of HIV and non-use of other forms of contraception. (Sibanda and Titus, 2017). This suggests that because of the lack of information about certain contraceptive methods amongst health care providers, misconceptions and judgmental views are created. Furthermore, misconceptions about contraceptive method can be decreased by accurate and appropriate health education on contraceptive methods (Coetzee and Ngunyulu, 2015). Coetzee and Ngunyulu (2015) stated that health education can increase the consistent use of contraceptives, and decrease the rate of unplanned pregnancies.

2.6 Reasons for Contraceptive Use

Fertility preferences are an essential measure for estimating fertility, calculating levels of unwanted and mistimed pregnancies and evaluating unmet need for contraceptives (Senott and Yeatman, 2012). Fertility preferences depend on various factors such as age, education, marital and socio-economic status. In addition, fertility preferences reacts to variations of life circumstance whereby individuals who have a preference for a certain family size may alter their fertility preferences in response to changes in economic or reproductive circumstances (Senott and Yeatman, 2012). The desire to stop childbearing is less commonly found in young people compared to older women. Women may be certain about wanting to have another child but maybe unsure when to have it, focusing on whether it is the right time or not or is she having a baby with the right partner and particularly on the number of children she plans to have over her lifetime. Therefore, parity may be low among young women who are

experiencing more economic uncertainties and relationship instability (Senott and Yeatmn, 2012).

2.6.1. Fear of Pregnancy

Unintended pregnancy is an issue of global concern and in need of serious intervention. It has remained a challenge for both developed and developing countries because of attitudes towards contraceptives (Finer and Zolna, 2011). In South Africa, between years 1990 and 2001, 53 percent of pregnancies were unplanned (Vundule et al., 2001) and in 2005, 55 to 75 percent of pregnancies were either unwanted or mistimed (Myer et al., 2007). Women who fall pregnant before enrolling in university have a higher chance of dropping out of school to take care of the baby (Antonishak and Connolly, 2014). Even though, they might continue studying while taking care of the baby, reaching educational goals becomes difficult. Therefore, opting to use contraceptives limit all these difficulties in order to secure a better future.

According to Osuafur and Maputle (2017), fear of pregnancy more than HIV/AIDS is the driving force of contraceptive use amongst young people. The reason behind the fear of pregnancy among most young people is the desire to further and finish their studies. Most young people want to obtain the appropriate educational qualifications and purse their careers (Kanku and Mash, 2010). As many studies have illustrated that educated, young people are the ones with highest percentage of contraceptive use (Dommisee, 2007; Vundue et al., 2001). However, in South African context, young people fear to be pregnant and are using them secretly in order to avoid conflict with their parents and partners. South Africa has high rates of unemployment, which is the other reason why young people fear pregnancy. They are afraid of the cost that comes with a child, leading them to use contraceptives (Kantu and Mash, 2010).

Although most young adults are not trying to become pregnant, many are not taking the necessary precautions to avoid an unintended pregnancy; hence, the levels of unintended pregnancy are still high (Kanku and Mash, 2010). The study by Manski and Kottke (2015) showed that both teenagers and adult women who were undecided about pregnancy in terms of their attitudes or motivation to avoid pregnancy had high chances of engaging in risky contraceptive practices. In other words, although young people attain contraceptives to prevent pregnancy, if they do not feel at risk of being pregnant and they do get pregnant they engage in risky practices such as illegal abortion.

2.6.2 Pregnancy Spacing

Most women get information about contraceptives from their health providers after giving birth (Henderson et al., 2016). This is when women seize the opportunity to rectify the 'mistake' by starting to use contraceptives (Henderson et al., 2017). Experience with pregnancy becomes a driving force in contraceptive uptake, and is also used to space pregnancy and permanently end childbearing.

A study in South Africa, Cape Town found that women did not intend to have a second baby and they wanted to wait at least three years to be pregnant (Crede et al., 2012). Another finding that was a concern in the current study was that although 34.5% of males and 79.1% of females reported having had unwanted pregnancies, they were not motivated to use contraceptives (Crede et al., 2012). The results of this study reflect that females and males who reported ever being pregnant or making someone pregnant were less likely to be using contraceptives (Crede et al., 2012).

According to Henderson et al. (2016:133) *"The postpartum period is a unique time in a woman's reproductive life as it provides her with the opportunity to transition from a focus on prenatal to preventive care and time to consider her own health and reproductive goals".* However, women at this stage are usually not given contraceptives that meet their needs. Women at this stage tend to focus more on the baby and forget about themselves (Henderson et al., 2016). They mostly go to health facilities for prenatal care and not for preventive care. This place them at risk of falling pregnant again, therefore, it is important for health care providers to encourage women at this stage to think about themselves and encourage contraceptive use as soon as possible (Henderson et al., 2016).

2.7 Barriers and perceived risks

2.7.1 Side effects

Side effects, especially those perceived to impair fertility, remain the leading cause of non-use of modern contraception. Myths and misconception about contraceptive methods can influence contraceptive choice. However, side effects are more influential in discontinuation of methods compared to contraceptive choice. Women tend to stop using a particular method when they observe side effects such as excessive bleeding and lack of periods. The type of method does

not matter when it comes to side effects, whatever preferred method that comes with uncomfortable side effects result in discontinuation (Alvergne et al., 2017; Maharaj and Cleland, 2006).

Reasons for discontinuation of contraceptives are different, but reviews of DHS data have demonstrated that side effects and health concerns associated with hormonal methods are major reasons for discontinuation (Ali and Cleland, 2010: Castle and Askiew, 2015). The majority of women have a strong fear of side effects due to lack of information and counselling and they feel unsure about the methods. Lack of community awareness about contraceptive methods inhibit contraceptive use, resulting in women deciding to rather not use contraceptives than to suffer with side effects. According to Muanda et al. (2017) women who were not using contraceptives because of the fear of side effects were open to use them in the future if they can obtain enough counselling and information about different methods.

One study found that the major reason for discontinuation of hormonal contraceptives is mostly side effects such as excessive bleeding that women encounter at the beginning or after using the methods (Alvergne et al., 2017). The reason excessive bleeding is perceived as a major side effect is that it could lead to death because of loss of so much blood from the body (Alvergne et al., 2017). The other fear resulted from bleeding that women experience includes dizziness, pain, skin conditions, mood swings and appetite changes. Other undesirable side effects are weight gain, lack of desire to have sex and experience in water in their body. These side effects are seen as more undesirable to male partners than females. Most studies have reported that partner opposition, mostly from a male partners, is a barrier to contraceptive use (Kanku and Mash, 2010). However, a study by Maharaj and Cleland (2006) among college students, reported a condom as the norm among young people in a sexual relationships. When comparing condoms with hormonal contraceptive, college students favoured condoms due to hormonal contraceptives side effects (Maharaj and Cleland, 2006).

2.7.2 Abstinence

Young people choose to abstain because of their religion and personal beliefs such as the belief that sex before marriage is wrong. This is mainly because the teachings of the bible condemns pre-marital sex and the husband is the only person who should see his wife naked. A study by Cooke-Jackson et al., (2015) reported that most participants reported that their religious beliefs

were significant factors influencing their decision to abstain from sex. The participants stated that they were waiting for marriage to have sex and wanting to remain pure (chaste) until marriage (Cooke-Jackson et al., 2015).

Furthermore, not having enough love and lacking desire for sex is another facilitating factor for abstinence because for some people sex is a love making process and it is difficult to make love with someone you do not love. According to Sprecher and Treger (2015), women report not having enough love as reasons to abstain. The study also compared ethnicity groups and found that, both White and Black participants chose to abstain because of personal beliefs. However, black participants also identified fear as the reason for abstinence and they were more likely to remain virgins than White participants (Sprecher and Treger, 2015). A study in the Eastern Cape, South Africa by Mda et al., (2013) mentioned that young women felt the right way to avoid pregnancy is abstinence.

2.8 Parent-Child Communication

Young people often find it hard to converse with their parents regarding sex and contraceptives. They are at a stage of their life were they are in the midst of transition from being a teenager to an adult, and this sometimes causes tension in family relationship because they want more freedom and it results in family struggles (Ogle et al., 2008). Vigoureux et al. (2018) study stated that women participants said they find it hard to discuss sex and contraception with their mothers. However, they reported that they found it even more difficult to talk to their fathers than their mothers. In addition, the study found that teenagers (15-19 years) had more difficulty in discussing contraceptives with theirs parents compared to young women (20-24 years). They often get information from their friends because they find them easier to talk to and they share similar experiences.

The transition to adolescence consists of major physical, emotional and psychological changes that makes a young person prone to various health and social problems. Therefore, parent to child communication about sexually related issues is essential at this stage. In Africa, parent to child communication is hindered by gender dynamics, religion, traditional norms and education. Females often find it easy to talk to their mothers while males find it easier to talk with their fathers about sex related issues. Mother-daughter communication is strongly influenced by the bond that tie the two together. Also, mothers feel the need to give their

daughters advice in order to have an effect on how they are raised. However, with boys, there is less discussions because they have fewer sexual and reproductive health issues than girls (Kamangu et al., 2017).

In many parts of Africa, the population is deeply rooted in their religious beliefs and religious practices. Their beliefs often contradicts the so called "earthly ways" because they believe that those ways do not come from God. Parent-child communication is compromised due to such customs and beliefs (Kamagu et al, 2017). Some religions prohibits sex before marriage, abortion and the use of contraceptives. Therefore, even if parents are aware of their child's behaviour, they are unable to discuss sex related issues that will reduce their child's risks of HIV, unwanted pregnancy or STIs rather they are supposed to teach them "Godly ways". Sometimes young people rebel against these teachings, which put themselves at more risk.

In South Africa, parental consent regarding contraceptives and sex is one of the main inhibiting factors amongst young people. South African traditional values are deeply rooted in society and sex in many cases is still a taboo topic (Chola et al., 2015). The norms inhibits parents, teachers and health facilitators to discuss sex related issues causing them to shy away from the topic and even lack courage to initiate the conversation. A study conducted by Mjwara and Maharaj (2018) stated that young women find it more easy to talk to their friends about sex related issues than their parents. It was also stated when the conversation is brought up, it is more of parents warning young women about the dangers of sexual intercourse (Mjwara and Maharaj, 2018). Furthermore, young women find that conversations with parents about sex and contraceptives tends not to be a judgment free zone but of harsh critique and embarrassing comments. They often hide their pills from their parents and this makes them forget to take them, which leads to unwanted pregnancy.

2.9 Partner Communication

Partner agreement as the inhibiting factor for contraceptive use depends mostly on different age groups and the nature of relationships (single or married). According to Manlove et al. (2012), in relationships where the male partner is older, contraceptives are less likely to be utilized. However, duration of the relationship does not cause the decline in contraceptive use but it leans more towards hormonal methods because contracting STDs is not an issue but preventing pregnancy is the priority (Manlove et al., 2012).

African countries are faced with child marriages, child labour and young women dating older men in order to reduce poverty. Child marriage is defined as a marriage or cohabitation before the age of 18 (Masikwa et al., 2015). The husband and his family often expects the wife to bear children soon after the wedding. African countries such as Mozambique, Burkina Faso and Malawi are reported to have high levels of child marriages (Masikwa et al., 2015). These marriages are accompanied by high levels of adolescent pregnancy, with young women giving birth to their first child before the age of 20 (Masikwa et al., 2015). This indicates low levels of contraceptive use among child marriages and these children not given a chance to have a say about their childbearing desires. Husbands and their families are often the key decision makers about fertility.

In Angola, one study found that partners played a supportive role in contraceptive use (Prata et al., 2015). In some relationships, partners were the source of information regarding contraceptives and it was easy to talk to their partners about contraceptives. The study in Southern Ethiopia stated that about 81% of contraceptive users reported joint spousal decision making (by both husband and wife) on issues related to contraceptive use (Turolo et al., 2006). Women who reported talking with a partner about contraceptives were more likely to intend to use contraceptives. However, if a woman is married or living with a partner, she would be less likely to intend to use contraceptives the next time she has sexual intercourse (Turolo et al., 2006).

Research studies have shown young women dating older men or multiple partners as a common trend. Young women in relationship with older men are not given liberty to negotiate safer sex and become exposed to violence if conversation about condom is brought up (Dellar et al., 2015). A survey in South Africa by Jonas et al. (2016) reported that during the three survey years, almost 9.5%, consistently reported that they had been forced to have sex. However, a study among students in Zambia by Nshindano and Maharaj (2008) found that young people felt there was nothing wrong with having multiple partners as long as it was beneficial. Young women from poor background saw dating multiple partners as a means of surviving and changing this behavior will lead them back into poverty (Nsindano and Maharaj, 2008). Young women date older men to access items such as money, airtime, gifts and clothes (Mda, Mahony, Yogeswaran and Wright, 2013). However, these relationships are associated with sexual coercion as the male partner is much older than the girl and more like to oppose contraceptive

use. Also, a study in Kwa-Zulu Natal, South Africa by Chimbidi et al. (2010) showed that having an older partner significantly reduced the likelihood of using condoms compared to those whose partners were the same age.

Furthermore, the payment of lobola (bride price) is another factor, which hinders the use of contraceptives amongst married women. Therefore men tend to think, because they have paid lobola they own the women and their bodies. Women getting into marriages is associated with childbearing, meaning because they are married they should just bear babies (Muanda et al., 2017). This is without considering the women's desired number of children and spacing, of which family planning gives them a chance to do so. Cultural attitudes could influence her husband to believe that it is his wife's duty to bear children or that only promiscuous women use contraceptives (Muanda et al, 2017). Furthermore, lack of information by men on contraceptives results in many refusing their partner to get contraceptives. For men without knowledge, stigma is the driving force inhibiting women to get contraceptives and make decisions about her sexual and reproductive health.

2.10 Summary

This chapter has provided the literature on obstacles faced by young women in accessing contraceptives. It also provided literature on reasons for using contraceptives. The literature has shown that although contraceptive uptake has increased by providing free contraceptives, low uptake and discontinuation of contraceptive method is a major concern globally. It is evident that various factors contribute to low uptake of contraceptives among young women, including knowledge, accessibility and availability of range of contraceptive methods.

CHAPTER THREE

RESEARCH METHODOLOGY

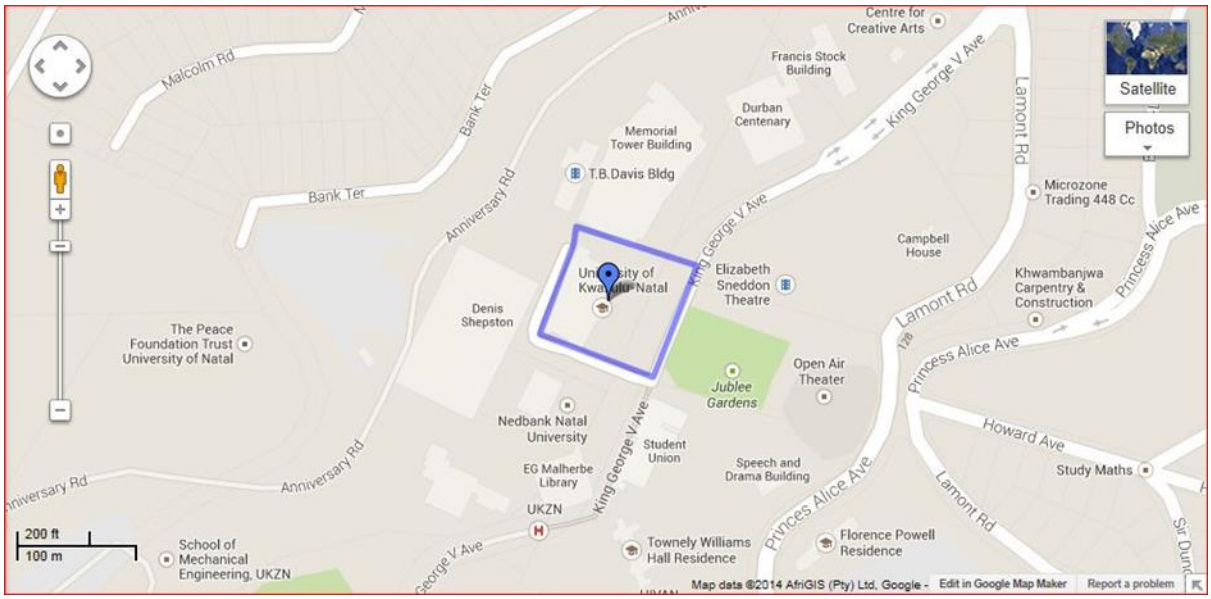
3.1 Introduction

This chapter outlines the research methodology that was used in conducting the study about facilitators and inhibitors of contraceptive use amongst White students. This study employed the qualitative research approach using semi-structured interviews. Qualitative research was used because as Cobbin and Strauss (2008) argue it allows for an understanding of the point of view of individuals that are interviewed. This chapter outlines the research methodology, the process of data collection and analysis. There is little research about White population's attitude towards contraceptive use and for this reason they were selected for the study.

3.2 Study area

Figure 3.1 Map of City of Durban, Kwa-Zulu Natal

Figure 3.2 Map of University of Kwa-Zulu Natal



The study was conducted at the University of KwaZulu-Natal (UKZN). Howard College in Durban, South Africa. Durban is the largest city in KwaZulu-Natal and third largest city in the country with population of 3, 5 million people. Prior to the arrival of the Nguni people and subsequent European colonialist, the area was populated by the natives of Southern Africa commonly referred to as the Khoi or San (Magwaza, 2011). The city is dominated by 73 percent black Africans, with Coloureds being the minority constituting three percent and Whites constituting 6.6 percent (Stats SA, 2013). The University of KwaZulu-Natal was formed on 1 January 2004 as a result of the merger between the University of Durban-Westville and the University of Natal. The two KwaZulu-Natal universities were among the first batch of South African institutions to merge in 2004 in accordance with the government's higher educational restructuring plans that will eventually see the number of higher educational institutions in South Africa reduced from 36 to 21. Confirmed by a Cabinet decision in December 2002, the mergers are the culmination of a wide-ranging of consultative processes on the restructuring of the Higher Education Sector that began in the early 1990s. UKZN has mostly black students (96%) with a total of 46 539 students enrolled in 2016 (UKZN Annual Report, 2016). Howard College was chosen as the area of the study because it has more White students than other campuses (UKZN annual report, 2016). Howard College was extended from Natal University College in Pietermaritzburg, which was also known as University of Natal. Howard College was opened in 1931, following a donation by Mr T B Davis. Howard College is situated in

King George V Avenue, Glenwood. The study focused on female White students aged 18 to 25 years with most respondents being only undergraduate students.

3.3 Research Methodology

The study used the qualitative research methods. The qualitative research approach gives a researcher an understanding of experiences from people's own point of view (Cobbin and Strauss, 2008). Qualitative research is primarily exploratory research. It is subjective research, thus allowing for the interaction between researcher and the subjects of the study. This interaction occurs through interviews and focus group discussions. The outcome of interviews helps the researcher to gain an understanding and in depth views about the topic of interest (Marshall, 1996). Qualitative studies aim to provide illumination and understanding of complex psychosocial issues and are most useful for answering humanistic 'why' and 'how' questions (Marshall, 1996). The aim of the qualitative researcher is to gather understanding on certain human behaviours in order to find why people behave in the particular way and the consequences of the behaviour (Oun and Bach, 2014). Therefore, qualitative methods are seen as appropriate for the purposes of this study to shed insight into contraceptive use among White young female. The advantage of qualitative research is that it allows a researcher to explore a topic in depth (Carlsen and Glenton 2011).

Qualitative research methods has been criticized for the use of a non–random, small sample size (Vanderstoep and Johnson, 2008). Therefore, findings may not be generalized to the larger population from which the sample was drawn (Vanderstoep and Johnson, 2008). According to Silverman (2010) qualitative research methods are more likely to leave out contextual sensitivities and focus more on meanings and experiences. This is one of the reasons of this study to use the qualitative method- the ability of the qualitative method to give meaning and experiences of people.

The focus of this study was to understand factors facilitating and inhibiting contraceptive use among young White students. This study used the qualitative methodology to understand factors facilitating and inhibiting contraceptive use among young White students. Qualitative research methods has an advantage of providing a depth of understanding of knowledge (Tewksbury, 2009). It also produces the detailed descriptions of participant's feelings and

experiences and interprets meanings of their actions (Denzin, 1989). For the purpose of this study 10 semi- structured interviews were administered.

3.4 Sample selection

According to Teilijingen (2014) semi- structured interviews entails prearranged questions, which can be changed based on what the interviewer sees appropriate. Interview based qualitative studies allows researcher and participants to interact which entails verbal fluency, clarification and analytical abilities in order to gather in-depth information (Cleary et al., 2014). Participants were firstly asked about their age to ensure that they fit the criteria of the sample. The participants were ask if they using any contraceptive method and reasons for using and not using were asked. The study used snowballing and purposive sampling, which is a non-random sampling. Snowballing is used when a researcher has difficulties in finding the appropriate members for the study. This procedure is implemented by collecting data on members referred by participants who had been in the study. Snowballing refers to the process of accumulation as each located subject suggests other subjects (Etikan et al., 2016). Purposive sampling is based on the researcher's judgment and the purpose of the study (Babbie and Mouton, 2001). Therefore, purposive sampling was applied by selecting members with specific criteria that was suitable for the subject of the study. In order to be eligible for the study they had to aged 18 to 25 years, female and White. In addition, they had to be registered students at the University of KwaZulu-Natal.

In this study, students between the ages 18-25 were selected. However, before signing the informed consent form, students were ask their age to see if they qualify to participate or not. The study used semi-structured interviews; this created an environment where participants communicated new information and ideas, which was enlightening and allowed for a deeper understanding of their contraceptive use behaviour by the researcher. South Africa is facing high levels of unwanted pregnancy and HIV amongst young people ages 18-25 (Panday et al., 2009). Therefore, students were selected for the study as they are mostly to represent the population facing these challenges and university students are in a better position to make informed decisions given their higher levels of education.

The selected areas were student parking, lecture rooms and the library. The sample size for semi-structured interviews was 10. Female students who appeared to meet the racial criteria

were approached, informed about the study and asked if they would to be willing to participate in the study. Although some of the students thought the study was only about contraceptives use the researcher explained that it was not the case but both sides needed to be explored. Even though the sample size is small but it does provide insights into the contraceptive behaviour of young White women.

3.5 Data Collection

The researcher directly approached female White students who were willing to participate after explaining the topic and purpose of the study. The researcher collected data herself by asking if people were willing to be interviewed. Each interview lasted not more than 30 minutes. The students were selected from student parking, lecture venues and the library where there majority of White students could be found at the university.

This study was conducted using semi-structured interviews, with 10 participants who agreed to have a one on one discussion. According to Teilijingen (2014) semi- structured interviews entails prearranged questions, which can be changed based on what the interviewer sees as appropriate. In addition, the questions can also be changed for clarity and to give explanations and inappropriate questions can be omitted and include additional ones (Teilijingen, 2014). The interviews were recorded digitally and lasted on average 20 minutes. Participants who took less minutes to finish were more likely to be non-users of contraceptives because they felt they had nothing much to contribute toward the study. Even though it was explained that the study wanted to explore both sides of users and non-users but some still felt they had nothing to contribute. Some students refused to participate in the study because they were not on contraceptives and some scheduled a time and day for the interview but never showed up.
Furthermore, the researcher prepared questions and participants answered all questions and gave clarity on issues not understood by the women. The advantage of qualitative research is that it allows a researcher to explore a topic in depth (Carlsen and Glenton, 2011). Interview based qualitative studies allows the researcher and participants to interact which entails verbal fluency, clarification and analytical abilities in order to gather in-depth information (Cleary et al., 2014).

After every interview, the information was transcribed in order to prepare for the next interview and rectify the mistakes to do better in the following interview. Transcribing after every

interview is vital for a researcher to reflect; the reflective researcher is required to be self-aware in order to create a dynamic process of conversing between the researcher and participants (Etherington, 2013).

Although the sample size was small, interviewees gave adequate information because they were knowledgeable about the subject of the topic. As Cleary et al. (2014:473) stated, *"an experienced interviewer, with a clearly defined research topic, and a small number of well-selected homogeneous interviewees (with adequate exposure to or experience of the phenomenon) can produce highly relevant information for analysis".* In addition, most participants had similar responses whether there were non- users or users of contraceptives. According to Chowhurry (2014), a researcher needs to reach a point of saturation for sample size and that point is reached when participants have similar responses.

The interview guide had seventeen questions, which were organized in terms of the objectives of the study. The interview guide was separated into sections but the structure of the guide is constructed in such a way to answer certain objectives. The first two questions ask about the demographics of the participants. The following set of questions ask about usage of contraceptive in order to get factors facilitating and inhibiting contraceptive use. It continues to interrogate the communication between parents and partners to find out about the relationship between them and participants. The last set of questions interrogate knowledge and accessibility to see if it is adequate and with their reach.

3.6 Data Analysis

Data obtained from semi-structured interview was analyzed using thematic analysis, which is a qualitative descriptive design. Thematic analysis is a qualitative technique used to analyze textual data and organise the data into themes (Forman et al., 2008). It is also described as a coding process and involves examining meaning and providing descriptions of social reality in order to create themes (Zhang and Wildemuth, 2009). According to Vaismoradi et al. (2016), a theme is a level that is more implicit and abstract and requires interpretation.

In this study, the researcher read the transcriptions and highlighted components that were meaningful and important to address the objectives. The components were coded in order to abstract important data conveyed by participants. The researcher organized codes and

compared them in order to find similarities and differences to allocate codes in relation to the research questions. Furthermore, themes were formulated and discussed in comparison with literature in order to get insights about the attitudes of female White students towards contraception.

3.7 Ethical considerations

This study is sensitive because it deals with a personal issue. However, due to the one on one interview setting at the discussion room in Malherbe Library participants views are protected and their wellbeing secured. Participation in the study was voluntary and only women who agreed to participate were interviewed. The researcher informed participants that they could withdraw from the study at any point and not answer the question they felt uncomfortable answering. Fortunately, the participants answered all the questions and gave thorough information and they did not withdraw from the study. However, participants who were not on contraceptives gave less information as they felt the study was not about them.

Informed consent forms were printed and administered to participants. The informed consent form consisted of the researcher's name and contact details, research topic and declaration form. Rose (2017) refers to informed consent as a voluntary agreement to participate in research. It is not simply a form that just need to be signed but a process, in which the subject has an understanding of the research and its risk. Therefore, the research and participant signed the consent form before commencing with the interview. This was to ensure that the participant was willing to take part in the study and was not forced. In order to protect the participant's identity, there were asked to not write their names or any form of identification on the form.

Ethical approval is vital when conducting a study because it ensures that participants are treated with respect and they are not at risk. The researcher applied for ethical approval and the University of KwaZulu-Natal granted the approval. The researcher also formally requested for the permission to interview students in Howard College. The gatekeepers' letter was granted by University of KwaZulu-Natal Registrar's office.

The signed consent forms were stored in the supervisor's office for safekeeping. However, the interview recording were transferred from the researcher's cellphone to the USB that is kept

safe in supervisor's research assistant's office. The results of the study will be published in the form of a dissertation and any form of identification will not be included on this document.

3.8 Reliability and Validity

According to Neuman (2014), validity means truthfulness. Validity seeks to find authenticity that realizes a single version of truth. "Authenticity means offering fair, honest and balanced account of social life from the viewpoint of the people who live it every day" (Neuman, 2014:214). This study ensured validity by asking questions in different way, so as to see if the previous answers corresponded with the new answers. The study wants to shed insights into the attitudes of White female students towards contraceptives, therefore asking the same questions in different ways that ensures validity.

According to Neuman (2014) reliability means dependability or consistency. The problem with reliability is that researchers often study processes that are unstable over time. This makes it difficult for a study to be dependable. However, this study used purposive sampling for selection of participants. The researcher closely followed the research guide to ask questions and excluded questions that might have resulted in biases.

3.9 Limitations of this study

Finding participants especially female, White students was difficult because they are a minority of White students at Howard College and there are international exchange White students. Some participants agreed to participate, scheduled the time and day for the interview but never showed up and ignored telephone calls. There is inadequate research done on contraceptive use amongst White population especial female, White students. Most research focus on contraceptive statistics among Whites but not on factors facilitating and inhibiting contraceptive use. Moreover, the study has a small sample size, which is not a true representation of UKZN White population. The sample was selected from one of the many campuses (Howard College) in UKZN. Furthermore, participants did not use any form of writing because interviews were recorded on the researcher's cellphone. However, some participants discussed their views before and after interviews, views that they did not want to be recorded.

3.10 Summary

In this chapter, an overview of methods used to collect data for this study was provided. Qualitative research methods was employed in this study and deemed suitable for understating factors facilitating and inhibiting contraceptive use among female White students. Ethical considerations of this study was explained and the importance of protecting participant's identity was highlighted. This chapter gave characteristics of the sample and how it was selected and limitations of the study were stated.

CHAPTER FOUR

RESULTS

4.1 Introduction

The aim of this chapter is to assess the attitudes of young, White students towards contraceptive use. This chapter firstly examines the socio-demographic characteristics of the sample and thereafter considers the relevant themes that have emerged from the analysis. These include awareness of contraceptives, sources of information, contraceptive use as well. Accessibility and availability of contraception amongst the study population were explored as well as the nature of communication with parents and partners. This chapter also examines the facilitators and inhibitors of contraceptives amongst female White students.

4.2 Sample Characteristics

Table 4.1 summarises the characteristics of the study population. The participants in this study were students aged between 18 and 25 years, with a mean age of 21.7 years. The study sample was limited to White female participants. Some students were currently in a relationship and some were not, with only one student who was married. The majority of students were using contraceptives and they started using at the age of 18 years. The most commonly used method of contraceptive was the pill, followed by both the pill and condoms and one said they were using condoms only and one said they were using the intrauterine device. This shows that White female student were knowledgeable about a range of contraceptive methods.

Table 4.1: Characteristics of the Sample

Interviews	Pseudonyms	Age During the Interview	Age for Starting Contraceptives	Marital Status	Contraceptive usage	Type of Contraceptive used
1.	Marie	21	20	Single	Yes	Pill
2.	Hope	20	None	Single	No	None
3.	Kim	21	18	Single	Yes	Pill and Condom
4.	Eve	25	17	Single	Yes	Pill
5.	Ciara	25	20	Married	Yes	Pill
6.	Christina	23	22	Single	No	None
7.	Chloe	20	17	Single	No	None
8.	Selena	22	18	Single	Yes	Condoms
9.	Samantha	20	15	Single	Yes	Pill and Condom
10.	Emily	20	17	Single	Yes	IUD

4.3 Contraception awareness

Awareness plays a vital role in motivating girls to adopt a method of family planning (Anjum, Durgawale and Shinde, 2014). It is evident that all White female students who were part of the study have heard about contraceptives. This indicates that there is a high level of awareness of contraceptives amongst the study population. Students expressed that the information that they attained about contraceptives was from various sources however most of the information that they had received came from healthcare providers.

> *"I have gone to the doctor and he informed me about the different contraceptives and which one to choose" (Marie, 20)*

> *"I went to the doctor, the general practitioner (GP), he first told me how contraceptives can be used for different things besides family planning. He then recommended the pill which was going to help with my acne." (Eve, 25)*

"I spoke to my doctor about issues I was having regarding my menstrual cycle and he informed me about various contraceptives which can regulate my periods" (Ciara, 25)

Females were given information about the health benefits of using contraceptives when they first started taking contraceptives. Health benefits such as regulating the menstrual cycle and treating acne were the more common reasons for initial usage. As respondents got into relationships they later became more aware of the contraceptive benefits of these methods. They became aware that they also can be used as a method either to prevent pregnancy or infectious diseases.

"I actually didn't think about going on the pill. My mom suggested I use it because it will help me with my period cramps. But now because I have a boyfriend I use it to prevent pregnancy and we also use condoms for STI's and stuff like that. (Samantha, 20)

"I went to see a doctor regarding my skin problem. He prescribed some medication for me and suggested I add some contraception pill in my treatment but I didn't like the side effects so I stopped. My boyfriend was not happy that I stopped as it was helping to prevent pregnancy but we just decided to abstain" (Christina, 23)

Even respondents who were not using contraceptives at the time of the study were aware about contraceptives and their benefits. Peers are an important source of information about the contraceptive benefits of these methods. Some of the women reported that they were informed about contraceptives by their friends. Family members, particularly other females were also another important source of information of contraceptives.

"I've never used contraceptives before but I've discussed it with my friends and my sister. It was fine they told me their point of view of using contraceptives. They told me if they were or they were not on contraceptives. Also, they give me information if ever I would want to go on contraceptives" (Hope, 20).

4.4 Sources of Information

There is a variety of sources of information that respondents identified during the interviews. Clinic providers, friends and the media are the most trusted sources of contraceptive information, consistent with other studies (Howard et al., 2008; Omo-Aghoja et al., 2009; Alege et al., 2016). The majority of respondents reported that their doctor was their main source of information about these methods. When they needed information they approached their doctor who did an assessment of their situation and then recommended the most suitable method for them.

> *"I got the information about contraceptives from my practitioner. He is the family doctor, I've been consulting him since I was a child. But he recommended a gynaecologist for me to insert my IUD. His secretary booked me an appointment and I went to consult with the gynaecologist" (Emily, 20)*

> *"The doctor told me about different contraceptives and then decided which pill I was going to use by looking in her book for symptoms and why you should or shouldn't use it. She choose it according to me as a person" (Kim, 21)*

A number of respondents also reported their friends as an important source of information. Other women also received information from their family members including their older sisters or mother. Information attained from the young women suggests that the information conveyed from friends is more detailed than information from their mothers. While their mothers provided them with information about contraception they mostly concentrate on the health benefits such as the role of contraception in preventing acne. Their sisters were more helpful because they also referred them to a medical practitioner.

> *"I heard my friends and my sister they were on birth control and they told me about it. They told me the reasons why they were using it and why they choose a particular method. They even told me how some were affecting their relationships because of mood swings and low libido" (Chloe, 20).*

"Yes I had a conversation with my friends. It is easier talking to them, they give you different perspectives because some had more experiences with contraceptives. My sister even took me to consult with the doctor". (Selena, 22).

School was also mentioned as a source of information for contraceptives, specifically the Life Orientation programme. School gave them information about a range of methods that will allow them to make an informed choice. However, they felt that if they need more information they had to research it on their own.

"It was also taught at school through Life Orientation class. Our Life Orientation teacher did inform us about different contraceptive methods, although she didn't mention much about side effects" (Selena, 22)

"We learned about it at school with the sex education program and they teach about different kinds and you can research more on your own for one that you interested in. I think they teach the bases of it and one can get more information from other sources" (Chloe, 20)

4.5 Accessibility and Availability of contraception

The accessibility and availability of various methods of contraception are considered to be one of the approaches that can improve maternal health as this will reduce the rate of unplanned pregnancies (Beksinska et al., 2013). It is evident that all respondents had access to contraceptives and these were available if intended for usage. All respondents who were using and discontinued using contraceptives did not report having a problem in accessing contraception. They reported obtaining their contraceptives from private health facilities mainly pharmacies.

"I normally get my contraceptive pills from Dischem or at Clicks pharmacy, it is not a hustle to get them, I just produce the prescription and they give it to me" (Eve, 25)

"My mom is the one who gets it for me monthly from Dischem. She just goes there with my prescription and get them for me". (Kim, 21)

"I used to get them from the Chemist whenever I needed to get more". (Christina, 23).

Some respondents mentioned that in order to get contraceptives from the pharmacy the doctor needs to issue a prescription. Even though they had to present a prescription at the pharmacy to obtain their contraceptives, respondents did not indicate that as hindrance in accessing contraception.

"I usually go to the doctor twice a year. She gives me a 6 month prescription for half of each year, in order to go to the pharmacy and be able to get my contraceptives pills". (Ciara, 20).

"I got the script from St Augustine hospital but I collect my pills in the pharmacy in Queensburg every month" (Samantha, 20).

One respondent said her mother is the one who gets her contraception from the pharmacy, which shows the transparency that exists between mothers and their daughters concerning contraceptives. In addition, it indicates the supportive role that the mother plays in assisting her to use her contraceptives.

"My mom is the one who collects my contraception pills every month from Dischem pharmacy. It helps me because sometimes I forget to take them every day let alone going to get them at the pharmacy. I really appreciate that from her" (Kim, 21)

Medical aid played a vital role in the easy accessibility of contraceptives. Respondents indicated that they had medical aid cover which enabled them to get direct and easy access to contraceptives without any difficulty. One respondent indicated that her hospital plan covered her contraceptives. This respondent mentioned that she was fortunate that the hospital plan covered the certain pill she was using as the plan does not cover every pill.

"My parents had me on medical aid before I got married so I was using my parents' medical aid to get my contraceptive pill. But now, since I am married, I am using my husband's medical aid to collect my pills." (Ciara, 25)

"I told my parents I was in pain and I need to see the doctor and they took me to the doctor for consultation. Because I am on medical aid and my doctor recommended it, it easy for me to get my prescription and go get them at the pharmacy" (Samantha, 20)

"I am not on medical aid but I am on a hospital plan. When I first went on the pill it was not covered, so we were paying for it with cash. Recently, it went on my hospital plan, now my hospital plan covers that pill." (Kim, 21)

Although access and availability of contraception may act as a barrier to contraceptive use this was not a problem among the sample of women. The cost of contraceptives may prevent women from using a method and directly contribute to pregnancy as was highlighted by one of the respondents.

"Obviously, financially I understand people can't always afford it but if you can afford it or you are at risk of anything or do not want to fall pregnant, you should always use contraceptives."(Kim, 21)

The researcher asked participants how much they were paying for contraception, especially for those who were not on medical aid or hospital plan. From this it was clear that the prices of contraceptives ranged between R150 and R200. This would make contraceptives out of reach for women living below the poverty line and they wanted to use contraception. However, respondent did not identify such amount as the problem and hindrance in accessing contraceptive. Cost was not obstacle for these women as they were able to afford paying for the contraceptive needs. In South Africa most women obtain their contraceptive supplies for free from public health facilities but these women obtained them at a cost from private health facilities. Again, what is clear is the importance of parents in facilitating access to contraception for these young women.

"I think the contraceptive pill is about R170- R180 and that is one packet to buy every month" (Eve, 25)

"The contraceptive pill costs between R150-R200 I don't know the exact amount because my parents are the ones who buys them for me." (Christina, 23)

4.6 Parents Communication about Contraception

Communication plays a vital role in the sharing of knowledge between individuals. Open positive parent- child communication on sexual and reproductive health issues has many high quality outcomes for children, families and the society at large (Kamangu et al., 2017). The majority of respondents from this study reported having open communication with their parents. This enabled participants to openly discuss matters related to contraceptive use. These young women mentioned that their parents knew there were using contraceptives and they were even assisting in collecting them from the pharmacy for their use.

> *"My parents knew I was on birth control. I just told them that I was on birth control and they didn't say much because my mother was on birth control when she was my age and she was having premarital sex". (Chloe, 20)*

> *"My mom is the type of person who will let you do what you want as long as you are not an idiot about it. So she is perfectly fine that I'm having premarital sex, as long as I'm safe. She was very supportive that I was going on a birth control again." (Emily, 20).*

> *"My parents are really open about contraceptives and sexual intercourse stuff. It is not necessarily that I need to be concerned as I said I'm not sexually active. I'm sure my parents would be very open to any discussion with regards to using it to prevent pregnancy and infectious disease once I become sexually active." (Marie, 21)*

Although most of the respondents mentioned that their parents knew there were using contraceptives, but most of them did not approve of its use for preventing pregnancy. There was limited communication about the contraceptive benefits about these methods. The women described that the discussion with their parents was not comfortable. A few of the women even stated that the discussion was somewhat awkward.

> *"We've never really had a sex talk. It always a bit awkward because my parents act as if it doesn't exist but I said to my mom I am in serious pain so I need to use the contraceptive pill. She was on the pill when she was my age for her period cramps it runs in my family. So it was mainly about the cramps in the beginning it was not for*

contraception. But now that I'm old it's different, but we still don't talk about it." (Samantha, 20).

"My mom is happy for me to go on it. But she said it's not an excuse to do anything. So that was an interesting conversation. It was even awkward when she said it in front of my boyfriend. I said don't mommy there is nothing to worry about. My dad, I think I just mentioned it to him. I was like "dad, I am going on a pill because of my periods and he was like ok". My mom was happier that it was to help me out" (Christina, 23).

However, two respondent reported not having communication about either contraceptives or sex with their parents. One of the respondent's response when ask about the communication between her and parents, indicated that she was only living with her father. In the interviews it became clear that many of the women had discussed contraceptives with their mother but not their father. This suggests that communication about either sex or contraception is not prevalent between daughters and fathers due to gender differences.

"I don't talk to my dad about contraceptives. It's a touchy subject. I won't talk to him that's why I'll go to my sister" (Hope, 20).

One woman mentioned that sex is a culturally taboo subject in her family. She could not talk to her parents about sexually related issue. There was the understanding in her household that she will be taught about this topic at school. She did not have an open relationship with her parents and was not comfortable engaging in a serious discussion about sex with them.

"My parents are Afrikaans, very strict. So if they knew that I'm having sex I'll be in trouble. Even though I'm 22. I don't really talk to them, we will have jokes now and then but I don't talk to them. I don't remember my mom sitting me down and be like "this is the birds and bees". I think they always assumed that the school will teach us. It comes up in conversations, but they are never like this is what you have to do and this is what you don't do. They assume we knew everything. I think it's because they come from an Afrikaans family. Again it is a taboo topic, you don't talk about those things because you have to admit that you are doing it. So talking about it is like admitting that you doing it. So you can't have open conversations about it". (Selena, 22)

Communication between parents and their children on sexual and reproductive health can be limited by gender (Kamagu, John and Sylvester, 2017). Whereby, parents discuss sexual related matters with children of the same sex (mothers communicate more with the girl child and fathers communicating more with the boy child). However, parents tend to feel shy about these conversations and this makes it difficult to openly talk to their children (Kamagu et al., 2007). The majority of respondents indicated that they felt more comfortable discussing sexually related matters with their mothers.

> *"It is easy to talk to my mom about sexual and reproductive health stuff because she is the woman. But I was always aware that my mom tells my dad everything, so by talking to her I always knew he will know anyway. It was always easy to talk to her and let her tell my dad rather than me telling my dad because you are daddy's little girl, you can't have those conversations." (Emily, 20).*

> *"I talk to my mom about sexually related matters because she understands it more. She is the one who even suggested I go on the pill because of my skin problem. My mom is the one who speaks to my dad about some of the things we discuss with her, but not everything. She spoke to him about me going on the pill. She just said I need to go to the pill and he said why, mom said because of her periods and he said OK, I don't need to hear more" (Samantha, 20).*

In opposition to the finding that the girl child finds it easier to talk to their mothers than fathers, one respondent mentioned that she found communicating with her father easier than communicating with the mother. This respondent perceived her mother as more strict and authoritarian while her father was less of disciplinarian and more compassionate.

> *"My parents are fine talking about sexual related matters and contraceptives. I'd probably tell my mom because she is more around at the house. I do usually talk to my dad about these issues because my mom is the strict one. So, I talk to my dad and then when I've talked to him about whatever I'm going through and I feel better than I can go talk to my mom". (Marie, 21).*

4.7 Partner Communication

A partner can play a role in aiding the successful use of contraception by way of encouraging meaningful conversation about safer intercourse and providing assistance in using contraceptive methods consistently and correctly (Widman et al., 2014; Amialchuk and Gerhrddinger, 2015 and Hall et al., 2012). Greater communication about sex with sexual or romantic partners has been associated with higher levels of contraceptive use among couples (Widman, et al., 2014). Most respondents who were in a relationship at the time of the study reported open communication with their partners about contraception.

One woman mentioned that her partner was particularly concerned about preventing pregnancy and therefore he was very careful about making sure all the necessary precautions were taken. She felt that she was less worried about the risk of pregnancy than he was but it was also because he was of another religious group from her.

> *"Bare open. He comes from…. He's Muslim and Pakistan. He comes from a different background. To him his parents don't know he's active. So he is very paranoid about anything happening. He wasn't a fan either that we were only using condoms for a long time, he wanted something else. We did have like one or two instances where the condom broke, he was even the one who went and got me an emergency contraceptive. He could freak out about it and I would be a lot calmer. He wanted to know everything that was going on always" (Emily, 20)*

> *"We are very open talking about contraception and anything related to our sex life. Like I said, we are careful with things like that. Like I said I'm not ready to fall pregnant but it's not just the pregnant factor, it is also HIV and STDs. "We talk about it openly like I am with my family."(Kim, 21).*

One respondent also mention how having similar beliefs and being of similar religion enforce communication and decision making.

> *"He is the same. We have the same religious beliefs. We are the same. We have the same like goals in terms of sex and marriage. It easier when you are on the same page*

because if you all have different beliefs it would be a little bit awkward. So it helps that we are on a same page". (Christina, 23)

In addition, one respondent who was not in a relationship at the time of the study mentioned that when she was still in relationship, communication with the partner was open and contraception was used consistently. In times when the contraception was not used correctly, dual protection was used. The respondent also mentioned that communication whether she was on contraception or not, with casual partners was not consistent and that was accompanied with no contraceptive use. However, in cases where communication occurred the natural contraception method would be used.

"I used to have a boyfriend but I broke up with him about a year ago. I have seen other people but it wasn't something super serious. I sometimes have one night stands, I don't tell them that I don't use any contraceptive method. Usually, they just assume I'm on the pill. Most guys just assumes that one is on some sort of contraception. Even my male friends have told me that they assume their partners are on contraception, therefore they don't use condoms either. Some of the guys I slept with had asked if I was on the pill and I told them I was not but we still didn't use condoms, we just pull out. When I was still with my ex-boyfriend, for two and half years, I was on the pill the whole time. In times when I used it wrong I would tell him about it and we would use a condom, we were super safe all the time. He got tested because we broke up for little bit in the middle and I asked him to get tested, I also got tested because I was on the pill." (Chloe, 20).

For some women there was a greater concern about the risk of HIV/AIDS rather than pregnancy. This was especially the case for women who did not have a stable partner.

4.8 Attitudes to Contraception

Attitudes toward family planning can influence contraceptive use. These attitudes are shaped on the basis of an individual's perception of the dangers of pregnancy, which may be influenced by peers and relationship dynamics (Naidoo, 2005). They can also be shaped by health benefits as was clear from the interviews. The majority of respondents in this study have shown positive attitude towards contraceptive both for contraception and non- contraception use. Some

respondents mentioned how contraceptives assist in regulating their periods, their moodiness and helps clear acne prone skin.

> *"It can help with your menstrual cycle to make it regular can cause some suffering from heavy periods, so it makes it regular, that's what my sister went on it for and also the skin. It balances your hormones as well. There's also a contraceptive part as well. Overall I think contraceptives are good because having a child is big deal". (Eve, 25).*

> *"The one thing that I've seen with the pill is that it is nice to control a person's mood a little bit. Also, the pill helps with regulating the menstrual cycle especially if you are the person who does not have a set date of periods and also bleeds for longer days. The pill is nice on those individuals because one can have period on a set time and it not long; it is very short."(Marie, 21).*

> *"Hormonal contraceptives helps when you have problem with your skin either it is dark or have uncontrollable acne. It can help clear it up and maintains breakouts. A person using hormonal contraceptives for skin can only breakout when they are on periods which is normal for girls. It also helps with making boobs bigger even if you are not pregnant" (Chloe, 20).*

The respondents in this study emphasized the importance of using contraceptives in preventing pregnancy. The women mentioned the benefits of contraceptives in preventing pregnancy. Respondents mentioned that having a child while in school is not a good reason as it is likely to lead to financially instability. It can force a woman to drop out of school and then she would have to look for a job to support herself. Contraceptive methods also prevent against sexually transmitted diseases (including HIV/AIDS). Preventing infectious disease is very important and some respondent mentioned the importance of using dual methods of contraception. Some methods are not as effective in preventing pregnancy so it is important to use dual methods to be completely safe against the risk of pregnancy and STIs.

> *"Using contraception prevents a person from falling pregnant and not catching infections. So everybody is on the safe side. I think even though you on the pill, people should use condoms in order to be safer to prevent STIs. Although the pill is 99% but it's also you protecting yourself from carrying anything or infections. I think if you can*

afford it you should use one and I think using two is better than using one. To be safe". (Kim, 21).

"Not at risk of falling pregnant and STI's. That is the main reason I know about contraceptives. It is good because people our age are still young to fall pregnant and die of AIDS. We still have a bright future ahead of us to have babies and be young parents. It is a financial burden for an individual which will cause financial burden to the family" (Hope, 20).

4.9 Contraceptive use

In this analysis, 'contraceptive use' includes all types of contraceptive methods used for both contraception and non-contraception purposes. The prevalence of contraceptives amongst respondents is high and the majority indicated they use some method of contraception. Most respondents started using contraception when they were in secondary school.

"Yes, I am using contraception. I started using it back when I was doing matric. My mom suggested I use one because I had started dating". (Ciara, 25)

"Yes I am on contraception. I started using it in high school when I was at my puberty stage, my skin I was acting up a lot, so I had to find something to help me". (Kim, 21)

"Yes I am taking some contraception. I've been a sporty person since primary school, but when I got to high school, I was involved in a lot of sporting competitions. So I needed something to regulate my periods and that's when I started using contraception". (Samantha, 20)

The oral contraceptive was used by the majority of respondents in this study. As Hooper (2010) stated that there are many factors that make a contribution to a woman's choice of hormonal contraception and these differ significantly amongst individuals. Respondents mentioned that oral contraceptives can be used for other health benefits besides family planning and in most cases they started using it for health benefits.

"I'm using the contraceptive pill called Yaz. It is included in my skin medication. Apparently there is only two oral contraceptives one can use as a skin treatment" (Marie, 21)

"Yes I am using the pill called Mircette. I went on it for two reason, the first reason was for family planning purposes. Secondly, I wanted to keep track of my periods" (Kim, 21)

"Yes, I am on a pill called TriNessa which is a pill I take once a day in order for it to work effectively." (Ciara, 25)

Two out of all respondents who were using contraception at the time of the study were not using oral contraceptives. One respondent mentioned using condoms because they were the cheapest and she did not have to keep them at her house. The other respondent mentioned having an IUD as her contraceptive method.

"I am using condom because they are the cheapest and I do not have to have them at my house because my parent will know that I am having sex". (Selena, 22)

"Yes I am. I recently got an IUD. I was using hormonal contraceptives before but the side effects were unbearable so I decided to change". (Emily, 20)

4.10 Factors Facilitating Contraceptive Use

4.10.1. Health benefits

According to Hooper (2010:750), "many newer hormonal contraceptives also offer important non-contraceptive health benefits, including reduced risks of ovarian, endometrial and colorectal cancers, benign breast disease and menstrual cycle disorders". As, some of the respondents of this study mentioned that, the main reason for using contraception was for non-contraceptive health benefits. They mentioned starting using contraception for clearing their skin from acne, regulating their periods and minimizing period cramps.

"Yes I am using contraception. I started using them last year when I was 20. I was having problems with my skin and my parents took me to the doctor and he suggested

I incorporate the pill with the skin medication that I had already started using". (Marie, 21)

"Yes I am using contraception. I started using it while back in high school. I went on it for my skin. My skin was reacting badly because of puberty and the change of environment" (Eve, 25)

"Yes I am using contraception. I started using it when I was in matric. The reason I started using was because I was having an irregular pattern of periods. So I wanted to regulate them so I'll know when I'll be on my periods and when are they going to end. They have really helped me track my periods". (Kim, 21).

4.10.2 Perceived Risk of Pregnancy

According to Rutenberg et al. (2001 :39), "understanding what adolescents know the risk of pregnancy and pregnancy prevention is important because this knowledge affects an individual's behaviour and reflects the general state of education on reproductive health." Some respondents in this study mentioned how vital it was for them to start using contraception because they were starting to be sexually active. Therefore, preventing pregnancy was the contributing factor to contraception uptake. It was also interesting to note that the fear of contracting STIs did not feature as much in their decision to use a contraceptive method.

"Yes I am using contraception. We started using condoms with my boyfriend when we decided to take our relationship to the next level and started being sexually active. The reason why we chose condoms in particular was because we didn't want my parents knowing we were having sex but mainly I didn't want to get pregnant in matric. So the main reason is to not get pregnant. (Selena, 22)

"Yes I am using contraception. I started using the pill when I was 20. Me and my husband, who was my boyfriend back then, were starting varsity. So we didn't want to have a child while studying. I started using contraceptives especially because I didn't want to get pregnant then. So I doubled up to make sure I don't get pregnant." (Ciara, 25)

4.11 Factors Inhibiting Contraceptive Use

4.11.1. Side effects

Side effects are the cause of non-use and discontinuation of contraceptives. The majority of respondents who were not using any method of contraception in this study stated that they were not using any method because of the fear of side effects. They mention discontinuation of the method there were using because of the severe side effects.

> *"I used to be on contraception before. But I stopped using them because when I started using it I didn't like it. I got most side effects that they had in the booklet that explains everything: bloating, nausea, depressing moods and increasing hunger. I had literally all of them. So I decide to stop using them and I've never tried any again". (Christina, 23).*

> *"Hormonal contraceptive makes a person depressed. They are always in depressing moods and that is not right for an everyday life. They also makes it hard to control your weight and cause nausea which leads to constant throwing up stuff" (Marie, 21).*

Respondents also mentioned not using contraceptives correctly and consistently which caused side effects. They were using an oral hormonal contraceptive method that required daily use and they often forgot to use it. Amongst the two respondents who reported having side effects from taking contraception incorrectly and inconsistently, one respondent indicated stopping using the contraception and the other indicated encouragement in ensuring correct and consistent contraceptive use.

> *"I used to be on contraception when I was 17 years old. I was still in high school. I started having mood swings, because I wasn't taking it correctly. Because of the inconsistently I stopped using it, I was forgetting it all the time, tried setting an alarm but it didn't work. So I was like, what's the use, let me just stop". (Chloe, 20)*

> *"For me with my pill, the only side effect I've had because I take my pill every day at the same time. If I didn't, because my hormone level changes, I usually get headaches.*

Therefore I make sure I take them every day, same time to avoid headaches". (Kim, 21).

4.11.2 Lack of knowledge

Universally, knowledge of at least one contraceptive method either modern or traditional is prevalent (UNDP, 2004). Knowledge of the different types of contraceptive methods by itself is insufficient to bring about significant change in behaviour that reflects correct usage (Naidoo, 2005). However, effective information about different contraceptive method can facilitate contraceptive use. Respondents mentioned that, a lack of effective knowledge about a range of methods of contraception is dangerous because of consequences that may prevail, for instance side effects that one was not aware of. Also, lacking sufficient knowledge about a specific type of contraceptive makes a person to take whatever is available. Therefore, being well-informed about contraceptives is very important in order to foster effective contraceptive use.

"I think with the pill you have to take it all the time every day because if you don't it won't be effective. I think that the problem is that people don't take them the same time every day. Because in most cases people are not informed and when they have little knowledge and they get into situations without knowing the consequences because they are not informed. People must know every detail about contraceptives because those details are very important". (Eve, 25)

"Lacking knowledge about contraceptives causes people to not know which type of pill to go for. Therefore they end up not using it at all or they take the one which are not suitable for their bodies and suffer terrible side effects." (Hope, 20).

4.11.3 Abstinence

Abstinence decision among young people may be the result of personal beliefs. Some young people abstain because of their religious beliefs. Also, the fear of HIV, pregnancy and infectious diseases leads to abstaining. Abstinence then becomes the factor inhibiting contraceptive use because the risk of pregnancy and infection is experienced by the individual. One respondent in this study mentioned not using contraception because she is not sexually active therefore she is not at risk of falling pregnant. Other respondents who discontinued using

contraceptives mentioned abstinence as their contraception. One woman said that she had been sexually active in the past but has decided to abstain to reduce her risk of pregnancy.

> *"I am not using any contraception because I'm not sexually active. I have never used one before because I've never been sexually active. I am not at risks of falling pregnant and contraceptives are meant to prevent that." (Hope, 20)*

> *"I was using contraception before, but it didn't treat me well. So now I am not using anything and I do not have sex. Abstinence is my contraceptive" (Christina, 23).*

Religion often hinders contraceptive use but literature shows that it depends on the type of religion, for example, Catholics are more likely to use contraceptive than Protestants. In this study, respondents mentioned their religion was against premarital sex. However, it was not against contraceptive use. Some respondents were abstaining because they wanted to save themselves for marriage. They also indicated that using contraceptives and abstaining was more a personal choice and because of personal beliefs rather than being enforced by the church.

> *"When I was young I was not a Christian, now I am and my life has changed. I'm waiting until marriage. I became a Christian when I was 22, so before that I had a boyfriend and we were sleeping together. I still don't feel confident enough on the pill, we still took extra precautions. I believe in waiting until marriage. But I believe if I get married for instance I'll take contraceptives until I feel we ready for a child, emotionally, financially and all those things." (Eve, 25).*

> *"It was my personal choice. The religious beliefs I come from is no pre-marital sex. It was something I want for my life. It was a choice I made for myself. I can't guarantee that I can have one partner but with marriage there is a little guarantee that you are going to stay with their person a little bit longer because divorce is a big process than just breaking up with someone for me. Personally I am a one person woman. I'm not like going out sleeping with other guys or kissing other guys I don't like how it makes me feel."(Christina, 23).*

"Well I am talking to a lot of Christian people and it seems as if it not that strict. But my personal beliefs and my family beliefs are quite strict with regards to sexual activities before marriage."(Marie, 21).

4.12 Summary

This chapter has presented results from semi-structured interviews conducted with White, female students at the University of KwaZulu-Natal, Durban. The chapter has attempted to describe and deepen understanding of contraceptive use among White young women and attitudes towards contraceptives use. It is evident that the White, female students in this sample had positive attitudes to contraception. The reason for high contraceptive use is high level of awareness among this group. Communication between them and their parents put them in an advantage for accessing contraceptives without difficulties. Many start using contraceptives for other purposes besides preventing pregnancy initially and this places them at an advantage in starting these conversation with their parents.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

In South Africa, the majority of studies on contraceptive use focuses on black communities and not much on other groups in South Africa. There has been limited studies, if any, on White communities. Unintended pregnancy is an issue faced globally and affects all communities. In the period between 1990 and 2001, almost 53 percent of pregnancies were unplanned in South Africa (Vundule et al., 2001) and in 2005, 55 to 75 percent of pregnancies were either unwanted or mistimed (Myer et al., 2007). Although contraceptive methods are offered for free in public health facilities in South Africa, the levels of unintended pregnancy remains high, suggesting that adequate awareness and use of contraceptives is lacking. According to Statistics South Africa (2018) 12.5 % of black African women aged 15-19 have given birth compared to 1.8% of White women. It is interesting however that Whites in South Africa have a lower TFR compared to Africans and Coloureds. The White population has high levels of contraceptive prevalence because of their higher socio-economic status. In terms of race groups, black women had the lowest contraceptive prevalence rate (47.2 %) and White women the highest (61.9%) (Chersich et al., 2017). This study was therefore undertaken to shed insights into contraceptive use amongst young White university students in Durban. The research attempts to explore factors facilitating and inhibiting contraceptive use among White, female students.

Most studies have focused on determinants of contraceptive use amongst young black females such as parent-child communication. Young Black females are bound by norms and traditional values that inhibits parents, teachers and health facilitators to discuss sex related issues causing them to shy away from the topic and even lack courage to initiate the conversation. However this study explores determinants of contraceptive use amongst White females. The study draws on the qualitative research method to explore these objectives. Semi-structured interviews were used to gather information on factors facilitating and inhibiting contraceptive use. The study draws on semi-structured interviews from a small sample of women studying in University of KwaZulu-Natal, Durban. The qualitative research may have limitations but the advantage of the qualitative research is being able to dig deeper into people's experiences. The study also uses the diffusion-innovation theory developed by Cleland and Wilson (1987) to understand the contraceptive use of young, White women.

This study draws from diffusion- innovation theory which explains the importance of diffusion of information in distributing contraceptives. It also states that fertility decline is produced by the diffusion of new ideas and knowledge about fertility regulations (Cleland and Wilson, 1987). The findings of this study indicate high level of awareness of contraceptives as all the interviews revealed that the women have heard about contraceptives. In addition, in the interviews it was clear that the young women are relatively well- informed about contraceptives and their usage. This finding is similar with the study by Hoque, Ntsipe and Nthabu (2013) which reported that university students had good awareness regarding contraceptives, with females having a clear understanding of the effectiveness of contraceptives. The high level of awareness amongst White women in this study could explains the low level of TFR amongst the white population in South Africa as suggested by diffusion innovation theory. Comparing the four population groups in South African using the 2011 population census, African Black and Coloured population groups had the highest fertility rate of 2.8 and 2.5 respectively whereas Indians had a fertility rate of 2.14 and White had the lowest fertility level of 1.8 (Statistic South Africa, 2015).

Furthermore, the diffusion- innovation theory argues that conveying of information depends to some extent on interpersonal links between people of high social status to those who are disadvantaged (Cleland, 2001). It also describes that the advantaged population tends to be more cosmopolitan, urban but adoption of contraceptives spreads to other sectors largely through interpersonal communication networks. African Black and Coloured communities lack accessibility to contraceptives due to distance, transportation and lack of awareness of availability of family planning services that prevails in rural areas. Therefore, if diffusion of knowledge can be the main emphasis, contraceptives will spread rapidly throughout socially and linguistically homogenous systems, regardless of the position of groups within the economic structure (Cleland, 2001). As the main objective of this study is to shed insights into perspectives of contraception this study can help to identify factors facilitating contraceptive use amongst the various communities in South Africa to decrease teenage pregnancy, unmet need and increase contraceptive prevalence rate.

Studies suggest that young people obtain information from a range of sources (Geary et al., 2016). This study found that healthcare providers are an important source of information for young students. When they need information about contraceptive methods or preventing

pregnancy they approached their doctor who did an assessment of their situation and then recommended the most suitable contraceptive method for them. This finding was similar with the study by Khurana and Bleakley (2015) which reported that participants were receiving most of their information on contraceptives from doctors or nurses. According to Khurana and Bleakley (2015), frequent use of health services was associated with the highest levels of knowledge of contraception when compared to all other sources. This study suggests that health facilities are an important source of information about contraceptives among young people. Findings also suggests that health providers from private health facilities are more likely to provide patients with more in-depth information in comparison to health care providers in public health facilities where African black and Coloured communities obtain their contraceptives in South Africa.

In contrast to the findings of this study, other studies have found that young people obtain their information from a range of source. In Nigeria, schools and other educational institutions are an important source of source of information for the unmarried and health care facilities were found to be the source of information for the married (Afolabi et al, 2015). This is in contrast to other studies conducted in South Africa which found that other young people are often an important source of information (Mkhwanazi, 2010; Mjwara and Maharaj, 2018). Many young people get their information about contraceptive methods from their peers. This could also explain the myths about contraception that exists among young people which mostly leads to incorrect and also, discontinuation of contraception. According to Mkhwanazi (2010) study stated that most boys and girls get information about sex and contraceptive from their peers. The information received from peers often promote certain notions about sex and relationships (Mkhwanazi, 2010).

Family members, particularly other females, were also another important source of information of contraceptives in this study. A study by Colleran and Mace (2015) reported the importance of diffusion of information amongst peers and family members. According to Colleran and Mace (2015:6), the interpersonal and socio-cultural factors, in particular the contraceptive behaviour of significant others including close friends and family, have the highest and most consistent effects on the probability of use of contraception. This suggests that open discussions amongst family and friends plays a vital role in fostering greater acceptance of contraception among young people. However, these discussions are mostly based on personal experiences, and may results in the emergence of myths and misconceptions about contraceptives.

According to Wellings et al. (2013) general practitioners and pharmacists are the main administers of most contraception methods, therefore it is vital that they have clear understanding and knowledge of different contraceptive methods that can be accessed and informed on their relative effectiveness. Young women mentioned having to acquire a prescription from their doctors in order to access contraception. The prescription was produced to pharmacist in order to obtain the contraceptive method. Also, young women mentioned that their doctors gave them information about one particular method and explained the side effects associated with the method. This suggest the importance of counselling of a range of methods by general practitioners resulting in an informed decision by young women. This is also more likely to occur in private health facilities as the health practitioner is not under extreme time constraints and does not usually have a long waiting period that is more common in public health facilities.

A study by Sweeney et al. (2015) reported how reluctant participants feel about discussing contraceptives with their general practitioner or pharmacist because they did not feel confident in asking them questions. The study also reported that general practitioners and pharmacists would assume that contraceptive uptake by the patients is consistent and taken correctly and that they understand the implications of their chosen method (Sweeney et al., (2015). This was similar to this study, where respondents mention that their general practitioner was the one deciding on the contraception method and gave advantages and disadvantages of the only chosen method. Also, discussing contraceptives was difficult for the respondents because the doctors are family doctors; they have been consulting with them since birth. Therefore, the interpersonal relationship between health care providers and young women obtaining contraception is vital in fostering contraceptive use. A study among young people in KwaZulu-Natal by Alli, Maharaj and Vawda (2012) found that interpersonal relationship between health care providers and young clients can be influenced by various factors such as staff attitudes towards young clients, contact time with patients, accessibility and availability of health services.

In South Africa, nurses in primary health care services play a major role in contraceptive provision (Morroni, et al, 2016). The research in South Africa demonstrates that health providers have solid inclinations about which strategies are suitable for women, particularly the individuals who are HIV-positive, unmarried, as well as young people (Holt et al., 2012;

Lince-Deroch et al., 2015). Health providers can likewise impact the method choice as well as continuation of methods, deliberately or inadvertently, through sub-standard or one-sided advising (Morroni, et al., 2016). Most of the issues identified through research that are said to be barriers of contraceptive use or continuation could be addressed through improved counselling and time spent with a client from healthcare providers. Counselling will foster good communication between patients and health care providers to prepare women for initial contraceptive use, choosing methods that are suitable for them, and to assist them with method switching when necessary.

The women in this study did not report experiencing problems in accessing contraceptives. Access to various contraceptive method has a great impact on fertility decline and improving people's lives (Gill, 2017). The respondents of this study usually obtained their contraceptive methods from private facilities. A study by Gill (2017) reported that White women indicated satisfaction with access to contraceptives compared to non-White respondents. This finding is similar to other studies, where respondents being White women, using and discontinue using contraceptives did not report having problem in accessing contraception. However, the study by Kamangu (2016) in Tanzania reported that women of reproductive age did not have problems accessing contraceptives when they intended using a method. This suggests accessibility and availability of contraceptives is not much of an inhibiting factor of contraceptive use for White women. Contrary to the findings of this study, the study by Mkhwanazi (2010) reported that nurses were the obstacle in young women seeking access to contraceptives. Young women complained about nurses being rude and deliberately insulting young women seeking contraceptives and ridiculing pregnant teenagers. Also, withholding information on how to use contraceptives correctly were said to be done by nurses (Mkhwanazi, 2010).

The study found that young White women were obtaining their contraceptives from private health facilities mainly pharmacies. The young White women noted direct and easy access to the contraceptive method prescribed. This was also fostered by them having medical aid and hospital insurance which grant them access to contraceptives. According to Dougall (2015) women with insurance mostly obtain their contraceptives in pharmacies. Therefore, uninsured women are less likely to use contraceptives compared to insured women (Dougall, 2015). In South Africa, the majority of modern contraceptive methods are offered in public sectors (Morroni, et al., 2016). According to the 2003 SADHS, 13 percent of women reported

obtaining their contraceptive method in the private sector (South Africa National Department of Health (SANDoH), 2007).

In addition, because the majority of South African women obtain contraceptives from the public sector, nurses plays a major role in contraceptive provision (Morroni, et al., 2016).The study by Holt et al. (2012) and Lince-Deroch et al. (2015) found that, mostly HIV-positive patients, unmarried, and young women are particularly at risk of discrimination by healthcare providers. This suggests the reasons for the level of pharmacy reliance shown by the participants of this study is to avoid discrimination by health care providers in health care centres. Also, they have medical aid and hospital plan insurance which grant them easy access to contraceptives without any difficulties. In addition, the public sectors in South Africa are faced with lack of contraceptives supply issues (Morroni, et al., 2016). This results in lack of availability of a range of contraceptive methods which does not often occur in pharmacies.

Furthermore, cost was cited as a factor that might hinders contraceptive use, by one of the participant in this study. The study by Nsubuga et al., (2016) reported similar findings whereby 21 percent participants of the study mentioned that contraceptives were not for poor people. However, Dougall (2015) argued that cost does not influence contraceptive uptake amongst women. But understanding how particular access system either promotes or impairs women's contraceptive usage is important (Dougall, 2015), especially in cases where women visit and obtain their contraceptives from family planning services centres and women who go to community colleges and universities (Reed et al., 2014). Contraceptive methods are obtained for free in these public facilities which decreases the financial burden of women who cannot afford to pay for actual contraceptive methods.

The South African government has shown interest in growing family planning services (Chola, et. al., 2015). They have committed to the Family Planning 2020 initiative, which is a global partnership between governments, civil society, donors and other stakeholders, aiming to expand contraceptive use to 120 million more women and girls by 2020 (Family Planning 2020, 2015). With such initiatives, women are provided with free family planning services to girls aged 12 and older without parent's consent (Mannava et al., 2015). Therefore, costs for an actual contraception is not much of an issue in South African women, however, place of residence, availability of services and transportation fees have a major effect on the contraceptive use of women. In the study by Mavuso and Maharaj (2015) participants

mentioned cost as barrier to access contraceptives whereby fees for transportation, health facilities being far from where they reside and non-conducive for users. This suggest the need for more conducive family planning facilities for women to assess contraception.

The study found that young White women's parents were the one who were obtaining contraceptives for them at the pharmacy. This is unfamiliar in the South African context as sex is the taboo topic. South African traditional values are deeply rooted in culture and sex in many cases is still a taboo topic among many families (Chola et al., 2015). The study by Mjwara and Maharaj (2017) reported that young women did not discuss sexual matters with their parents, they preferred talking to their peers. It also stated that the lack of communication may lead to lack of awareness of the risks associated with unprotected sexual engagements (Mjwara and Maharaj, 2017).The study by Mkhwanazi (2010) showed that most mothers were aware when their daughters have started having sex, but because of sex being a sensitive topic and respectful conduct regarding sexual matters between generations meant that mothers could not talk directly to their daughters about sex. Mothers then discourage girls from engaging in sexual activity by corporal punishment and restricts girls' movements (Mkhwanazi, 2010).This finding is similar with the findings of this study, as it was ascertained that open communication with parents and partners led to better health outcomes (Irani et al., 2014; Kamangu et al., 2017).

According to Gavin et al., (2015) parent-child communication about sex related matters has positive effects for young people including better contraceptive use and healthy sexual behaviour. A study in Tanzania by Muthengi et al. (2015) observed that parent-child communication about HIV was mostly associated with condom use at first sex and consistent condom use compared to conversation about mainly family planning. This suggests that certain topics on sex related matters are effective in fostering contraceptive use. Another study suggest that most young people emphasized the importance of having discussion with their parents about sex and sexuality (Mabhuda and Madiba, 2017). The young people in the study felt that communication with parents on sexuality provides them with preparation for sexual decision making that will reduce their risk of teenage pregnancy, STIs, and HIV infections (Mabhuda and Madiba, 2017:169).

The present study found that respondents had communication with their partners about contraceptive. This is unfamiliar in the African context as male partners are mostly the ones

who dictate contraceptive use and number of children. In Angola it was reported that male opposition to family planning and limited female decision-making power was an obstacle to contraceptive use (Prata et al., 2003). A study by Prata et al. (2017) reported that women who were not sure about their partner's opinion on contraceptives were more likely to decide not to use contraception due to fear of partner's opposition. However, a study by Tumlinson et al. (2013) in Kenya reported similar findings whereby men who have discussed use of family planning with their partners were more likely to use contraceptives. In addition, Palamuleni (2013) stated that contraceptive use is directly related to frequency of discussion of family planning with the partner whereby women who had discussed family planning with the partner were using contraceptives.

In the Western Cape, South Africa, Peer et al. (2013) found that women who reported men being entitled to dictate childbearing decisions, were more likely to use emergency contraception. The study by Mchunu et al. (2012) showed that female respondents did not have difficulty discussing condom use with their partners. They go on to argue that these findings might be different in transactional sex relationships as less or no power of negotiating condom use are more common. This suggest that couples of the same age group and not having transactional sex are more likely to have open communication about contraceptives.

The study found that the most commonly use contraceptives reported by young White women was oral contraception also known as the pill. Most studies in South Africa reported the oral pill as commonly used by Whites and Indians, and injectable contraception is more prevalent amongst Blacks (Chersich et al., 2017). The health benefits of contraceptives such as skin treatment, regulating menstrual periods and moods were mostly mentioned as the facilitators of contraceptive use. According to Kavanaugh and Anderson (2013) non-contraceptive health benefits have been ignored and the focus of research has only been on side effects. Various methods have been approved by FDA to treat menstrual-related conditions, such as heavy bleeding, migraines, premenstrual dysphoric disorder (PMDD) and acne (Kavanuagh and Anderson, 2013). Interestingly, a study in United States found that about 58 percent of women using oral contraceptive pill do so for non-contraceptive reasons (Jones, 2011).

Globally, fear of experiencing side effects are the main inhibiting factors of contraceptive use and is the main reason for discontinuation of contraceptive. The majority of participants in this study mentioned side effects as the reason of not using and discontinuing contraceptives. This

was similar to the study by Chebet et al. (2015) which reported that the majority of women had concerns about hormonal contraceptive side effects. It also stated that side effects were the leading cause of avoiding future use of contraceptive methods, discontinuing use, switching methods which puts women at risk of unintended pregnancy (Chebet, et al., 2015).

There is limited research focusing on the contraceptive use of White. The national surveys mostly focus on the number without delving deeper into the reasons for contraceptive use as well as the facilitators and inhibitors of use. This research focus on White female students in order to shed insights on contraceptive use amongst this population group. Factors facilitating and inhibiting contraceptive use was explored using the qualitative research method. Qualitative research method helps the researcher to attain deeper insight into issues related to the topic and be able to assess meanings and perceptions (Chalhoub-Deville and Deville, 2008). Using semi-structured interviews as the tool enabled white students to share their experiences and perceptions for deeper understanding of the determinants of contraceptive use among this group. This research can be used as the starting point in digging deeper and shedding insights among other groups of the population in the country.

This study had a small sample size which does not represent the whole White population. This was due to difficulty in finding participants because there is a small number of White students in the study area. Therefore, the findings of this study may not be generalizable to the whole population. However, these findings can be used as the start in focusing on White population to produce more research amongst this population group.

5.2 Recommendations

Difficulty in finding other segments of the population apart from Africans calls for a need for more research on contraceptive use specifically in South Africa among young White people and all population groups. In order to shed insights to be shared amongst other population groups, there should be more adequate information on contraceptive use. Further research should be conducted on factors facilitating contraceptive use among Whites especially males and females. The reliance on pharmacies in obtaining contraceptives should be explored deeper in order to increase access.

The findings of this study suggest that communication is associated with higher levels of awareness and uptake. Parent and child communication should be actively encouraged mostly in black communities as this will increase levels of awareness and reduce the risks of unprotected sex among young people. Open communication allows young people to open up about changes they experience concerning their sexual and reproductive health and will enable them to use contraceptives for other health benefits. As Akinwale et al. (2009) stated that health care providers should assist parents with knowledge and skills to support young women's sexual decision making by emphasizing on sexual communication. Also, implementation of intervention programmes targeting parents who are less educated or have no education and are usually not comfortable discussing sex related matters (Akinwale et al., 2009). According to Gavin et al. (2015) exposure to parenting intervention is associated with improved parent-child communication, improved condom use skills among youth and open communication. As Ndinda et al. (2017:12) stated that "the message in family planning campaigns should include modules on parent-child communication to ensure that parents communicate important information on sexual behaviour in ways that are acceptable to and appropriate for the youth".

Also, participants of this study mentioned strong communication between them and their partners. They mention that their partners are more open about discussing contraceptives with them. In addition, they also felt that their partners were supportive of their contraceptive use and method choice. Some studies have argued that men's role towards family planning issues is non-existent (Greene and Biddlecom, 2000). However, the study by Cox et al (2013) indicated a positive association between partner communication and contraceptive use. As, Murithi et al. (2016) stated that the study findings support the need for programming geared toward increasing communications within couples and particularly to support male involvement in family planning and reproductive decision-making. There are programs that had recognized the importance of involving men in order to promote sexual and reproductive health. These programs suggests that active participation of both men and women can work as the key strategy for reducing unmet need for family planning. (Becker and Robinson, 1998).

As Tumlinson et al. (2013) have stated that interventions focusing on partner communication regard family planning have a potential of increasing contraceptive prevalence. According to Prata et al. (2017) IEC campaigns formed to involve men in order to increase family planning use are essential and have shown progress. In addition, Palamuleni (2013) stated that one of the vital factors which have hindered successful implementation of the family planning

programme in Malawi is minimal male involvement. This suggest the importance of male involvement in family planning and it impact on increasing contraceptive uptake.

As, Alli, Maharaj and Vawda (2012) stated that adequate training in interpersonal relations is essential in helping overcome communication problems and enabling providers to interact with young clients at a more personal level. Health providers should be trained to be professional in order to avoid being judgemental and provide young clients with good service.

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Appendix I: INTERVIEW SCHEDULE

How old are you?

Tell me about your background.

Are you on contraceptives? If not, Why?

Have you ever used a contraceptive?

How old were you when you started using contraceptives?

What type of contraceptive method are you using?

Where did you find out about contraceptives?

How did you know which one was suitable for you?

Have you ever discussed using contraceptives with anyone? Friends, Partners, Family?

Where do you collect your contraceptives?

How often do use your contraceptives?

How is the communication between you and your parents regarding contraceptives?

Do you have a partner? If yes

How is the communication between you and your partner regarding contraceptives?

What is the main reason for using or not using a contraceptive?

What are some of the advantages of using contraceptives?

What are some of the problems with using contraceptives?

Appendix II: INFORMED CONSENT FORM

Informed Consent Form

19 August 2016

Dear Respondent

My name is **Bongimpilo S. Zulu** from the University of KwaZulu-Natal (Howard College campus) in Durban. My contact details are as the following: my cell number is 081 564 8956 and my email address is **mpyloh92@gmail.com**.

You are being invited to consider participating in a research project entitled: **Facilitators and Inhibitors of contraceptive use among White University students in Durban, South Africa.** The aim of the project is to shed insights into contraceptive use of young White students in Durban. The study will be conducted by myself in English in a venue and time that is convenient for you at the campus. You are advised to choose a time slot that is not in conflict with your timetable and academic activities to conduct the interview. I do not anticipate any risks to you participating in this study. I hope the study will give understanding to contraceptive use among young students.

I……. have been informed about the study entitled **Facilitators and Inhibitors of contraceptive use among White University students in Durban, South Africa** provided by **Bongimpilo S. Zulu.**

- I understand the purpose and procedures of the study project.

- I have been given an opportunity to answer questions about the study and I have had answers to my satisfaction.

- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time would affecting any of the benefits I usually am entitled to.

- I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

- If I have any further questions, concerns or queries related to the study I understand that I may contact the researcher at the provided contact details above.

- If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

Humanities and Social Science Ethics Administration
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X54001
Durban
4001
KwaZulu-Natal, South Africa
Tel: +27 31 260 4557 – Fax: +27 31 260 4609
Email: HSSREC@ukzn.ac.za

I confirm that I have read and understand the contents described above and the nature of the research study and my questions have been answered to my satisfaction. I give my informed consent to participating in the research study. I understand that my participation is completely voluntary and I am at liberty to withdraw from the study at any time, should I so desire, without incurring any penalties. I acknowledge and agree to information I provided, been used collectively in the form of a completed theses, for conference purposes and for publication in a recognized journal.

I hereby provide consent to:

Audio record my interview: **YES** OR **NO**

_____ _____ _____

Signature of participant Date Personal Email (optional)

_____	_____	_____
Signature of researcher	Date	mpyloh92@gmail.com

Appendix III: ETHICAL APPROVAL

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

20 October 2016

Ms Bongimpilo S Zulu 2102507199
School of Built Environment & Development Studies
Howard College Campus

Dear Ms Zulu

Protocol reference number: HSS/1444/016H
Project title: Facilitators and Inhibitors of Contraceptive Use among White University Students in Durban, South Africa.

Full Approval – Committee Reviewed Protocol

With regards to your response to received 19 October 2016 to our letter of 10 October 2016, the Humanities & Social Sciences Research Ethics Committee has considered the above mentioned application and the protocol has been granted **Full Approval.**

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

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

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)

/px

cc Supervisor: Prof Pranitha Maharaj
cc Academic Leader Research: Prof Oliver Mtapuri
cc School Administrators: Ms Nolundi Mzolo

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

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

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

Appendix IV: GATEKEEPERS LETTER

17 August 2016

Ms Bongimpilo Simphiwe Zulu (SN 210507199)
School of Built Environment & Development Studies
College of Humanities
Howard College Campus
UKZN
Email: 210507199@stu.ukzn.ac.za

Dear Ms Zulu

RE: PERMISSION TO CONDUCT RESEARCH

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

"Facilitators and Inhibitors of Contraceptive Use among White University Students in Durban, South Africa".

It is noted that you will be constituting your sample by performing interviews and/or focus group discussions with White students on the Howard College Campus.

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

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

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

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR SS MOKOENA
REGISTRAR

Office of the Registrar
Postal Address: Private Bag X54001 Durban, South Africa
Telephone: +27 (0) 31 260 8005/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: registrar@ukzn.ac.za
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