Contraceptive use amongst women of rural KwaZulu-Natal: A case study of Ntabamhlophe

Masters Dissertation

By

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COLLEGE OF HUMANITIES

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ABSTRACT

Sexual and reproductive health practices among women has been widely researched in South Africa. However, little is known about the contraceptive practices of older women in rural areas of South Africa as they are often excluded in research. The benefits of using contraceptives include the prevention of unintended pregnancies, limiting and spacing births as well the prevention of HIV and STIs. In developing countries, especially in Sub-Saharan African countries, contraceptive prevalence rates are low. The latest results from the 2016 South Africa Demographic and Health Survey indicate that contraceptive prevalence among South African women has gradually increased but remain critically low when compared to other countries. In addition, the statistics indicate that contraceptive use is lower in rural areas in comparison to urban areas. The aim of this study is to shed insights into contraceptive use in a rural area in KwaZulu-Natal, South Africa. This study relied on collecting qualitative data using in-depth, face-to-face interviews with women. Fifteen black women aged between 25 and 35 years from the rural area of Ntabamhlophe in KwaZulu-Natal were interviewed. The collected data was used to identify factors that promote or inhibit contraceptive use. The study found that awareness of contraception exists, however this does not translate into correct and consistent use of contraceptives. The collected data found that the majority of the women were not using any method of contraception. The study reveals that attitudes to contraception play a critical role in decision-making associated with contraceptive use among rural women. The desire to limit or space births and evade child mortality influences contraceptive use. Socio-economic factors such as educational level and employment have an influence on the use of contraceptives as these are seen to promote the use of contraceptives. Factors that inhibit the use of contraceptives include cultural beliefs and practices, myths and negative misconceptions, fear of contraceptive side effects, attitudes of health professionals, as well as the unavailability of a range of contraceptive methods. This study recommends the development of community intervention programmes that aim at educating selected groups on contraceptives. This study further stresses the need to increase male involvement in sexual and reproductive health issues as a means to increase contraceptive use. Additionally, more efforts should be made to increase the availability of contraceptives in rural areas.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASFR	Age Specific Fertility Rate
CCG	Community Care Givers
CPR	Contraceptive Prevalence Rate
DOH	Department of Health
HIV	Human Immunodeficiency Virus
IUD	Intra Uterine Device
KZN	KwaZulu-Natal
LARC	Long- Acting Reversible Contraceptives
MGD	Millennium Development Goals
MPoA	Maputo Plan of Action
SADHS	South Africa Demographic Health Survey
SDG	Sustainable Development Goals
SEM	Social Ecological Model
SSA	Sub-Saharan Africa
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
UN	United Nations
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Among women of reproductive age (15-49 years), complications arising from pregnancy and childbirth are the leading cause of disease, disability and death in developing countries (WHO, 2010). In many developing countries, poverty, malnutrition, lack of sanitation and education lead to health consequences for women and their families while experiencing an unintended pregnancy (Yazdkhasti, 2015). Unintended pregnancy is also among the most troubling public health issues. Unintended pregnancy and its negative consequences can be prevented by access to and use of contraceptive services including emergency contraception as these are essential in preventing and spacing pregnancies. According to White and Speizer (2007), the use of contraceptives reduces the number of unintended pregnancies, thus saving women from risky pregnancies and unsafe abortions. Furthermore, contraceptives help couples and individuals realise their right to decide freely and responsibly if they desire to have children, when they desire them and the number of children they should have. The use of contraceptive methods has resulted in improvements in health-related outcomes such as reduced maternal and infant mortality and improvements in education and economic outcomes, especially for girls and women (UN, 2017). Other benefits of contraceptive methods include the prevention of cancers and sexually transmitted infections (STIs) including HIV/AIDS (Chipeta, 2010).

> "Contraception is defined as the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. Thus, any device or act whose purpose is to prevent a woman from becoming pregnant can be considered as a contraceptive. In any social context, effective contraception allows a couple to enjoy a physical relationship without fear of an unwanted pregnancy and ensures enough freedom to have children when desired. The aim is to achieve this with maximum comfort and privacy, at the same time minimum cost and side effects." (Jain, 2011:1)

Jain (2011) categorises contraceptive methods into traditional, modern, surgical and other methods. Traditional methods of contraception include coitus *interruptus*, lactational amenorrhea and rhythm method. Modern methods encompass male and female condoms, oral contraceptive pills, emergency contraceptive pills and injectable contraceptives. The most

common methods are the intrauterine devices (IUD's), female sterilisation (tubectomy) and male sterilisation (vasectomy). Other known contraceptive methods are the diaphragm, the hormonal implants and the hormonal contraception which is specifically for women.

Contraceptive use has received substantial attention and became a commonly researched topic over the past few decades. This interest has been prompted mostly by the economic, health and social outcomes associated with the use of contraceptives. At a global scale, the interest in contraceptive use has been influenced by the decrease in fertility levels. One of the preconditions for a substantial fertility decline is having knowledge and mastery of effective means of fertility regulation such as contraception (Coale 1973 cited in Weeks, 2011). The decline in fertility rates of different countries can be observed in the total fertility rate. The total fertility rate (TFR) is the number of children a woman is capable of bearing by the time her reproductive career comes to an end that is, if she were to utilise all those years bearing children at the current observed age corresponding to specific fertility rates (Weeks, 2011). In the 1990s, the global TFR ranged from 2.5 to 5.5 births per woman but the trend indicates a steady drop in all the major regions of the world. However, the decline in the fertility rates is much slower in Africa. Other parts of the world such as England, Denmark and Norway, began the transition from high to low fertility levels much earlier than African countries (Casterline, 2001).

Since the year 1970, global rates indicating contraceptive use trends have been on a substantial growth trajectory. The prevalence of contraception has risen from 35% in 1970 to 63% in 2017 (UN, 2017), with projections suggesting that the number of women set to adopt contraception is likely to increase from 778 million in 2017 to 793 million in 2030. Modern contraceptive methods constitute the most commonly used method worldwide. Comparatively, Eastern Asia boasted the highest percentage in terms of use of contraceptive use across the world. Statistics show that the contraceptive prevalence rate (CPR) for the Eastern Asian region stood at 81% in 2017 (UN, 2017). Wang (2016) asserts that the prevalence rates for Eastern Asia are high owing to elevated levels of use of contraception in China. The central Chinese government overtly promotes the one child policy, which calls for the availability and the subsequent use of a diversity of contraceptive methods imperative as a strategy that seeks to reduce the levels of fertility in this country (Wang, 2016).

According to the United Nations (2017), in almost all the regions of the world, the majority of women of reproductive age, whether married or in sexual relationships, are sexually active,

hence they are in a position to use contraceptives. Globally, statistics for the year 2017 indicate that 63% of the women in their reproductive ages had been using some form of contraceptive method. The use of contraception reportedly surpassed 70% in Europe, Latin America, the Caribbean and Northern America, while on the other hand, in Middle and Western Africa, the record stood at merely 25% (UN, 2017). Modern contraceptive methods constitute the most commonly used category, constituting almost 92% of all the users of contraceptives worldwide (UN, 2017). In Africa, contraceptive prevalence rates were reportedly higher in the Southern and Northern African regions, with contraceptive prevalence rates of 65% and 54% respectively. Comparatively, these rates are higher than the rates recorded in Western and Middle African countries (UN, 2017).

The South Africa Demographic and Health Survey (SADHS) indicates the contraceptive prevalence rates in South Africa. Overall, modern contraceptive usage in the year 1998 was 61% in South Africa. The survey further looked at demographic and geographical differences related to contraceptive use and found that there was a difference between rates recorded in urban and rural areas. Urban contraceptive use rates were 67% and rural rates were recorded at 54% (DOH, 1998). There was also a notable difference in fertility levels between urban and rural areas. Total fertility rates of urban areas were 2.3 births per women**,** while rural TFR was slightly higher at 3.9 births per woman (DOH, 1998).

In 1998, South Africa aimed to increase its contraceptive prevalence rate to 65% by the year 2003. The country was able to attain their target, as there was an increase in overall CPR between the years 1998 and 2003 (DOH, 2004). However, geographically and demographically, some groups remained marginalised, particularly women in rural areas (United Nations, 2017). Subsequently, there were interesting changes that occurred in the CPR of urban and rural areas. The 2003 SADHS indicates that the CPR of urban areas remained stable between the years 1998 and 2003, while there was an increase in the uptake of contraceptives in the rural population. Urban contraceptive use prevalence remained at 67%, while the CPR of rural areas increased to 62%, (DOH, 2004).

The data from the SADHS 2016 suggests that the contraceptive prevalence rate for South Africa is 55% for married women and 60% for sexually active women (DOH, 2017). Consistent with the past SADHS, the 2016 report indicates that fertility rates in urban areas were lower than that of rural areas. The TFR of urban areas was 2.4 births per woman compared to rural areas with a TFR of 3.1 births per woman in the year 2016 (DOH, 2017). A

comparison between the 1998 and the 2016 SADHS reveals that the modern contraceptive prevalence rates amongst women in South Africa remained almost unchanged as these were 55% in 1998 to 54% in 2016. Furthermore, the statistics deriving from the 2016 SADHS indicated that among currently married and sexually active unmarried women combined, 58% of them were reportedly using at least a modern contraceptive method (DOH, 2017).

In 1998, the SADHS indicated that KwaZulu-Natal (KZN) was one of the three provinces with the lowest contraceptive prevalence in South Africa with rates below 60%. By 2016, the contraceptive prevalence increased slightly from the rates recorded in 1998. For KZN the data suggests that 61.2% of women were using at least one contraceptive method (DOH, 2017). The available statistics suggest that despite the increase in the use of contraceptive methods in rural areas, the rates are still lower than the rates recorded in urban areas (DOH, 2017). It is therefore imperative to explore the use of contraception in rural areas to identify the factors that promote or inhibit the use of contraception since an understanding of these factors can assist in identifying the causes of low use of contraceptive methods.

Several factors have necessitated research on the use of contraceptives in a rural area. By definition, a rural area refers to a geographical location located away from towns. The findings of previous studies conducted on the use of contraceptives in the rural areas of KwaZulu-Natal are indicative of a variety of factors that determine the use of contraception by women (Ndinda *et al.*, 2017). A study conducted in rural KwaZulu-Natal suggests that there is reluctance among rural women of reproductive age to use modern contraceptives owing to a variety of factors such as negative myths and misconceptions, culture, gender inequality and women's sense of powerlessness (Ndinda *et al.*, 2017).

The use of contraceptives by women aged between 25 and 35 years in rural areas is arguably a phenomenon that has been under-explored in the South African context. Researchers have attempted to explore the use of contraceptive methods among different groups of women. However, the paucity of the earlier studies that focused on the dynamics of use and non-use of contraceptives among women of more advanced reproductive ages necessitates greater explorative studies (Solanke, 2017). In the South African context, the studies conducted on the use of contraceptive methods mainly focused on teenagers (Seutlwadi *et al.*, 2012). In attempting to address the knowledge gap, the focus of this study is on women between the ages of 25 and 35 years old, who reside in Ntabamhlophe, a rural community in Northern KwaZulu-Natal. This study focuses on this age group specifically based on evidence from the

SADHS report, which indicated that 59% of women in this age group use contraceptives in KZN. These rates are lower than all other age groups except for the age group of 35- 49 year-old women (DOH, 2017). This is in contrast to research that suggested that the relationship between age of women and their contraceptive use is inverted and forms a 'U' shape. Meaning that the likelihood of contraceptive use is highest amongst women aged between 25 and 35 years (Aviisah *et al.*, 2018).

In rural areas, the use of contraceptive methods is a phenomenon that requires further exploration and this therefore is the motivation behind this study. The study particularly seeks to identify the factors that promote and inhibit the use of contraception among the rural women with specific reference to a rural community called Ntabamhlophe found in the province of KwaZulu-Natal.

1.2 The prevalence of contraceptive use

By 2017, Africa had the lowest contraceptive use prevalence rate as compared to all the regions of the world. Ackerson and Zeilinski (2017) makes an allusion to the fact that the studies conducted on contraceptive use across Africa to date, indicate that prevalence levels are low owing to the desire among Africans to have large families, the low-socio-economic status of the continent and the inaccessibility of health facilities. The prevalence of contraceptives was 36% across the African continent. This indicates a gradual increase from the prevalence rates of the years 1970 and 2000, which were 5% and 25% respectively (UN, 2017).

As statistics indicate that contraceptive prevalence rates are the lowest in Africa, it is, however, important to note the steady growth in the use of these contraceptives within the continent. The contraceptive prevalence rate is steadily increasing, especially in the Sub-Saharan African (SSA) region. The gradually increasing rates are arguably and partly due to the dictates of the Maputo Plan of Action (MPoA) to which 48 health ministries in the SSA region assented (Tsui *et al.*, 2017). This plan of action is an advocacy of universal sexual and reproductive health, thus positioning family planning at the core of its programmes (Tsui *et al.*, 2017). The United Nations (2017) projects a gradual increase in the levels of use of contraceptives to 45% by the year 2030.

Since indications suggest that the prevalence of contraceptive use is on a growth trajectory in the Sub-Saharan African region, the opposite is true about the South African context where the phenomenon is on a gradual downward trend. Reports from the South African Demographic and Health Survey are comparable between the 1998 and 2016 periods, indicating a decrease in the use of contraceptives in South Africa within this timeframe (DOH, 2017). These statistics show the percentages in terms of use of different contraceptive methods by women aged between 15 and 49 years across the nine provinces.

The SADHS of 1998 indicated that 61.2% of the women were using contraceptives and more than half were using a modern contraceptive method. The recent contraceptive prevalence rate in South Africa indicates that 58% of the women were using a modern contraceptive method (DOH, 2017). Less than 1% of the women who were using contraceptives during these periods opted for traditional methods. The slight decrease in the use of contraceptives in South Africa is arguably resulting from the 18% of women in 2016 who reported an unmet need for contraceptives (UN, 2017). Thus, with time, more women would indicate their desire to use contraceptives, though their demand for the service is seems insatiable. Sedgh *et al.,* (2016) concurs, adding that women with an unmet need for contraceptives are aware of the contraceptive options but they do not have access to health facilities and at times, the costs are too high. A study using data from demographic and health surveys conducted in 52 African countries, which included South Africa, confirmed these results (Sedgh *et al.*, (2016).

Background characteristics play a role in determining the use or non-use of contraceptives among women. As such, different background characteristics influence some women to be more likely to use contraceptives than others. The SADHS of 2016 depicts that marginalised groups, particularly rural women with lower educational levels are less likely to use contraceptives and have a lower prevalence of contraceptive use (DOH, 2017). The report further suggests that even though the contraceptive prevalence rates are on the increase in rural areas, they are still lower than urban areas. With reference to the contraceptive prevalence rates in KwaZulu-Natal, a slight increase from 58.3% in 1998 to 61.2% in 2016 is clearly discernible (DOH, 2017). A study to investigate the use of contraceptives use conducted across nine rural areas in the province of KZN found that the persistence on

cultural beliefs, lack of access to health facilities as well as gender and power relations contribute to the reluctance to use contraceptives in these areas (Ndinda *et al.*, 2017).

1.3 Rationale for the study

The low use of contraceptives among women in rural areas of KwaZulu-Natal is the main reason behind this study. As Hartlage (2001), notes rural women are a group that is marginalized and researchers often under-represent them as far as their use of contraception is concerned. This perception of low contraceptive use manifests itself in the SADHS 2016 report, which indicates that urban areas have higher levels of contraceptive use when compared to rural areas. Moreover, the province of KwaZulu-Natal experienced a 15.6% decline in CPR between the years 2003 and 2016 (DOH, 2017). This allows further exploration to measure the association of this decline and the low levels of contraceptive use seen in rural areas. Further, fertility rates of rural women are higher than women living in urban areas, it is therefore important to explore the association between the fertility levels and the levels of contraceptive use.

The third goal of Sustainable Development Goals (SDGs) is to ensure universal access to sexual and reproductive healthcare services including family planning information, education and integration of reproductive health into national strategies and programmes by the year 2030 (UN, 2017). The SDGs were developed to address the unattained goals that were stipulated in Millennium Development Goals (MDGs) to be met by the year 2015. Goal five in the MGDs was to increase the CPR of South Africa to 55 % by the year 2015, however, this goal was not achieved as the CPR was 54% in the year 2016 (DOH, 2017). Despite the small difference in percentage, increase in abortion rates, which are a result of unintended pregnancies, could be manifested in low contraceptive use (Peer, 2012). Further, policy makers are concerned about the unmet need for contraceptives in rural areas as this is seen to constitute a major risk for women, their families and societies (Peer, 2012).

Therefore, this study seeks to explore the phenomenon of contraceptive use in Ntabamhlophe. Further, this study hopes to aid the government and policy makers in formulating interventions that could increase contraceptive use prevalence in rural areas to help close the

gap that exists between urban and rural areas as well as to ensure universal access to family planning services.

1.4 Aims of the study

The overall aim of this study is to gain insights into contraceptive use among older women of reproductive age living in a rural area.

The specific objectives are:

- To ascertain women's awareness of contraceptive methods.
- To explore the perspectives and experiences of rural women in terms of contraceptive use.
- To investigate the factors promoting and/or inhibiting contraceptive use amongst older women in rural areas.

The study used qualitative data from in-depth interviews with older women in Ntabamhlophe, KwaZulu-Natal. Interviews were conducted with fifteen African women living in Ntabamhlophe.

In order to address the aims of the study interviews were used to answer the following key research questions:

- Are women aware of the various contraceptive methods?
- What are the main methods of contraception?
- What are the factors promoting or inhibiting contraceptive use among women?

1.5 Theoretical framework

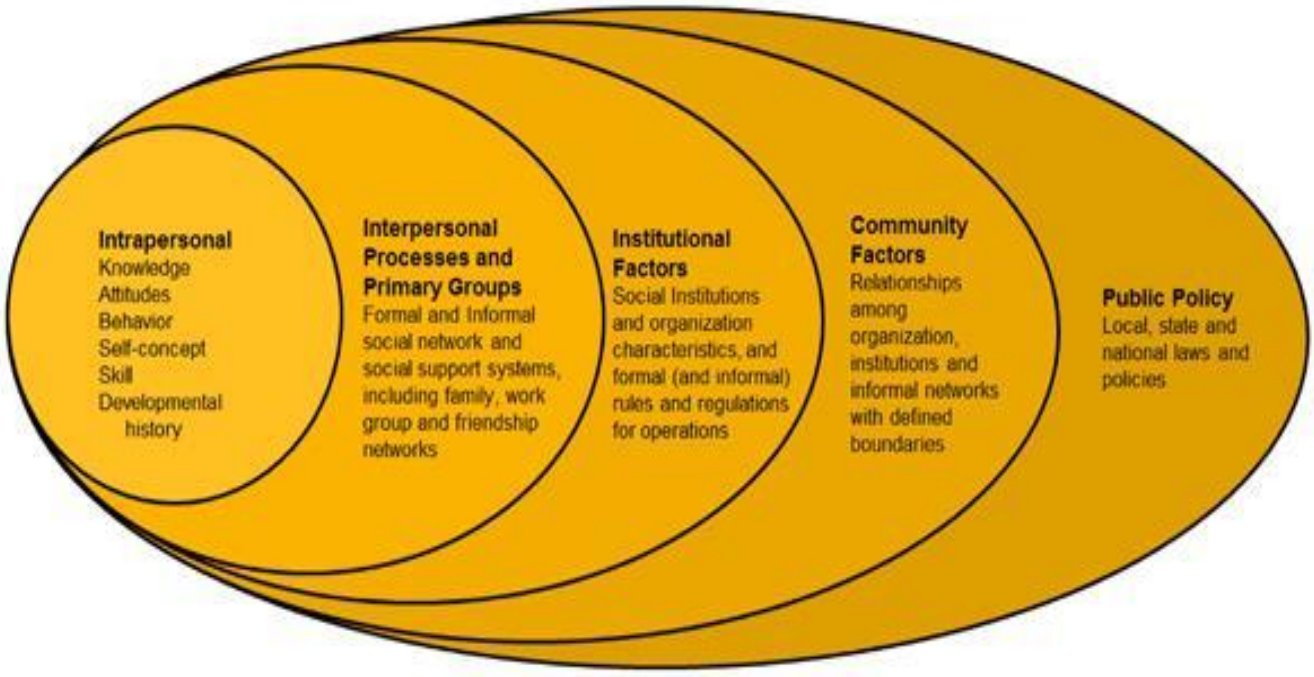
This section of the chapter will elaborate on the theoretical framework that guides this study. The theoretical framework used pays attention to both behavioural and environmental determinants and is ecological in its perspective. The social ecological model (SEM) focuses on concepts and different levels, which assist in understanding contraceptive use. This model

is relevant to health and health interventions as it focuses on both the individual and the population levels as determinants of health and health interventions (McLeroy, 1988).

Urie Bronfenbrenner and McLeroy developed two versions of the Social Ecological Model that researchers commonly apply in their studies. The SEM of Bronfenbrenner consists of interlocking spheres of influence, which are the *micro, meso, exo* and the *macro*-systems (Bronfenbrenner, 1977 in McLeroy, 1988). These sub-systems help to provide an understanding of the small factors stemming from the individual, family and community-based structures to the broader structures such as societal norms and policies. These models view behaviour in relation to its individual and environmental determinants. The model suggests that the above-mentioned system have an influence on determining human behaviour (Bronfenbrenner 1977 as cited in McLeroy, 1988). This model focuses on the interlinked relations between the different sub-systems and emphasizes that all existing sub-systems play an equally important role in maintaining balance of the whole system (Paquett and Ryan, 2001)

With specific reference to this study, the SEM of McLeroy (1988) takes into account the fact that people do not exist in isolation and there are levels of influence, which affect human behaviour. Individuals do not exist independently and the society that surrounds them influences their behaviour (McLeroy, 1988). As such, this model is applicable in contextualising all the factors associated with contraceptive use among older women in rural areas. The model comprises of five levels of influence that affect human behaviour. The five levels of influence are the intrapersonal, interpersonal, organizational, community and the public policy levels. The intrapersonal level consists of individual characteristics that influence behaviour. Such influences include an individual's knowledge, skills and self-efficacy. The interpersonal level consists of the individual's family, friends and peers. Therefore, interpersonal processes and groups provide both identity and support for the individual. The institutional level encompasses churches, stores and community organizations. At this level, the rules, regulations, policies and structures that constrain or promote behaviours are core. The community level depicts the social networks and community norms and regulations. Public policy level includes the local and national policies and laws that regulate or support health-related practices and actions (McLeroy, 1988).

Figure 1.1 McLeroy's social ecological model



Source: McLeroy (1988)

The intrapersonal level is the immediate level in terms of determining behaviour associated with contraceptive use. This level asserts that the individual's knowledge, thoughts and perceptions have an influence on the women's perspectives associated with the use of contraceptives, (McLeroy, 1988). Following and closely linked with this level is the interpersonal level. The interpersonal level includes group structures and the relationship between individuals and group structures such as family and peers (McLeroy, 1988). The relationship that the individual has with family and peers has an influence on women's decisions and opinions regarding the use of contraception. The patterns of contraception use among peers are an integral factor considered at the intrapersonal level (Thompson and Spainer, 1987). At the institutional level, structures such as churches and community organisations exist. Churches and community organisations are linked with religion, culture and actions of community groups. Religious and cultural perspectives, as well as community actions can either promote or constrain rural women's behaviour regarding the use of

contraceptives. The community level has factors that include social networks and community norms. These factors play a crucial role in this study since they are important in the understanding of the norms of the rural community with reference to the use of contraceptives. This level can also be attributed to the negative myths and misconceptions regarding contraceptives that are held by rural communities. The public policy level relates to the policies that regulate family planning services and practices. This includes public health services such as clinics and hospitals. In the context of this study, this can refer to the availability and access to free contraception to the women residing in rural areas.

The SEM is the most relevant theoretical framework to this study as the objective of the study is to get insights into the awareness, perspectives, experiences and the factors influencing or inhibiting the use of contraception among rural women. This model guides the study in its quest for an understanding of both the interpersonal and intrapersonal attributes that influence contraceptive use among older women living in rural areas. Sallis (2015) asserts that ecological models of health behaviour are applicable to the exploration and the subsequent understanding of individual's health-related behaviours. This understanding then guided the study in exploring the interpersonal and intrapersonal attributes that influence the attitudes of rural women towards the use of contraception.

The ecological model further assists the researcher in exploring women's intrapersonal attributes, which include their personal feelings, opinions, experiences and perspectives regarding contraception and as such, the researcher was able to access information on the factors facilitating and inhibiting use. This study further explored the interpersonal attitudes that influence the use of contraception. These include, but are not limited to, societal and public policy influences that affect use of contraception, the availability of contraceptive methods as well as other attributive factors that are beyond the individual but yet influence the use of these contraceptives.

1.6 Organisation of chapters

This dissertation is organised into five chapters. Chapter one presents the background and the rationale of the study to create a solid basis of this study. This chapter further discusses the theoretical framework that guides this study. Chapter two reviews relevant literature that

underpins this study. The literature under review explores the history of the use of contraceptives in South Africa as well as knowledge of contraceptives. The chapter further unravels the factors that promote the use of contraception on the one hand and those that tend to inhibit use on the other, within the South African context and other parts of the world. Chapter three discusses the methodological design of the study. This is inclusive of the study population, the study design and the data collection process as well as data analysis. The chapter further outlines the ethical considerations and the limitations of the study. Chapter four presents the main findings from the interviews conducted with rural women. The final chapter is a discussion of the main findings, aligning them with the initial objectives of this study and sums up the whole study by proffering possible recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of contraceptive use dynamics. The purpose of this chapter is to provide an in-depth review of the existing literature and past study findings relevant to the use of contraceptives. The literature review traces the history of contraception in South and provides an in-depth exploration into the various factors that promote the uptake and use of contraceptives as well as the factors that inhibit contraceptive use.

2.2. The history of contraceptives in South Africa

Historically, racial groups divided the South African population and these groups were separated geographically according to racial lines. Reproductive health policies that were established between the years 1974 and 1994 were a result of the implications of the apartheid government, which governed South Africa during this time (Maharaj and Rogan, 2007). As South Africa pursued contraceptive policies in its own way, other governments elsewhere also introduced family planning programmes targeting particular demographic groups. Rural residents, people of lower economic class as well as the poor citizenry of countries such as India, Mexico and the United States of America were the main targets of family planning programmes (Potter 1999 cited in Norling, 2015).

The provision of free family planning services in South Africa resulted from political initiatives as the apartheid government introduced contraceptives as a deliberate move to curb the growth of the non-white population (Norling, 2015). Further, Ndinda *et al.*, (2017) alludes to the fact that family planning programmes in South Africa were the brainchild of the controversial apartheid regime and the thrust of contraceptives was to thwart the African population at the same time encouraging the growth of European migrants. However, Kaufman (2000) argues that the apartheid government did not introduce contraception on a racial basis; instead, these were available freely to all women who sought to use them. Government officials highlighted that the introduction of family planning programmes was driven by a growing demand for contraception and these were not aimed at curbing the

population of any racial group (Kaufman, 2000). Further, family planning services were introduced to foster economic development in South Africa. When the apartheid government improved provision of family planning services in the 1970s and 1980s, the employment rates for African women rose substantially in the country (Norling, 2015). These women were naturally under obligation to limit the number of children with contraceptives in order to secure employment and earn a living.

According to Caldwell and Caldwell, (1993:5)

> "Aside from a single clinic in Cape Town, family planning services during the first half of the twentieth century were generally restricted to white residents and received little government funding. By the early 1960s, a National Family Planning Association operated several dozen urban clinics that offered family planning services to members of all racial groups. In 1963, the national government first provided a small grant to the National Family Planning Association. These grants rose consistently throughout the rest of the decade and, in 1970, the government fully funded and began to assume control of the Association's clinics."

The above briefly indicates the progression of the provision of contraceptives in South Africa. The National Family Planning Programme of 1974 expanded family planning clinics across the country. Contraceptives were mainly targeted at Black women living in urban areas because White women had already been enjoying the benefits of contraceptives prior to this (Kaufman, 2000). The increase in the use of contraceptives was attributed to the increase in the accessibility of family planning counselling among the majority of the Black women**.** In 1987, the South African government was already operating 2641 family planning services and an additional 54 475 mobile service points countrywide. An estimated 250 000 Black women were visiting family planning clinics every month. In 1974, 35% of black women were on contraception and by the late 1980's, the percentage had risen to 50% (Department of Health, 1998). The rapid expansion of family planning clinics in previously white areas accounts for present day differences in contraceptive prevalence between the urban and rural areas (Oosthuizen and van Zyl, 1998).

African leaders who advocated for the dethronement of the apartheid regime were strongly against the idea of family planning programmes in South Africa. According to Ferreira (1984 cited in Norling 2015), family planning was synonymous with the political apparatus of the

White apartheid government of that era. This means that the majority of the Black women in South Africa viewed family planning with contempt as they construed it to mean an oppressive instrument just like other aspects of the apartheid regime. Kaufman (1998) asserts that family planning programmes perpetuated white dominance while oppressing and exploiting the Black minority, further supporting the notion that the apartheid regime introduced family planning as a strategy that enhanced further oppression and the exploitation of black people. In spite of these sentiments, the black South African community also raised concerns about the side effects of the different contraceptive methods.

Generally, campaigns against family planning cited the side effects that contraceptives had on an individual. There were fears about the injectable contraceptive *Depo Provera* having cancerous effects, a scenario that further generated enormous suspicion (Norling, 2015). This perception became a major cause for concern, as the non-white community believed that contraceptive methods would usher in detrimental health complications for women. According to Kaler (1998), the Zimbabwean government banned the use of *Depo Provera* in 1981 but the South African government continued to offer the injection at family planning clinics.

Despite the African traditional leaders being against the use of contraceptives based on the objections already cited, the use of contraceptives among Black South African women escalated steeply during this period. Norling (2015) mentions that between the years 1970 and 1980, the use of contraceptives rose substantially among Black South African women. However, racial segregation was a major determining factor in the provision of family planning services. During this period, there was a difference in the types of family planning services as well as contraceptive methods that were supplied to different racial groups (Maharaj and Rogan, 2007). Mobile clinics were introduced to Black communities and were situated near places such as shops, which were frequently visited by Black women (Kaufman, 2000). The racial undertones in the provision of contraceptives were noted mostly in the distribution of the different contraceptive methods. More permanent means of contraception and long-lasting injectable contraceptives were promoted to black women and in some instances without their knowledge or consent. Less severe methods such as the contraceptive pill were administered to the White population (Cooper *et al.*, 2004). The history of

contraceptives in South Africa accounts for the differences that exist in contraceptive use between urban and rural areas (Kaufman, 2000).

The literature on the history of contraceptives in South Africa assists in understanding how the provision and use of contraceptives came about in this country. This history depicts the motives behind the introduction of contraceptives in South Africa. The literature on the history of contraceptives exposes the fact that employment creation for black women increased demand for contraceptives amongst the black South African women during the latter part of the Apartheid era. This literature is important as it makes it possible to interpret the manner in which this has affected women's perspectives on the concept of contraception as well as how women, particularly the rural-based Black South African women, have been applying these perspectives up to this day. This then leads to a discussion of the knowledge on contraceptives and different contraceptive methods.

2.3 Knowledge of contraceptives

Knowledge of contraception varies between women and there needs to be comprehensive assessment of knowledge pertaining to contraceptive use across all perspectives (Bongaarts, 1995). According to Pazol *et al.,* (2015), better knowledge of contraceptives allows women to appreciate the effectiveness of contraceptive methods, thus empowering them to identify the methods that best suit their circumstances. Contrary to this, inadequate knowledge on contraceptives often results in incorrect perceptions about contraceptives. Inadequate knowledge of contraceptives has been associated with avoidance, incorrect, inconsistent and discontinuation of contraceptive use (Wood and Jewkes, 1997).

The findings of a study conducted in the United States indicated that there are significant gaps in knowledge about contraception. The study found that knowledge pertaining to long acting contraceptive methods was lowest (Craig and Rocca, 2014). According to the same research findings, substantial deficits existed regarding the knowledge women have of different contraceptive methods. The study further confirmed that high percentages of women had the least knowledge about female sterilisation, reversible implants, the IUD as well as natural family planning methods (Craig and Rocca, 2014). Further, inadequate knowledge on contraceptives is one of the causes of the documented high percentages of unintended

pregnancies. According to Schrager and Hoffman (2008), despite the availability of reliable contraceptive methods in the United States, half of all pregnancies are unintended due to inadequacy of contraceptive knowledge.

The United States of America (USA) as a developed country has the necessary provision of family planning services. It is however, important to note that the lack of knowledge does have an impact on the utilisation of family planning services. A study conducted in Wisconsin aimed at measuring women's knowledge of contraception concluded that lack of knowledge as well as holding incorrect facts about contraceptives result in sexually active women who do not use contraceptives (Schrager and Hoffmann, 2008). The evidence from studies conducted in the USA indicates that a lack of knowledge inhibits women's potential to use contraceptives.

Schrager and Hoffmann (2008) note that in developing countries, research that measures women's knowledge of contraception is insufficient. Studies conducted on knowledge that pertains to contraceptives in developing countries indicate that awareness of contraception differs even between developing countries and between the different parts of that country. In Africa, research indicated that inconsistency characterises knowledge of contraception among young women mostly in Sub-Saharan Africa compared to other regions (Blanc and Way, 1998). One may argue that the patterns in earlier literature show low levels of knowledge of contraceptives and this does have an impact on the observed low levels of use of contraceptive in this region. This further illustrates the point that when women know little about contraceptives, they are less likely to use the methods due to this lack of knowledge.

Biney (2011) asserts that lack of knowledge about contraceptives among Ghanaian women led to the failure of contraceptive use, which lead to high unintended pregnancies. However, recent studies conducted in some parts of Africa indicate that knowledge about the use of contraceptives is high. Findings from a study conducted at the Makerere University in Kampala in Uganda indicates high levels of knowledge pertaining to the use of contraceptives. The study comprised of 1008 female participants and results indicated that 86.7% of the participants had correct knowledge about contraceptives (Nsubuga *et al.*, 2016). One may assert that this context is important in matters that relate to the knowledge people

hold towards contraceptives, as women in different social settings have access to different resources, which results in them acquiring different levels of knowledge of contraceptives.

One of the earlier studies conducted on knowledge pertaining to contraceptives in South Africa indicated that knowledge was generally poor. Furthermore, notable confusion and misconceptions regarding contraceptives persists (Richter, 1996). This relates to another study conducted in two clinics in Johannesburg during the year 1998. The study concluded that the majority of women lacked adequate knowledge about the correct and consistent use of contraceptives. As a result, women on injectable contraceptives were late for their clinic appointments and those on oral contraceptives knew very little about the correct use of this method (Beksinska *et al*., 1998). This further indicates that even when the women do use the contraceptives that are available to them, they do not understand how to use these methods correctly and effectively, which means that they might not necessarily work in the way that they expected of them.

Recent studies indicate that nearly all (93.4%) of South African women in their reproductive ages have in one way or the other received information relating to the use of contraceptives (Morroni *et al.,* 2016). Further, the findings of previous studies indicate that in South Africa, knowledge of contraception is higher amongst women who have higher education levels (Seutlwadi *et al*., 2012). However, with the high levels of contraceptive knowledge noted in recent times, Lince- Deroche *et al.,* (2015) assert that knowledge of contraceptives has more of an influence on the intention to prevent pregnancy, but not the actual use of contraceptives. It is noted that even though women may have an awareness of contraception, the platform to use it is not guaranteed.

A study conducted in nine rural areas in the province of KwaZulu-Natal, yielded interesting results concerning knowledge of contraception. Availability of educational programmes, which focus on the provision of knowledge pertaining to contraception, was predominant and as a result, women did have a certain level of knowledge about contraceptives (Ndinda *et al.,* 2017). However, as much as the women in the studied areas possessed knowledge of contraceptives, unintended pregnancies still remain a challenge due to the low use of contraceptives. Augmenting these reports is a study conducted to investigate unintended

pregnancies in KwaZulu-Natal, which attributed the unintended pregnancies to inadequate understanding of contraceptives. Haffejee *et al.,* (2018) indicate that knowledge on the use of contraceptive contained misconceptions and confusion, thus leading to inconsistent and non-use of contraceptive methods. Ndinda *et al.,* (2017) stipulate that having knowledge of contraceptives does not translate into changes in sexual behaviour. This indicates that even in cases where there is adequate knowledge about contraceptives and methods available, use of contraceptive remains low and thus unintended pregnancies continue to rise.

It is important for women to have knowledge of the stakeholders who provide family planning services. Being equipped with this knowledge allows those who wish to use family planning services to be aware of where these services are available (Pazol *et al.,* 2015). Having knowledge on where contraceptives are accessible has an impact on the use of contraceptives. The information regarding the accessibility of modern contraceptives in rural KwaZulu-Natal is often not easy to find (Ndinda *et al.,* (2017). The inaccessibility of information then acts as a barrier to women who have the correct knowledge on where they can access modern contraceptives (Seuwtladi *et al.,* 2012).

Societal norms and culture have been influential in the knowledge that exists regarding the use of contraceptives in the province of KZN. Subsequent to this, knowledge on sexual and reproductive health in general is distorted because initially, parents do not speak to their children about these matters. When parents speak to their children, it is done in a reproachful manner, thus transferring altered knowledge. Ndinda *et al*., (2017) allude to the fact that parents do not discuss issues related to sexual and reproductive health with their children as culture regards it as taboo and outrageous. Considering that some women are not sufficiently informed about contraceptives from an early age, they are less likely to access further information on contraceptives.

2.4 Factors promoting the use of contraceptives

For the purpose of this study, it is important to explore literature that focuses on the factors that promote contraceptive use. The use of contraceptives depends on a range of factors such as access to available contraceptive methods, women's choice, health and religious beliefs as well as perceptions of the effectiveness of contraceptive methods (Oluwole, 2012). Socio-

economic factors such as education and involvement in the labour market plays a huge role in promoting the use of contraceptives among women. Furthermore, other factors such as the desire to limit family size and child mortality promotes the use of contraceptives amongst women (Solanke, 2017). This section of the chapter will discuss literature pertaining to factors that promote the use of contraceptives.

2.4.1. Education

Education is beneficial to individuals and the society. Education is important in finding solutions to health, social and economic issues, Ikhioya (2014). In addition, the literature acknowledges women's education as an important determinant of reproductive behaviour and many governments support women's education as a means to promote smaller family sizes and increase modern contraceptive use (Larson and Stanfors, 2014). Studies from both developed and developing countries have concluded that a decrease in fertility rates is associated with higher levels of education. According to Carr (2000), cited in Jiang and Hardee (2014), education is the best contraceptive. In instances where women are better educated, they tend to make informed health-related decisions and thus are able to avoid unwanted pregnancies by using contraceptives. Acquiring an education is time consuming and thus reduces women's demand for children and increases the desire to delay conception (Gordon *et al.*, 2011).

According to Jiang and Hardee (2014), countries with higher levels of education amongst women indicate slow population growth, low fertility and higher contraceptive use. However, although it is evident that education provides women with more consensus to use contraceptives, it is not certain that the relationship between education and the use of contraceptives exists the same in different contexts. Larson and Stanfors (2014) assert that the impact of education on the use of contraceptives differs according to location, culture and level of development. An earlier study (Jejeebhoy, 1995) observes that the relationship between women's education and contraceptive use differs from country to country as in African countries; larger families have been a norm even when women are more educated.

Some studies conducted in developing countries produce empirical evidence indicating that women's education is associated with the use of contraceptives and the desire to limit births.

A study conducted to determine the influence of the spread of schooling on fertility rates in Sub-Saharan Africa, the use of contraceptives was observed to contribute to the fertility transition. Data shows that all countries that have achieved mass schooling present evidence of entering into the fertility transition where there are few births per woman (Jiang and Hardee, 2014). A study conducted in Nigeria showed that the higher the level of education, the greater the chances of contraceptive use (Moronkola and Fakaye, 2008 cited in Peer, 2012). Similar patterns manifested themselves in Ghana, Uganda and Ethiopia, where increasing education has led to an increase in the use of contraceptives (Buyinza and Hisali, 2014). A study conducted in Iran yielded results, which show that women with no education were less likely to use contraceptives compared to women who had primary level education. Further, women with primary level education demonstrated lower rates of contraceptive use when compared to women with university level education (Therani *et al.,* 2001 cited in Peer, 2012). This indicates that in comparison, different levels of education result in variations in contraceptive use.

The aforementioned studies indicate that higher levels of education lead to an increase in the use contraceptives while low levels of education can be attributed to low contraceptive use. Ikhioya (2014) asserts that among South African women, reading and comprehension skills assist women to better access information and as a result there is a greater demand for family planning services. Rural areas in South Africa are characterised by low levels of education therefore, the use of contraceptive is likely to be low. Referring to the SADHS of 2016, 7% of South African women had no formal education (DOH, 2017). Further, women with no education had a TFR of 4.5 while women with university level education had a TFR of 1.9 (DOH, 2017). Thus, this factor contributed to low levels of use of contraceptives amongst women who have no formal education in South Africa. Education relates to labour involvement and economic dependence of women, which is also a factor that is seen as promoting contraceptive use and will be discussed subsequently.

2.4.2 Employment

According to Font-Ribera *et al*., (2008), women who have a disadvantaged economic status face the risk of unintended pregnancy. In many developing countries, women are unable to make autonomous decisions about their sexual and reproductive health due to their economic

dependence and unemployment (Oluwole, 2012). Women's economic empowerment plays a pivotal role in reducing constraints that affect women's sexual and reproductive health (Choudhury *et al.,* 2018). Thus, women's employment and involvement in the labour market promotes the use of contraceptives among women.

Women participating in the labour market through employment have a higher rate of contraceptive use in comparison to those who are unemployed or homemakers (Choudhury *et al.,* 2018). This is because employed women procure an income and have control over household decisions. Consequently, these women have more control over reproductive decisions. Islam *et al*., (2016) asserts that evidence shows that women's employment status has a strong link with contraceptive use, as employed women enjoy more autonomy. Furthermore, studies have found that women who earn their own income in an active way find alternative satisfaction. This satisfaction competes with bearing and raising children, which promotes the use of contraceptives among women (Palamuleni, 2013).

According to Islam *et al.,* (2016), among the several socio-demographic determinants of contraceptive use, employment status is one of the most influential factors. Studies conducted to assess the impact of women's employment on contraceptive behaviour support this line of thought. According to Solanke (2017), a study conducted in rural Nigeria indicated that there is a positive relationship between women's employment and the use of contraceptives. The study found that with women's employment, fertility decreases and the use of contraceptives increases. Employed women showed a higher likelihood of ever using a modern contraceptive method than those who are unemployed. Similarly, a study conducted in Mahikeng, South Africa found that employed women were more likely to use contraceptives because of effective communication regarding sexual and reproductive matters among employed women.

As the antecedent studies show, women's employment does have an influence on the use of contraceptives. As such, employment fosters the use of contraceptives in various ways. Palamuleni (2013) states that for women, employment comes with the acquisition of money, sometimes stressful and demanding work environments that are incompatible with fertility. Further, exposure to a work environment provides women with a different surrounding and

gives ideas that are unwelcoming to childbearing. If employment leads to an increase in the prevalence of contraceptive use, this correlates with the desire to limit family size, an aspect the subsequent section will discuss.

2.4.3 The desire to limit family sizes

The demand and use of contraceptives can be correlated to the number of children that are desired. The use of contraceptives is pivotal in the process of women wanting to limit the number of children or space births. Further, this contributes to a decline in fertility rates, which also correlates to the use of contraceptives. According to Van Lith *et al.* (2013), empirical evidence suggests that there has been an increase in the desire to limit births among women in SSA. In developing countries, 57% of women in their reproductive careers have the desire to space childbirths and to end childbearing by the use of modern contraceptives (Hailee *et al.*, 2016). Further, the proportion of women who desire to limit instead of postponing childbearing, has risen steadily. This then leads to an exploration of how the desire to limit births has had an impact on the use of contraceptives amongst women in SSA countries.

Van Lith *et al.* (2013) indicates that the demand for contraceptives has links with the desire to cease childbearing as opposed to the demand for delaying childbearing. The findings indicate that the use of contraceptives to limit births has a great impact on fertility rates. According to Susuman *et al*., (2014), the average TFR of Ethiopian rural areas are six children per woman. A study conducted in Northern Ethiopia indicates that nearly 75% of women who use contraceptives do so to limit the births. The study found that the desire to limit births is done mostly by utilisation of Long Acting Reversible Contraceptives (LARC) and permanent methods (Hailee *et al.*, 2016). This indicates that women in rural parts of Ethiopia do have the desire to limit births and thus this leads to an increase in the use of contraceptives.

Nigeria is the most populous country in Sub-Saharan Africa. A study conducted in Nigeria found that there is an estimated 35 million women of reproductive age and the TFR stands at 5.5 children per woman (Oche *et al*., 2018). Further to this, the study discovered that the reproductive careers of some women in rural areas of Northern Nigeria started as early as 19 years of age. Contrary to the above-mentioned study conducted in Ethiopia, this study found that women were limiting their family sizes based on a desire for male children as well as to

protect their health (Oche *et al*., 2018). Furthermore, the uptake of contraceptives was then seen to be low and the desire to limit family sizes was low, thus fertility rates are high. One may say that this indicates that early childbearing and having a low desire to limit family size contributes to the low use of contraceptives. Further, the desire to limit family size is an important factor that contributes to the use of contraceptives as compared to not having the desire to limit births.

2.4.4. Infant mortality

The reduction of child mortality, namely children under the age five, is one of the aims of the third Sustainable Development Goals (SDGs) of the United Nations. The aim of the SDGs is to reduce neonatal mortality to 12 per 1000 births and under 5 mortalities to at least 25 per 1000 births by the end of 2030 (United Nations, 2015). Family planning and the use of contraceptives is pivotal in reducing high-risk births, thus decreasing infant mortality as well as under five mortalities. In developing countries, especially in SSA, more effort is required to reduce infant mortality. This is because in SSA, the rates of infant mortality have been persistently higher than other developing regions between the years 1990 and 2016 (Aheto, 2019). Increase in the use of contraceptives had a direct impact on the reduction of infant mortality (Chikandiwa *et al.,* 2018). Thus, infant mortality is another factor that promotes the use of contraceptives as the use of these has direct links with to the decrease in infant mortality rates.

The evidence from previous studies suggests that an increase in the use of contraceptives leads to a decrease of high-risk births and thus a decrease in infant mortality. In South Africa, contraceptive prevalence is low and thus unintended pregnancies and high-risk births are prevalent. It is reported that nearly 40 000 children under the age of five die in South Africa each year (Chola *et al.,* 2015). Contraceptive use has been one of the measures that will save the lives of children, by preventing high-risk births by increasing the use of contraceptives. A study found that if the CPR of South Africa were to increase by 0.68% per year, by the year 2016, high-risk births would have reduced by 23%, meaning that 7000 infant births would be averted annually (Chola *et al.*, 2015). This is congruent with evidence from a study conducted in Burkina Faso, which found that regions that record low contraceptive prevalence also have high levels of risky births and infant mortality (Maïga *et al*., 2015). This

goes to highlight the importance of contraceptives as a means to decrease child mortality, thus making child mortality a factor that promotes the use of contraceptives.

Contrary to the above-mentioned study, other studies have shown a different relationship between the use of contraceptives and infant mortality. This indicates the importance of exploring the factors that contribute to infant mortality before the promotion of contraceptives as an intervention for these. Analysis of demographic and health surveys from Kenya and Zimbabwe indicated interesting results. This study concluded that Kenyan, contraceptive prevalence rates had direct links with a reduction of high-risk births and infant mortality. However, infant mortality had a direct link with other factors such as HIV prevalence (Chikandiwa *et al.*, 2018). Zimbabwe showed patterns of high contraceptive use as well as high infant mortality. The government increased efforts to provide contraceptives to all those that require them, but the high infant mortality rate results from some provinces being predominantly rural and thus, having limited access to health services (Chikandiwa *et al.*, 2018).

2.4.5. Influence of peers

The influence of peers has been noted to be a factor that promotes contraceptive use. Peer influence enhances contraceptive use because it is easier to discuss sex-related issues with people of the same age group. According to Thompson and Spainer (1987) peers are a trusted source of information concerning sexual and reproductive matters based on their own experiences, which they share with their peers.

Studies have shown concern with how peers, partners and family members have an influence on activities such as the use of contraceptives. Evidence suggests that younger people are more influenced by the environment and people that they surround themselves with mostly (Nathanson and Becker, 1996). Therefore, peer influence has an impact on their sexual and reproductive decisions. Shah and Zelnik (1981) note that peer influence on teenagers is stronger than the influence of parents. The sexual behaviour and contraceptive use of teenagers is consistent with that of peers, which indicates that peers are a strong source of influence.

The contribution of peers to conformity regarding contraceptive use is associated with the power of peers being an attractive and supportive group. Nathanson and Becker (1996) note that women offer assistance to each other to get to the health facilities and procure contraceptives as well as encouragement to use contraceptives correctly and consistently. Through the support of peers, women are more likely to be encouraged to utilize contraceptives. Further, contraception is seen to be an issue that is discussed more amongst women peer groups as unintended pregnancy has a greater impact on women, thus peers encourage each other to use contraceptives.

2.4.6 Age

According to Firman *et al.,* (2018) few studies have used largely representative samples to examine the association between the use of contraceptives and how the relationship differs between age groups. This indicates that there is reason to examine how women's age can affect their use or non-use of contraceptives. Age is an important component regarding the use of contraceptives. Sensoy *et al*., (2018) asserts that women's age is a very important factor in deciding when a woman will begin and end her reproductive career. Further, age helps in determining how long a woman will wait for another birth. According to Peer (2012), age differences in contraceptive use are prevalent in developing countries, showing that across different age groups, there are differences in the rates of contractive use. Paying attention to how age is an influencing factor towards the use of contraceptives is important to understand the differences in contraceptive use across different age groups.

Maternal age at first birth is an important determinant of the choice to use or not use contraceptives. Women who have children earlier are more likely to use contraceptives. Sensoy *et al.,* (2018) asserts that younger women often have fertility desires that are stronger than those of older women. A study based on the 2011 Uganda Demographic Health Survey found that more women in the age group of 15-24 wanted to have another child while women in the age group 25-34 did not want any more children (Asiimwe *et al.,* 2014). The relationship between fertility desires and age can be linked to contraceptive use in a sense that older women who do not desire to have more children, are more expected to use contraceptives than those that desire to have more children. Studies have shown that older

age is associated with an increase in contraceptive use as seen in studies conducted in rural Bangladesh and Ghana. (Solanke, 2017)

In most cases, contraceptive use increases until age the age of 39, and then starts to decline (Aviisah *et al.,* 2018). According to Nonvignon and Novignon (2014), a study conducted in Ghana established a relationship between women's age and contraceptive use. This study suggests that contraceptive use rises with age then eventually falls after some age group. Similarly, in a study conducted in Kenya contraceptive use was highest among women aged between 20-39 years in comparison to those below age 20 and over 39 years of age (Okech *et al.,* 2011). The influence of age on contraceptive use amongst South African women can be noted in the different prevalence rates noted across different age groups. The 2016 SADHS indicated a CPR of 68.7% among women in the age group 15-24, which was the highest recorded rates. In comparison to the age groups 25-34 years and 35-49 years, which showed percentages of 58.9% and 50.8% respectively (DOH, 2016). Thus, age can be seen to be an influencing factor in contraceptive use, but in South Africa, the influence is greater among the younger age group than it is on older age groups.

2.4.7 Place of residence

The region in which women live influences contraceptive use. Past literature shows that there are differences in contraceptive use rates between developed and developing countries as well as between urban and rural areas (Oosthuizen and van Zyl, 1998). Hence, differences are seen in contraceptive use rates of countries such as Europe, South Africa and Congo for instance. This indicates that region and place of residence are a determining factor in contraceptive use (Izale *et al.,* 2014). Place of residence has an impact on the use of contraceptives as it has been previously noted that contraceptive use is higher in developed and urban regions than it is in developing and rural regions of the world. It is important to note that contraceptive use rates vary even in countries that have similar economic status, based on differences in health services and other factors that influence contraceptive use. For instance, there are differences in contraceptive use even in developing countries within the Sub-Saharan African region (UN, 2017).

This section of the literature review has discussed the various factors that promote the use of contraceptives. The following section of the literature review will discuss factors that inhibit the use of contraceptives.

2.5. Factors inhibiting contraceptive use

The use of contraceptives is an important component of proper family planning but various factors tend to inhibit it (Ackerson and Zielinski, 2017). The social ecological models' concept of multiple levels refers to how behaviour affects and is affected by multiple levels of influence. This is an important component for this study as it is important to look at the multiple factors that are involved in inhibiting women from using contraceptives. Thus, literature looking at factors that inhibit contraceptive use is explored. It is important to understand the inhibiting factors of contraceptive use as these external factors have an influence on the behaviour and perceptions of women towards contraceptives.

According to Ndinda *et al.*, (2017), cultural, gender and power relations, arguably, have implications for reproductive health rights among women in rural Kwa-Zulu Natal. Hence, exploring the relevant literature and fostering an understanding of the factors inhibiting the use of contraceptives from different perspectives will assist in understanding the influences that shape the non-use of contraceptives among women who reside in rural areas. This section discusses the factors that inhibit the use of contraceptives, at the same time referring to the impact this has on the use of contraceptives among older women residing in rural areas.

2.5.1 Gender inequality

Male dominance and the pressure men exert on women to prove their fertility are common in South Africa, especially in the rural areas with men being the decision makers (Stephenson *et al*., 2008). In rural patriarchal societies, women have to maintain submissiveness and accept males as the decision-making authority, it follows then that women living in rural areas have limited authority to make the decision to use contraceptives. In a study conducted in Zambia, the findings revealed that only 20% of the interviewed men and 70% of the interviewed women approved of contraceptives (Biddleton and Fapohundra, 1998). The same study found that the possible reasons for these percentages were the perceptions that contraceptives

encourage infidelity; making men lose control of their wives and that the use of contraceptives reduces the number of children the man wishes to have (Biddleton and Fapohundra, 1998). This is an overt indication of male dominance and gender inequality, which has an impact on the use of contraceptives as well as limiting women from accessing contraceptives. Patterns of gender inequality clearly have an influence on the low use of contraceptives. Women living in communities that are largely patriarchal are submissive and are unlikely to use contraceptives if their partner is opposed to their use of a family planning method.

Due to the patriarchal systems that are dominant in African countries, family planning efforts are unlikely to be successful in this particular context (Keele and Flake, 2005). Ackerson and Zielinski (2017) concur with this observation, indicating that the social influence that males have in society are predominantly against the use of contraceptives. Their concerns border on the desire to prevent the motivation to space births and limit family size using contraception. In some instances, even if the women desire to use contraceptives, men tend to override their decisions and therefore the couple fails to use contraceptives.

2.5.2 Traditional contraceptive methods

Discussions on the factors that influence the use of contraceptives by women in rural KwaZulu-Natal dominated scholarly work in recent years. In these discussions, indigenous or traditional methods of contraceptives for women in KwaZulu-Natal came under spotlight. The practice of virginity testing or *ukuhlolwa* is an indigenous method that ensures that women are tested and made to remain virgins until their readiness for marriage in order to avert unwanted pregnancies (Ndinda *et al*., 2017). This practice is still applicable in many parts of Kwa-Zulu Natal. This method of contraception is still one of the most preferred and encouraged methods in rural areas. Its effectiveness lies in that it enables women to abstain from engaging in sexual relations and thus succeed in preventing pregnancies. Virginity testing is an important factor to consider that many rural women in KwaZulu-Natal often preferred as a method of contraception. The practice is indeed one of the factors that influences women in their decisions whether or not to adopt modern contraceptive methods. There is a raging debate on how virginity testing could be integrated into the mainstream of modern methods dominated the discussions around contraceptives (Ndinda *et al*., 2017). One

may argue that this is an important point to consider because it is evident that even though traditional methods of contraception are still used in rural areas, there are still unwanted pregnancies that could be easily prevented by adherence to modern contraceptive methods.

2.5.3 Religion

According to Srinkantan and Reid (2008), despite a wide range of contraceptive methods available to women worldwide, a number of factors hinder women from accessing them. Religion is one of the factors that impede women's access to contraceptives. According to Srinkantan and Reid 2008), personal beliefs and values are shaped by religion and in turn they act as a barrier to women's access to contraceptives. Women who hold strong religious beliefs, which are sometimes against the use of contraceptives, can influence them to avoid using contraceptives basing their decisions on their religious beliefs. As such, one may reiterate the need to consider religion as a factor that indeed influences women or couples to use or to shun the use of contraceptives.

The views of a given religious population greatly affect their attitudes to sex and contraceptive choices. This implies that particular individuals act in accordance with their religion, which may influence their abstinence, their unwillingness to use contraceptives or the need to have many children according to the scriptures of that particular religion. Thus, if a given religious population share a common religious orientation that opposes the use of contraceptives, one may surmise that the use of contraceptives in that particular population is likely to be low. In developing counties, religion influences women to choose not to access or use contraceptives. This resonates with the following observation, thus: "in many parts of Africa, the religious leaders and practices are against the use of contraceptives" (Srinkantan and Reid, 2008:130). An analysis of this statement further reveals and captures the essence of the religious views regarding the use of contraceptives amongst Roman Catholicism and Islam. The statement also depicts how religious views influence the use of contraceptives for the followers of a particular religious' persuasion. Notably, different religions hold different perspectives regarding the use of contraceptives.

Lo Presti (2005) argues that throughout much of history, sex has been valued mostly for procreative reasons. This statement alludes to how the Roman Catholics view sexual

intercourse as a means of procreation and not for pleasure. Further, Schenker (2000) argues that Roman Catholicism contends that the primary purpose of marriage and sexual intercourse is procreation and every act of intercourse must remain subject to conception. One may argue that viewing sex as a means of procreation while discouraging the use of contraceptives is a perspective attributable to high birth rates. Women or couples who subscribe to this religious belief which views sex and marriage as the mode of procreation are unlikely to use contraceptives and more likely to have many children as they adhere to their religious beliefs disregarding the use of contraceptives. For strict believers the interpretation would be that they have limited or no authority whatsoever to use contraceptives as this contravenes their religious beliefs.

The banning of contraceptives by Roman Catholicism is inclusive of unnatural means of contraception encompassing chemical and barrier methods. The only officially approved methods of contraception are abstinence and the rhythm method (Maguire, 2003). Roman Catholics only allows its followers to use the above-mentioned methods of contraception, which it considers natural since it advises against the use of unnatural methods of contraception.

Moreover, Roman Catholics prohibits all forms of abortion together with emergency contraception. Lo Presti (2005) echoes the same sentiments, arguing that according to the doctrines of Roman Catholicism, a new person or new life begins during the time of conception. Hence, if followers of this religion ascribe to these beliefs, they are not at liberty to apply emergency contraception including abortions, which increases birth rates. A study conducted in Matemwe, East Africa (Keele and Flake, 2005) supports these findings when it reports that women's views on contraceptives greatly draw some influence from their religious beliefs. The women who took part in this study strongly believed in their religion since they reported that their reproduction and the number of children they should have are reflective of God's will and they, as parents, can hardly interfere (Keele and Flake, 2005).

In the Islamic faith, the means of contraception is regarded as going against the wishes of God (Manning and Zuckerman, 2005). Thus, it clearly stands out that women are likely to be influenced by their religious belief and therefore choose not to use contraceptives, which they

think contravene God's will. For example, "The *Quran* warns against the use of unnatural methods of birth control suggesting that in using such methods as hormonal contraceptives, the woman is killing life inside her." (Keele and Flake, 2005:36). This indicates that the adherents of Islam, who happen to hold this notion, are unequivocally unlikely to seek clarity from health care professionals in this regard. According to Srinkantan and Reid (2008), the modesty that the Islam religion associates with its female believers prohibits women from exposing themselves to intimate medical examinations conducted by health care providers. This can be said to have an impact on women of this religion not visiting health facilities to seek family planning services. Therefore, religion can be noted as a factor that inhibits the use of contraceptives.

2.5.4 Fear of side effects

Hormonal contraceptive methods have been criticised for having undesired side effects. These side effects differ depending on the different contraceptive methods, though they reportedly diminish if the user uses the same contraceptive method continuously, (Longwe, 2012). The common side effects of contraception reported in earlier research include weight gain, acne, mood changes, nausea, dizziness and irregular periods (Baar, 2010). One may further surmise that due to these reported side effects of contraceptives, women may refrain from using contraceptive methods or discontinue using them once they experience such side effects.

In a study that explored the factors that influence the use of contraceptives among the women living in the crisis-stricken areas of Sub-Saharan Africa, the identified side effects of the contraceptives were the factors that inhibit the use of contraceptives. According to Ackerson and Zielenski (2017), a combination of studies in Sub-Saharan Africa indicated that women were unwilling to use contraceptives because of the side effects, which they assumed caused death and infertility. This then proves that the side effects of the contraceptives are indeed inhibitive to women who might benefit from using them and thus, to some extent, this accounts for the observed low rates of contraceptive use in the Sub-Saharan African region.

In 2014, a single-rod sub-dermal implantable contraceptive found its way into the South African health system (United Nations, 2017). Researchers conducted a study to investigate

the factors that influence women's choice of implantable contraceptive devices in a rural district hospital in Knysna, Western Cape (Potgieter *et al*., 2018). The study found that many women were reluctant to use this device. The reasons for rejecting the device boarded on the side effects and other women had the device removed due to side effects such as pro-longed menstruation and headaches (Potgieter *et al*., 2018). However, this study maintains that the women received information and counselling services regarding the side effects of this contraceptive method. This indicates that majority of women avoid using certain contraceptive methods based on side effects.

Consequently, the issue of women not using contraceptives due to side effects has to be reduced by certain measures. As the World Health Organization suggests, there is a need to assess the medical eligibility of women before and during the time that they are using a contraceptive method. In this way, women can use suitable contraceptive methods that best suits them and the chances of experiencing the side effects are minimal (WHO, 2010). This possibly leads to increased contraceptive prevalence rates if the programme seeks to eliminate the side effects since they tend to inhibit the use of contraceptives, especially among the women living in the rural areas. However, Clealand (2014) indicates that women's choice of contraceptive methods do have limits in developing countries. This means that in some instances, women use those contraceptive methods readily available at the nearest health facilities, regardless of their side effects. In this context, there are also limited resources and funds that impede the assessment of women's medical eligibility for specific contraceptive methods.

2.5.5 Myths and misconceptions

According to Eram (2017), negative myths and misconceptions about family planning impede the use of modern contraceptive methods. Such misconceptions about contraceptives spread through the informal communication systems such as peers and community members. Thus, if society constantly spreads these misconceptions about contraceptives, the result would be the perpetuation of negative perceptions, thus, causing a negative impact on the rates of contraception use among women. Paz (2004) echoes the same sentiments, arguing that the use of contraceptives is low in communities that do have popular myths and misconceptions about contraceptives.

A study conducted in rural Malawi (Chipeta *et al.,* 2010) indicated that the majority of the women in that country did not use contraceptives and the female participants who took part in the study reported common myths and misconceptions, which wrongfully resonate with the use of contraceptives. The male respondents in the same study reported that contraceptives have an adverse effect on male reproductive organs and that using condoms causes blisters and sores in their genitalia, a development which ultimately weakens their manhood (Chipeta *et al.,* 2010). The negative misconceptions that were prevalent in that community had a direct link with the low use of contraceptives in this area (Chipeta *et al.,* 2010). One may assert that when misconceptions are existent in both women and men in a community, disregard for the use of contraceptives holds greater sway as the people are more likely to subscribe to the belief that contraceptives are not conducive for them. Furthermore, it is quite common that people who hold misconceptions about contraceptives are unlikely to seek professional assistance to that end.

Further, in a study conducted in Ghana, various respondents reported numerous myths and misconceptions regarding contraceptives (Adongo *et al.*, 2004). Many people held numerous beliefs concerning the use of contraceptives, arguing that they predispose the females to cancer. They further asserted that implants might dislodge and go missing in the woman's body. They also confided that IUDs might shift in the uterus, that condoms lead to non-erection in men and that the use of contraceptives can lead to the birth of abnormal children in the future (Adongo *et al.*, 2004). The misconceptions this study exposed had consequences severe enough to thwart the use of contraceptives. One may maintain that if these beliefs are common in a community such that women strongly believe that using contraceptives has detrimental effects on their reproductive health, the use of contraceptives is bound to be low.

The above-cited studies depict the myths and negative misconceptions that surround the use of contraceptives and they indeed explain the low use of contraceptive. Sub-Saharan African countries are not exceptional and myths and misconceptions act as a huge hindrance to women's inclination towards contraceptives. These negative misconceptions are preponderant and there is need for addressing them. Government and other stakeholders need to ensure that the correct information about contraceptives is relayed to communities to educate women and couples the correct use and the possible side effects of these

contraceptives. According to Eram (2017), having an understanding of these myths and misconceptions is imperative in developing educational programmes and policies that aim at dispelling these negative misconceptions. One may argue that developing educational programmes that dispel negative myths and misconceptions that surround the use of contraceptives in the rural areas can result in an increase in the prevalence of contraceptives.

2.6 Summary

This chapter has presented the main findings from the literature relevant to the use of contraceptives. The literature reviewed in this chapter pertains to the use of contraceptives from both the global and the South African perspectives. The study has also referred to the studies conducted in South Africa and other parts of the world. Due to the scarcity of South African literature that speaks directly to the use of contraceptives amongst the women of mature ages in rural areas, this study has drawn on literature that depicts the use of contraceptives amongst the women of a similar socio-economic status in other parts of Africa. The literature suggests that the use of contraceptive tends to vary between developed and developing countries and similarly, between the urban and the rural areas. It therefore became imperative to explore the literature that discusses the factors that either promotes or inhibits the use of contraceptives among the women much further. Evidently, the reviewed literature indicates that knowledge of contraception has an impact on its use. A further exploration of the available literature indicates that high educational levels, involvement in the labour market and a desire to limit family size, promotes the use of contraceptives among the African women. However, gender inequality, cultural and religious beliefs as well myths and negative misconceptions are seen as factors that inhibit the use of contraceptives among African women.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

There has been an increase in the research that focuses on the use of contraceptives among women in developing countries. The overall objective for this study, as discussed in chapter one, is to shed insights into the use of contraceptives among older women of reproductive age in rural KwaZulu-Natal. The study draws on qualitative data from in-depth interviews in order to obtain an understanding of the factors that promote and inhibit the use of contraception among older women in rural KwaZulu-Natal. This chapter provides detailed explanations for the type of research design and research methodology applied throughout this study. This chapter begins by describing the study population and the study area. It then examines the research design; data collection processes and considers the sampling procedures used for this study. Thereafter, the data analysis techniques used for this study are described. Lastly, it highlights the ethical considerations taken as well as some of the major limitations of this study.

3.2. Study setting

The study area in which the researcher conducted the study is Ntabamhlophe, a rural area situated in KwaZulu-Natal. Ntabamhlophe is an area that falls within the jurisdiction of Estcourt, which is in the UThukela District and it is known as the White Mountain. Ntabamhlophe is 32 kilometres from the centre of Estcourt (see Figure 3.1). The area was previously under the Imbabazane Municipality but the authorities merged it with the Umtshezi Local Municipality to form the Inkosi Langalibalele Municipality after the local government elections of 2016. Ntabamhlophe has 11 sections namely: Bhoshi, Goodhome, Ezinyosini, Kwa-Dlamini, Eshayamoya, Ezinyosini, Ezimfeneni, Seventeen, Mhubeni, Sobabili and Dutch sections. Ntabamhlophe is a sparsely populated area mainly consisting of small houses (see Figure 3.2). This rural area is predominantly African and the majority of the inhabitants are mainly isiZulu speakers. This study focuses on Ntabamhlophe as a whole. It does not focus on one particular section of the area. Drawing from the Census reports of

2011, the population of Imbabazane Municipality was 113073, of which 112531 were Black and 60245 were females (Stats SA, 2012). The study focuses on fifteen women from the whole of Ntabamhlophe Area.

Figure 3.1 Location of Ntabamhlophe, KwaZulu-Natal

Source: UThukela District Municipality (2018)

Ntabamhlophe is an area characterised by high unemployment rates. Accordingly, 6234 people from Ntabamhlophe area reported that they do not have a household income to support their needs, as none of the household members were employed (Stats SA, 2012). Agriculture or farming (both commercial and subsistence) is the most common economic activity. In this area, those individuals who are employed work in the factories and industries such as the textile factories predominantly found in Estcourt Town. Nestlé and Bata Shoe Factory are the most dominant employers in Estcourt Town. Households also generate their own income through self-employment and small-scale enterprises such as tuck-shops and beer halls. Furthermore, the tourism sector provides employment to the people in this area as well since Ntabamhlophe is adjacent to historical sites such as Giants Castle and the Drakensberg. There are also a few social services in Ntabamhlophe area and these include a clinic, schools as well as a library (see Figure 3.3).

Figure 3.2 Housing in Ntabamhlophe, KwaZulu-Natal

Figure 3.3 Social Services in Ntabamhlophe, KwaZulu-Natal

3.3. Research methodology

There is a variety of research designs in research but this study employs a descriptive research design. A descriptive research design suits this study since it thoroughly describes the use of contraceptives in Ntabamhlophe area. There are two methodological approaches adopted in exploring phenomena in the world of research and these are the qualitative and the quantitative research methodologies. Therefore, this study adopted qualitative research

methods, which, according to Creswell (2013:182), "involves interactive and participatory methods of data collection; strong emphasis is given to the need for the researcher to build rapport with the participants and involve the participant in the discussions." Furthermore, the qualitative research approach seeks to develop detailed explanations, in-depth understandings and analytical interpretations of the various issues that exist in the world (Mason, 2002).

This study aimed at providing detailed insights into the use of contraceptives among older women who are still active in terms of reproduction and sexuality. The rationale for adopting the qualitative methodology is the desire to ascertain perspectives and experiences of women on contraceptives as well as determining the factors that either promote or inhibit use. The qualitative research design collects data in the form of verbal language or observations and allows the researcher to study selected issues in depth and in detail (Terre Blanche and Durrheim, 2006). The qualitative methods include different techniques such as face-to-face in-depth interviews, focus group discussions, case studies and life histories. For the purposes of this study, the qualitative methods are therefore the most appropriate in fostering an in-depth understanding of the use of contraceptives among older women in the rural areas.

Considering the sensitivity of the topic under research, some of the older women in the rural area may have been inclined towards viewing the subject as taboo. Thus, the researcher used in-depth, face-to-face interviews to enhance full interaction with the participants. Qualitative research methods succeed if the researcher establishes rapport and a trusting relationship with the participant in order to ensure that the interviews solicit useful data. Hence, the qualitative methods used in this study are relevant for an in-depth understanding of the use of contraceptives in the rural areas.

3.4. Sampling

There are strategies that researchers employ when the process of sampling is taking place and the researcher chooses the most relevant strategy that suits that particular study. The sampling strategy used in this research is a non-probability sampling strategy, which is purposive in its orientation. Non-probability sampling does not involve the random selection of participants. Purposive sampling depends on the judgement of the researcher regarding the characteristics of the population (Lunsford and Lunsford, 1995). Purposive sampling becomes useful when a researcher needs to reach a targeted sample from a population quickly (Trochim, 2006).

Purposive sampling is used to find suitable participants who fit the criteria that is required to be met in order to participate in the research study.
For this study it was important to select a sample that serves the purpose of providing the information required by the research topic.

In a research study, there are criteria that need to be met by the potential participants in order to be considered for the study. These requirements ensure that there are similarities among the participants with regards to factors such as age, gender and location. To be eligible for the study women had to be aged between 25 and 35 years and residing in Ntabamhlophe. The researcher recruited the participants of this study together with the Community Care Givers (CCGs), who work as health assistants in the Ntabamhlophe community. The CCGs had the knowledge of which households could have individuals who fit the requirements for this study. The selection process of the participants was done by going house to house to visit the potential participants and explain the purpose of the research study. Once the desired number of participants was reached, the researcher was able to have selected a sample of 15 women aged between 25 and 35 years to provide valuable information and shed insights into the use of contraceptives among the older women living in rural areas.

3.5. Data collection

For this study, the qualitative data was collected by means of in-depth interviews. Taylor and Bogdan (1998: 77) define the term interview as "face to face encounters between the researcher and the informants directed towards understanding informant's perspective on their lives, experiences or situations as expressed in their own words". Thus, the study employed in-depth face-to-face interviews so that the collected data had its basis in the participants' responses. The use of interviews ensured that the participants expressed their perspectives and experiences regarding the use of contraceptives as well as other factors this study sought to investigate.

The data collection process for this study took the form of in-depth face-to-face and semi-structured interviews. All the interviews took place in the participants' homes in order to ensure that they felt most comfortable. Each interview occurred in a private room to ensure maximum privacy and the absence of disturbances. The researcher introduced the research study to all the participants during the recruitment process and the women that were

interested in participating in the study endorsed their commitment and therefore made an appointment with the researcher for the interview to take place.

The researcher asked the women that had agreed to participate in the study to sign an informed consent form (Appendix II) to indicate their understanding of the rationale for the study and willingness to participate in the study. The researcher asked the participants for their permission to have the interviews recorded with an audio device. The researcher assured all the participants of confidentiality. The interviews were conducted in both English and IsiZulu and each interview lasted approximately 25 minutes. The use of pseudonyms ensured anonymity in the reporting of the findings. The interviews consisted of guiding questions that were in relevant to the study.

Each of the interviews contained a list of questions that were the same for all the participants who took part in the study. These questions were, however, adjustable depending on the circumstances of each one of the participants, solely for interpretation purposes. The interviews contained both closed-ended and open-ended questions. Firstly, the researcher asked the participants closed ended questions to solicit information about their demographic and socio-economic characteristics. Then, the researcher asked the participants open-ended questions to enable the participants to fully engage with the topic and give responses that shed insights into the topic. These questions solicited information concerning the participants' awareness of contraceptives, their attitudes towards contraceptives, their experiences and perspectives regarding contraceptives as well as the factors that either influence or inhibit the use of contraception (Appendix I). Prior to the commencement of the study, the researcher asked the participants to choose the language they would prefer to during the interviews and the choice had to be between English and isiZulu. The researcher conducted eight interviews in isiZulu and seven in English. All the participants expressed their willingness to be audio recorded. The recorded interviews are kept at the University of KwaZulu-Natal for storage for a period of 5 years as per university policy.

According to Blaikie (2003: 28), "once relevant data towards a particular study has been collected or compiled it is important to gather the tools to assess how and to what extent the research questions can be answered". In qualitative research, data analysis is a continuous process that begins informally during the data collection process. Data presented in qualitative research is easily interpreted if it is categorized into themes. Having themes from

the collected data helps to make concepts clearer in relation to the topic being studied. The data was collected and analysed manually following Durrheim's (2006), five steps of data analysis discussed as follows:

In qualitative research, data analysis begins at a point when the researcher engages in the thorough process of reading the transcripts repeatedly to enhance familiarity (Ullin and Tolley, 2004). Verbatim transcripts were derived from the recorded interviews. The transcripts were thoroughly read to create familiarisation with the information that the participants had provided. Once the transcripts were read, immersion occurred when the researcher re-listened to the recordings from interviews in order to have the correct interpretation of what the respondents said during the interview.

Once familiarisation and immersion had taken place, the researcher then coded the data by labelling and organizing the data into categories. Once the categories are formed, similar codes are then merged to create themes. Themes create a broader understanding of the similar responses that were given by the participants and help identify how the research questions have been answered. The information was then examined to identify information that was not captured initially. Then, the collected data was checked in comparison with each other, the literature review and the theoretical framework, which guided this study. This was done to ascertain whether the study managed to answer the research questions.

3.7 Reliability and validity

The central concern for any research study is its ability to maintain credibility and the degree to which research data is both reliable and valid. Researchers should ensure that their studies are valid, reliable and carefully thought of and conducted. Thus, reliability and validity are core characteristics the researcher needs to articulate in the study.

Neuman (2014: 212) defines reliability as "dependability or consistency. It suggests that the same thing is repeated or recurs under the identical or very similar conditions." The study ensured reliability by subjecting all the fifteen participants from the designated study area to the same interview questions to which they had to respond. The purposive sampling techniques guaranteed the reliability of the study by ensuring that all the fifteen participants

who took part in this study were eligible for the study and thus, were able to provide information that is rich and reliable for this study. The researcher signed a non-disclosure agreement to ensure that the information the participants contributed remains private and confidential. This helps the researcher to build rapport with the participants and this contributes to the participants' provision of reliable information owing to the rapport that the non-disclosure agreement established. The researcher ensured that the environment where the interviews took place was comfortable to ensure a sense of privacy and confidentiality during the interview.

Neuman (2014: 212) states, "validity suggests truthfulness. It refers to how well an idea "fits" with actual reality." To ensure the validity of the research findings, the researcher ensured that the interview questions were in simple language and the questions thoroughly explained to the participants to ensure that they understand them and thus, the responses they would give would be valid. The interviews took place in a language that the participants felt comfortable with, choosing between IsiZulu and English. The researcher conducted the interviews personally. The researcher received the information directly from the participant and not from a secondary source, thus making the information valid.

3.8 Ethical considerations

Ethical considerations are important when using qualitative research methods as these ensure that there is a general set of principles that the researcher will abide by during the study. The Gatekeepers consent to conduct the study in Ntabamhlophe was granted by the Inkosi Langalibalele Municipality. The researcher obtained ethical clearance to proceed with the study from the Human and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (Appendix III). Once consent was obtained from the relevant authorities and ethical approval for the study granted, the researcher was then able to meet with the participants to thoroughly explain the study to them.

The researcher introduced herself and informed the participants about the aims and objectives of the study. She explained how their responses would help in achieving these goals. Each respondent had to give consent to participate and then sign an informed consent form to this regard. However, the researcher explained that each participant had the freedom to withdraw

from the interview process at any time if felt that they no longer wished to continue. The study adheres to ethics by following the four widely accepted principles outlined below Banks (2006).

Principle One: Autonomy and respect for dignity of persons

This principle emphasises the requirements for voluntary informed consent, confidentiality and the obligation to protect the identity of communities in certain instances (Wassenaar, 2006). This study ensured that this occurred by using the informed consent forms and emphasising confidentiality as mentioned before. The researcher used pseudonyms to conceal the identities of those who were not at liberty to have their identities disclosed.

Principle Two: Non-maleficence

Preventing doing harm and doing wrong to participants is central to this principle (Wassenaar, 2006). To some extent, this study borders on a sensitive topic and the researcher conducted the interviews in a manner that ensured that no harm occurred to the participants during the study. As mentioned before, the researcher conducted these interviews in an environment that was comfortable for the participants and the researcher gave assurance to the participants that they were free to withdraw from the interview or from being part of the study at any time. The researcher conducted the interviews in the language the participants preferred between IsiZulu and English.

Principle Three: Beneficence

This principle obliges the researcher to maximize the benefits that the research will afford to the participants of the study (Wassenaar, 2006). This study will be beneficial to the participants in the sense that they could receive valuable information regarding the use of contraceptives by participating in this study.

Principle Four: Justice

Justice generally requires that people receive what is due to them and that researchers treat participants with fairness and equity during all the stages of the research (Wassenaar, 2006). This study ensured justice by clarifying possible risks that the participants were likely to suffer and by specifying the means to minimise these risks as they apply to the participants. For instance, if need arose that that the researcher had to reimburse the participants money for transport, the researcher does that and it is ethical and it minimises the risks on the part of the participants. However, for this study, the researcher did not reimburse participants in any way as the researcher travelled to the homes of the participants.

3.9. Limitations of the study

The limitations of a study arise from the methodological features or the design of the study that influence how the researcher conducts the study and how the researcher interprets these findings. According to Price and Murnan (2004), limitations are the constrictions on the generalizability, applicability to practice, and/or the utility of findings that result from the ways in which the researcher initially chose to design the study and/or the method used to establish internal and external validity. Though the researcher carefully considered and chose the study design and methods, there were still limitations to this study.

Regarding the process of the data collection, the limitation manifests in honesty, which lies with the participants. The participants might be willing to engage in the interviews but they might not be honest in their responses. The researcher assured the participants of confidentiality. The researcher further emphasised the concept of confidentiality, which the informed consent form stipulates. Both the researcher and the participant signed the informed consent form before the commencement of the interviews.

The use of audio tools is important during the interview process because the researcher is able to capture all the information. The interviewer can play the audio device again, if necessary, for the purposes of transcription and data analysis. Seeking consent to use the audio tool can be a problem as some participants might not be comfortable with the recording of their speeches during the interview, regardless of confidentiality assurance. In such

instances, the researcher has to be extremely attentive in order to take down the notes during the interview

The withdrawal of participants from the study could also be problematic if the participants suddenly become disinterested in participating in the interview. The participants reserve the right to withdraw from the study at any point, should a problem arise. The researcher, with his or her permission retains and analyses the relevant information that they had already provided prior to the withdrawal of the participant.

The availability of participants is a limiting factor in this study. The participants might not be available or choose not to avail themselves for interviews. Given the sensitivity of talking about contraceptive use, some participants might not be entirely willing to share information on this particular topic. To mitigate this limitation, the researcher has to emphasise the potential values inherent in this study, highlighting the importance of discovering new knowledge on such research topics as the use of contraceptives amongst the South African women living in rural areas.

CHAPTER FOUR

FINDINGS

4.1 Introduction

Overall, the aim of this study was to enrich the existing knowledge on the use of contraceptives amongst the older women of reproductive age in Ntabamhlophe, a rural area located in KwaZulu-Natal. This study has drawn on qualitative research methods from fifteen in-depth face-to-face, individual semi-structured interviews. The study draws on social ecological models to investigate contraceptive use among women. This chapter initially describes the demographic profiles of the women. It then outlines in more detail the factors that promote or inhibit the use of contraceptives among these women

4.2 Sample profile

Table 4.1 below presents the socio-demographic characteristics of the interviewed participants. In total, fifteen women were interviewed for the study. All the participants were inhabitants of the rural area called Ntabamhlophe. The participants were women aged between 25 and 35 years. The average age of the sample was 31 years old and all the women in this sample were Black and Zulu speaking. Of the women in the sample, nine reported being in a long-term relationship, three were married and three stated that they were cohabiting with their male partners. Of the participants, only six of them stated that they completed their secondary school education. In terms of employment, ten of the participants reported that they were unemployed. Of the five participants who were employed, two worked as general workers, one worked as a domestic worker the other one as a cashier and the fifth one was self-employed. Out of the fifteen participants, thirteen reported having at least one child and eleven of the women had more than one child. Two of the participants reported that they did not have any children. In terms of use of contraceptives, six of the participants reported ever using a contraceptive method. Two out of the six participants were currently using a contraceptive method. The two participants that reported to be using contraceptives reported that they are using the injectable contraceptive method at the time of the interview.

Most of the participants reported the stigma associated with the use of contraceptives in the community. The participants reported that the clinic was far away, adding that the attitudes of the health professionals at the clinic was another reason for the non-use of contraceptives in this area. The participants shared the same sentiments regarding the need for younger women to use contraceptives more than the women in their age range. This is particularly important because the women agree that at their age range, they are more likely to marry and bear children and therefore there was no need for contraceptives.

Table 4. 1 Sample profiles

Interview	**Pseudonym**	**Age**	**Marital/Relationship status**	**Level of education**	**Number of children**	**Employment status**	**Ever use contraceptives**	**Current contraceptive use**
1	Nonhla	25	In relationship	Matric	1	Unemployed	Yes	No
2	Beauty	31	In relationship	Matric	2	Unemployed	Yes	No
3	Gladness	34	Married	Grade 10	4	Unemployed	No	No
4	Lusanda	28	In relationship	Matric	0	Unemployed	Yes	No
5	Zinzile	33	In relationship	Grade 11	2	General worker	No	No
6	Lungile	28	In relationship	Matric	0	Unemployed	Yes	Yes
7	Sizophila	32	In relationship	Grade 11	3	Domestic worker	No	No
8	Zanele	34	Married	Grade 10	3	Unemployed	No	No
9	Thulisile	32	In relationship	Grade 9	2	Unemployed	Yes	No
10	Wenziwe	35	Married	Grade 11	5	Unemployed	No	No
11	Ntombi	30	Cohabitating	Matric	2	Cashier	No	No
12	Bonisiwe	35	In relationship	Grade 9	2	Seamstress	Yes	No
13	Zimbini	33	Cohabitating	Grade 8	2	General worker	Yes	Yes
14	Thobile	35	Cohabitating	Grade 11	3	Unemployed	No	No
15	Nondumiso	28	In relationship	Matric	1	Unemployed	Yes	No

4.3 Awareness of contraceptives

All the participants expressed awareness of the contraceptives as they all reported that they had heard of at least one contraceptive method. It is important for participants to have heard of a wide range of contraceptive methods as this indicates that the participants were to a certain extent informed about contraceptives, which can lead to the use of these methods. The participants indicated that they were aware that using contraception prevents unwanted pregnancies and HIV. The participants reported their awareness of the injectable and oral contraceptives as well as the condom, traditional methods, the implant and female sterilisation methods. The participants were also aware of the availability of these contraceptive methods at the clinic. The injectable contraceptive was the most commonly known contraceptive method as all the participants indicated that they were aware of this method. The participants indicated that the three-month injectable contraceptive *(Depo-Provera)* was the most commonly known among them. Table 4.2 presents the findings on the contraceptive methods that the participants indicated to be aware of as well as the number of participants that indicated their awareness of it.

Table 4.2 Awareness of contraceptive methods

Type of contraceptive	**Participants aware of method**
Condom	9
Injectable contraceptives	15
Oral contraceptives	8
Traditional methods	4
Spermicide	0
Contraceptive patch	0
Intrauterine Contraceptive Device (IUD)	0
Sterilization	1
Implant	5

Some of the participants reported a lack of awareness of all other methods of contraception except for the injectable contraceptive method.

> *I do not know much. I know that there is an injection.* (Gladness, 34 Years)

> *I know that there is an injection that you can take if you do not want to fall pregnant. The injection is the common one that other women talk about. It is the injection used to prevent pregnancy.* (Lungile, 35 Years)

Some of the participants indicated their awareness of a variety of modern contraceptive methods, including the pill (oral contraceptive), the implant, and condoms. Some women also identified traditional methods, including the withdrawal method and thigh sex.

Below are some of the comments by the participants who were aware of a variety of contraceptive methods

> *I know of a few ones that include the pill, the injection and the implant. I am not sure about the implant, but I know of those two, the pill and the injection.* (Beauty, 31 years)

> *You can do ukusoma (thigh sex). If you are practising thigh sex, there is no penetration and so you cannot fall pregnant.* (Thobile, 35 years)

> *Of these contraceptive methods, I know the injection and the condom and these can also prevent pregnancy. There are also the contraceptive pills.* (Bonisiwe, 34 years)

One of the participants reported that she was aware of injectable and oral contraceptives as well as female sterilisation. This participant elaborated her awareness by explaining that when a woman is older and no longer wants to have children, she can go to the hospital and be sterilised to prevent pregnancy.

> *I know of an injection that can prevent pregnancy for three months. There are also pills that you can resort to if you are scared of the injection. I also know that as a woman, there is sterilisation (ukuvala). When you are older and you have maybe enough children, I know that at the hospital, they are able to just sterilise your reproductive system completely to prevent pregnancy in the future.* (Ntombenhle, 30 years)

One of the participants mentioned the importance of using dual protection (a condom plus another contraceptive method). Dual methods offer double protection against pregnancy and STIs (including HIV/AIDS). Dual-protection is important because it promotes healthy sexual behaviour through preventing HIV and STIs as well as unintended pregnancies. Further, awareness on dual protection is important as it indicates that one is aware that using modern contraceptive methods prevents pregnancies but not HIV and STIs. The participant expressed that she was aware that the use of this method protected her from contracting HIV and unwanted pregnancy as well. This participant mentioned that she obtained this information from the community caregivers who work as health assistants in the community.

> *I heard about this from Community Care Givers. I remember them saying that it gives double protection. You may take the contraceptive pill and use a condom as well. In this way, you have protection from both pregnancy and HIV. That is why it is called double protection.* (Lungile, 28 years)

It is also important to understand if the women have the knowledge on how contraceptives are used. According to Finer and Zolnar (2011), the inconsistent and incorrect use of contraceptives contributes to a high incidence of unintended pregnancy. Hence, it is important to have knowledge on how to use the contraceptives correctly and consistently to guarantee effectiveness. This study indicated that most of the women did not have adequate knowledge on the correct use of these contraceptives. Some of the participants indicated that they were only aware of contraceptive methods and did not know any further information about them. Some of the participants indicated that their knowledge on how contraceptives are used is limited because they had never used them before. These participants reported that

they did not know the correct ways to use contraceptive methods to prevent unintended pregnancies. Some of the participants were of the belief that the contraceptive pill is only to be taken when one is to engage in sexual intercourse and that injectable contraceptives are taken on a monthly basis.

The comments expressed below indicate that some of the women had limited knowledge on the correct use of contraceptives.

> *I do not know how these contraceptives really work. Well, the health personnel gives you an injection, but I am not sure how long it works. I think you can also take the tablet when you are about to have sex to prevent falling pregnant.* (Zanele, 34 years)

> *The health personnel at the clinic give you an injection. You have to take it. I think every month you have to go to the clinic to get the injection.* (Thobile, 35 years)

> *You will have to visit the clinic when you want to take the injection. Whenever you want to prevent, they will give you the injection. As for the pills, maybe they give them to you once a month. Then, when you take them, you would have prevented pregnancy.* (Bonisiwe, 34 years)

Some women indicated that they had adequate knowledge of the correct and consistent use of contraceptives to prevent unintended pregnancies. They had the correct knowledge mainly regarding the oral pill, injectable contraceptives and the condom. They knew that that the pill should be taken daily at a certain time in order for it to be effective in preventing pregnancies. In addition, women indicated that the injection is taken on monthly intervals (2 or 3 months), depending on which injectable method is being used. They further indicated that they had to use the condom every time they had sexual intercourse for it to be effective in preventing HIV and unintended pregnancies. Below are some of the comments the women expressed indicating that they had knowledge of the correct use of the contraceptive methods.

> *You take the injection in three months so that you do not fall pregnant in those three months. You must take the pill every day if you do not want to fall pregnant. The*

implant they put it somewhere in your body and then it prevents you. (Thulisile, 32 years)

The condom is used every day. The injection, they inject in months when you have the appointment at the clinic. Then the pills, I know that you have a time to take it. If you were told that you must take those tablets by 8 o'clock, it is necessary that you must take them at that time because if you make a mistake, you will get pregnant. (Zimbini, 32 years)

4.4 Access to contraceptives

Ellertson *et al*., (1995) argues that in order for women to be able to use contraceptives, they do not only need knowledge about them but women should also have access to them. The participants indicated that they were aware that they could get contraceptives from the clinic. However, the women did indicate that going to the clinic to get these contraceptives was sometimes problematic. The women mentioned that the clinic is far away and thus it is not easy for them to go to the clinic to get contraceptives.

Some of the participants felt that the clinic was far from them and not having money for transport to travel to the clinic was a challenge and this limited their access to contraceptives. Distance can serve as a barrier to women accessing contraceptives, as they are mostly unable to get to the clinic to obtain contraceptives. As much as there is a clinic that does cater for contraceptive needs, the women do not access them because the clinic is too far from them. The large numbers of patients and long queues at the clinic were also seen as preventing women in the area from accessing the contraceptives. Since this is a rural area, not all the women had the opportunity to go to the nearest town. In addition, they did not have the finances to access private health facilities including pharmacies.

From the reports of the participants, it is evident that they are aware that heath facilities offer free contraceptives. However, there are costs that the participants incur with accessing health facilities, for instance, transport fees. This then proves to be problematic for the participants as unemployment is widespread in the community. The cost of living is too high and the

women have many other expenses. Hence, spending money on accessing contraceptives is problematic for the women.

Some women stated that visiting health facilities solely for contraceptives is a waste of money and time. They argued that it is understandable for someone to pay to travel to health facilities if they are sick and need medication. Some indicated that it is not easy to wake up early to walk a long distance to health facilities and wait in a long queue for hours just to access contraceptives. Below are some of the participants' comments regarding the problems with accessing contraceptives.

> *Okay, maybe the reason why they might not be easily available is that the clinics are far. They are far from our homes. Women have to travel a very, very long distance to reach the clinic, so it becomes difficult. You know that when things happen, things happen very fast. It might happen that the contraceptive is not available to the women that stay far even if they are already sexually active. Because they stay far, far from the clinics, hence women fall pregnant a lot around here.* (Sizoplila, 32 years)

> *Like I said, I feel that contraceptives are a problem to get because you cannot keep waking up early and standing in a long queue at the clinic just for them. The clinic is always full and you can spend the whole day there, just for the pills.* (Bonisiwe, 34 years)

> *The problem is that the clinic is far. Even if you want them, you cannot just go to the clinic every time. The taxi prices have gone up; we do not have money for the taxi. I am not working. It can end up being as if you are wasting money. I do not know how those that use them get them.* (Zanele, 34 years)

4.5 Attitudes towards contraceptives

The study found mixed attitudes towards the use of contraceptives. Some of the women were in favour of contraceptives and others were against their use. The women that favoured contraceptives indicated that it is good to prevent unwanted pregnancies. The women were

aware that they were at risk of pregnancy as they were all sexually active. The use of condoms was also favoured as some of the women were aware of the risk of HIV. Two of the participants mentioned that using contraceptives helped in reducing abortion rates. These participants were aware that using contraceptives to prevent unintended pregnancies saves women from having to terminate the unintended pregnancies. This is consistent with a study by Chescheir, (2017) who notes that the availability and correct use of effective contraceptives is associated with decreasing abortions.

Some of the women favour the use of contraceptives as a means to avoid complicated situations such as being unmarried with a child and becoming a single mother. The study also indicates that attitudes that favour the use of contraceptives does not necessarily transfer to use of contraceptives, as some of the participants who are in favour of the use of contraceptives are currently not using them. However, participants did express that they are in support of contraceptives as these allow for the delaying and limiting births. The comments below illustrate how some of favourable attitudes to the use of contraceptives.

> *Contraceptive use on my part, I would say is okay. Because if women use them, there is no teenage pregnancy and abortion, especially if you have a child, and then another one. Contraceptives are a good thing. It allows you to have a better future and not worry about a child. Even me, if I had used contraceptives, I would not maybe have two children. When the father of the child leaves you that is stressful. It is okay to use contraceptives. It prevents you from many things.* (Beauty, 31 years)

> *Okay, as a mother, I think it is right to use contraceptives. Because sometimes a woman gets pregnant, then after 9 months gets a baby. Then you see next year that maybe the same person is pregnant. While the child is still small and not growing well but then you are having another child.* (Zimbini 33 years)

From the responses, it is clear that the women were aware of the implications of unintended pregnancies and having many children, especially for the poor living in rural areas. Poverty shapes the attitudes towards the use of contraceptives. Women may be more accepting of

contraceptives as a means to prevent pregnancies if they are poor and know that they cannot afford to have children.

> *I support contraceptives, reason being because it protects you. We as rural women are poor, even here you can see the poverty. We cannot afford to be having children at a young age, or many children. It is happening here in rural areas that the women are not using them and they are bringing children into poverty.* (Lungelwa, 28 years)

> *I do not have anything against them; I can say it is okay to use them. I mean if you are already struggling to feed the few children that you have with the little money that you are making, then how can you feed more mouths. You can use them.* (Ntombenhle 30 years)

There was also some opposition to contraceptive use by some women. The study indicates that the women who were against the use of contraceptives have reasons to support their unwavering attitudes towards the use of contraceptives. Some of the women felt that contraceptives are supposed to be used by younger women. The women expressed the view that contraceptives are not suitable for the women of their age range. Further, they noted that even at their older age, there might still be a desire to have more children.

> *I think contraceptives are for the young ones, I do not like them. Even when I was younger, I did not use them. I do not like them. Why must I use an injection to prevent pregnancy? I know that it is not good for me. No, I do not feel good about them, I do not promote the use of them, especially for women my age, you cannot be grown up and preventing to fall pregnant. It is better if the younger ones use them.* (Zinzile, 33 years)

> *If you are a woman of my age, I do not think it is good to be using them. When you are maybe 35 or 36 years, you can still want to have one more child, but if you are using contraceptives, then you cannot have a child.* (Bonisiwe, 34 years)

Some of the participants expressed that older, married women have no need for contraceptives. Some of the women felt that older married woman should bear children and

thus refrain from using contraceptives. These women further mentioned that being married or living with your partner makes it difficult to use contraceptives and condoms, thus women need to accept that they will fall pregnant. There is a high value placed on childbearing especially for married women.

> *I have never used them; I do not like them. I do not think I will ever use them because I already have children and I can still have other children, and I am a makoti (wife) in this house. I do not feel good about a woman my age maybe who is also a makoti using prevention. I do not think that it makes sense.* (Zanele, 34 years)

> *I do not think that it is a good idea to use contraceptives. If maybe like me you are living with your partner or your husband, I know that it is not easy to use a condom every time because you have not used it before in the past years. Even contraceptives are not easy because you know you are a wife so you need to have children. You must know that you will have children.* (Bonisiwe, 34 years)

4.6 Contraceptive use prevalence

This study investigated the prevalence of contraceptive use among the participants. The study was interested in whether the participants have ever used a contraceptive method and whether the participants were currently using a contraceptive method. In this regard, six of the participants reported ever using a contraceptive method before. The most commonly used contraceptive method was the injectable contraceptive. All six of the participants that have ever used a contraceptive method, reported to have used an injectable contraceptive method before. Only two women indicated that they were currently using a contraceptive method. The comments below illustrate the women's responses concerning them ever and currently using contraceptives.

> *Yes. I have used contraceptives before. I used the one they call idepo (Depo Provera). The 3 months' injection.* (Nonhla, 25 years)

> *I have used contraceptives, but not the pill. I used the injection.* (Lusanda, 28 years)

I am using contraceptives, the injection. (Lungile, 28 years)

Some had experience with using more than one method in the past. One of the participants had experience with using both the injectable and oral contraceptives. A few of the women reported that they used the condom in the past. Others reported also using traditional methods such as abstinence and as a way of avoiding unintended pregnancies. One woman noted that she had undergone virginity testing as a young woman and in this way, she was encouraged to abstain from sexual intercourse.

The way that I use to prevent pregnancy is the condom. Even though it is not 100% safe because it can bust. I still used it. (Zimbini, 33 years)

When I was a young girl, we were taken for virginity testing and then in that way I remained pure. When we are going for virginity testing they encourage us to not have sex until we are married, that means that I was not having sex. (Thobile, 35 years)

One of the participants mentioned that she had not used a condom or any other modern method of contraception. She had, however, experienced using a traditional method of contraception. The participant indicated that she had experience with using the withdrawal method. The participant used this method to prevent pregnancy.

I had sex a few times before I fell pregnant and I was not using a condom or preventing with injection, but my partner was ejaculating outside of the vagina (withdrawal method). I knew that I was not going to fall pregnant because I knew that he was not ejaculating inside. (Zinzile, 33 years)

4.7 Barriers to contraceptive use

The interviews revealed that there are many factors that prevent contraceptive use among women. In the rural area there are many commonly held beliefs about contraception. As a

result, participants had negative attitudes towards the use of contraceptives and associated the use of contraceptives with younger, unmarried and promiscuous women.

Most of the participants concurred that it is younger women who should use contraceptives. These participants were of the opinion that girls and younger women who are not interested in having children at the time or are still in school use contraceptives to avoid pregnancies. One of the participants mentioned that girls who are currently schooling use contraceptives as a means to exercise their rights and do as they please. The participant further elaborates that the young girls use contraceptives because they are aware of the implications of teenage pregnancy such as facing expulsion from school.

> *I would say maybe the younger ones are doing it because now they are clever and have rights. They do whatever they like.* (Zinzile, 33 years)

She added

> *I think the young girls. Here in Ntabamhlophe you see the high school girls busy with the taxi drivers every day so they do not want to fall pregnant because they will be kicked out of school. They must prevent.* (Zinzile, 33 years)

Most of the participants were of the opinion that women who use contraceptives are promiscuous. The participants mentioned that promiscuous women have many sexual partners, thus they use contraceptives to avoid unintended pregnancies.

> *Maybe it is because they have multiple partners. I do not know why you would prevent if you have one partner that you are loyal to. Why would you prevent to have something that God has given you? (*Gladness, 34 years)

One of the participants expressed that women who use contraceptives do not trust themselves and their partners. The participant commented that women who use contraceptives do not trust themselves to be faithful to their partners or that their partners are being faithful to them.

She further added that the women do not trust that they can abstain from sexual intercourse, and therefore use contraceptives to avoid unintended pregnancies.

> *They use it to prevent falling pregnant, maybe because they do not trust themselves or their partners, so they do not want to have children.* (Zinzile, 33 years)

She added

> *I mean that maybe they do not trust that they can close their legs. They do not trust that they can behave; therefore, they just want to keep on having sex with everybody and not fall pregnant. Therefore, I think those women that use contraceptives do not trust their partners as well, maybe they are not sure about them and they do not want to have their children.* (Zinzile, 33 years)

Some of the participants mentioned that stigma surrounding the use of contraceptives is rife in this rural area. Women who use contraceptives in the community are given negative labels. They are branded as 'loose' and seen as having many partners. The participants themselves were aware of this stigma and they indicated that this perpetuated the non-use of contraceptives by women in this area. One of the participants mentioned that it is not easy for women to visit health facilities to access contraceptives because of the stigma. The participant mentioned that if women are seen by members of the community visiting the health facilities to access contraceptives, they will be spoken about in a negative manner. The participant mentioned that neighbours speak ill of women who access contraceptives and associate it with abortions.

> *You know if the neighbours maybe see you at the clinic, they can start talking about you and say that you are having abortions and you are preventing to fall pregnant. We have heard it before. They talk about people that they see at the clinic and when you do not fall pregnant, they say you had an abortion, you are preventing.* (Thobile, 35 years)

4.7.1 Attitudes of health professionals

In the interviews, women reported that the negative attitudes of the nurses at the clinic have an impact on the low rates of contraceptive use. A South African study indicated that nurses generally stigmatize the use of contraceptives, especially among teenagers and they rather influence those that seek contraceptives to abstain from sex (Wood and Jewkes, 2006). In the context of older women, most of the participants reported that the nurses at the clinic judged the women who used contraceptives making embarrassing remarks that made it difficult for the women to access contraceptive methods. The participants voiced the concern that the nurses expressed negative comments that reflected the stigma around the use of contraceptives. Some of the participants mentioned that they had seen or experienced these negative attitudes exhibited by the health professionals themselves.

The women mentioned that the behaviour displayed by the nurses at the clinic prevents them from visiting the clinic to access contraceptives. Some of the women indicated that the nurses shouted for those who had visited the clinic for contraceptives as they allocated a family planning nurse for them. However, they expressed the feeling that the behaviour infringes on their right to privacy as they access contraceptives. The participants further reported that this lack of privacy resulted in people labelling them as loose. The following is a comment a participant made regarding the negative attitudes of the health personnel at the clinic.

> *It is not easy to visit the clinic to access contraceptives at my age because the nurses accuse us of sleeping around. They further insinuate that we use contraceptives to prevent falling pregnant. In addition, visiting the clinic is embarrassing because the nurses just shout and call you openly and give you the contraceptives. Therefore, the whole community gets to know that I am using contraceptives* (Zinzile, 33 years).

> *I know that the youth say that it is not easy for them to go to the clinic to get contraceptives because the nurses despise them. Maybe, if you are a grown up woman who wants to use contraceptives, the nurses can talk about you because you are already old enough to have babies* (Nondumiso, 35 years).

> *There is a feeling that girls who use contraceptives are promiscuous. Even the nurses at the clinic often say the same things accusing the young women of sleeping around. However, that is not the case. Anyone should just access the contraceptives if she does not want to have children.* (Ntombenhle, 30 years).

One of the participants reflected on her experiences with health workers at the clinic and stated that their behaviour compels women to stop going to the clinic to get the contraceptives. The participant mentioned that the nurses at the clinic shout at them.

> *I have used contraceptives before, the nurses at the clinic just shout at you, and that is known around here. So then I also did not like that and I stopped going to the clinic for that reason.* (Thulisile, 28 years)

One of the participants reported the negative attitudes of the nurses at the clinic towards women accessing contraceptives. She indicated that this is responsible for the low contraceptive use among women in rural areas. She further explained that nurses felt that women should not engage in sex before marriage and therefore should not be using contraceptives.

> *Yes, yes it plays a role because we as rural women, we have been taught to groom ourselves, to prepare ourselves for marriage. So if you are a girl maybe you are in high school and you are coming for contraceptives, they look at you in another way. They look at you with the eyes of being a parent. Because we have been told that we have to take care of our bodies and that our bodies are the temple, you know and you are coming with contraceptives, it is as if you know things that you are not supposed to know.* (Lungile, 28 years)

The women felt that the nurses who work at the clinic would criticise them for using contraceptives as they regard them as older women. The women attributed this to the stigma attached to women of their age group. The community expects them to have children and the use of contraception goes against this expectation. Hence, the participants reported that it is not easy to access contraceptives since the nurses are judgemental.

4.7.2 Contraceptive myths and misconceptions

Negative myths and misconceptions about family planning are a barrier to the use of modern contraceptives (Eram, 2017). This shows that having myths and unproven facts about contraceptives influences women's reluctance to use modern contraceptive methods.

One of the participants mentioned that men feel that having the injection in your body decreased sexual pleasure. She mentioned that the contraceptives make women less sexually satisfying to their husbands and this could lead to the male partners being unfaithful.

> *Men say that the contraceptives make them to not enjoy sex, they say that it makes the woman dry and you can feel that you have the injection in your body, and they say that it is not nice. So if your husband says that, he will go to look for others that are not using them and they can enjoy the sex with them.* (Zinzile, 33 years)

Another participant mentioned that her friends had shared a similar experience with her. This indicates that this is a common belief in this community. She said:

> *I remember when I once told my friend that I am using the contraceptive injection to prevent, she told me that my partner would leave me because the sex will not be nice anymore. They say that when you are on injection, your partner does not get "hard", like the penis is soft so he does not enjoy sex.* (Thulisile, 32 years)

There are beliefs that contraceptive use alters sexual encounters. Many felt that the use of condoms interrupts sexual intercourse. In addition, some argued that the use of condoms makes sexual intercourse different and not as enjoyable as it is without a condom. One of the participants mentioned that men do not want to use condoms because they do not feel satisfaction during intercourse. She then briefly discussed her experience as shown below.

> *We have all heard men say that you do not want to eat a banana with the peel. Men do not want to use condoms. They say that the sex is different with the condom. They do not feel you. I am staying with my partner, since we are together; he has told me*

that he does not want to use a condom because it does not feel good. I also understand. (Ntombenhle, 30 years)

Some of the women mentioned that there are also some strongly held beliefs that contraception contributes to infertility. One of the participants mentioned that this occurs if a woman uses contraceptives and she has never had a child before. The participants further expressed concern that long-term use of contraception leads to infertility. The comments expressed by some of the participants regarding this myth are as follows.

They say that if you are using contraceptives and you have never had a child before, then you will never have a child. (Lungile, 28 years)

Another participant said.

I know also that using contraceptives can stop you from having children, and the women around here, are aware of that sometimes we talk about these things. They say that if you are preventing for a long time then you can end up having something and problems in your womb. Then it is blocked, then after that, you can no longer fall pregnant and they have to take your womb out because it is now giving you pain. (Thobile, 35 years)

4.7.3 Contraceptive side effects

According to Barr (2010), most of the women do not experience severe side effects from contraceptives and that side effects due to contraception can go away on their own in a few months. The common side effects associated with using contraceptives include weight gain, mood changes, headaches, nausea, headaches, irregular periods and sore breasts. Certain types of contraceptives are more likely to cause side more effects than other methods (Longwe, 2012). The participants in this study were aware that contraceptives have side effects. The most common side effects the participants knew was weight gain. Most of the participants mentioned that they were aware that contraceptives change the appearance of a woman's body and lead to weight gain as well.

One of the participants described how the bodies of the women who use contraceptives change.

> *Some of them get fat, some of them the body shape changes. Their bodies when they are walking, it is like shaking. It is not firm like a woman's body should be. They do not have children, so obviously it is the contraceptives changing their bodies.* (Gladness, 34 years)

She added.

> *Contraceptives… the things that they use have an effect on their bodies, the body changes. You can see a woman that maybe last year, they were fresh and had a good body, after some time, and their body has changed because of the contraceptives*. (Gladness, 34 years)

> *Some people they say that they gain weight, so other women may not use them because they are afraid of gaining weight.* (Sizophila, 32 years)

One of the participants mentioned that she experienced weight gain herself when she was using the injectable contraceptive method.

> *I can say that it is true that you gain weight, because when I was using the injection, I can say that I noticed that my appetite was big and I was eating a lot so that is why I gained weight.* (Nondumiso, 28, years)

Most of the participants mentioned that they were aware that contraceptives interrupt their menstrual cycle. Some of the participants mentioned disruption of menstruation as a side effect of contraceptives based on information that they heard from other women. Other participants who had used contraceptives reported that they had experienced these side effects

themselves. The comments below illustrate what the women had to say regarding contraceptives and how it disturbance of menstruation.

> *There are problems that the women experience. I have heard that it blocks your blood. You do not have your periods, so it disturbs nature. I am sure that is how other women develop problems and are not able to have children.* (Wenziwe, 35 years)

> *I know that she said that she was bleeding a lot, so like that cannot be good for the body of a woman. I think it is as if you are having an abortion because of the contraception that is why there is bleeding a lot. So I can say that maybe you have a long menstruation because of the contraceptives.* (Zanele, 34 years)

This participant reflected on her own experience of irregular periods, which resulted from using contraceptives.

> *With the injection, for me there was a time where I just bled for like a full month or two months of that time. It was not heavy bleeding, but it was just like a long time.* (Lusanda, 28 years)

This study has indicated that the participants are aware that using contraceptives does have side effects. The participants were able to illustrate this by discussing the side effects of contraceptives that they know of and some reflected on how using contraceptives affected them personally.

4.7.4 Proof of fertility

There is a common perception among some of the participants that women need to have children to prove their fertility. The participants mentioned that within their age group, especially amongst married women, there was the need for them to have children to demonstrate their fertility. The women mentioned that if you are a married woman, it is important to have children and grow the family. The participants noted that children are a

blessing and in some families, there might be a desire for a male child for the purposes of continuing the family name. Some families view children as a commodity and believe that it is important to have children that will take care of their parents in old age. Hence, if there is a need for women to prove their fertility and a desire for children, the use of contraceptives are is prohibited.

From the comments of the participants, it is clear that married women are expected to have children. The participants indicate that once a woman is married, she needs to start having children to show her husband that she is able to bear children and thus grow the family to the desired size. Some of the women elaborate that since they are married, it is not an option for them to use contraceptives. One of the participants mentioned that she had a child before she was married, thus she could not use contraceptives after she had gotten married, as there was a need for her to have more children. The participant further mentioned that having children proves that the woman is a good wife, thus using contraceptives and not having children would alter this image.

> *I am married, so as a married woman you should have children. It is something that I should do. I had my one child before I got married and it is from the same father. When I got married, I knew that I was supposed to have more children. So I could not prevent to have many children, because I am supposed to be a good wife.* (Gladness, 34 years)

One of the married participants mentioned that the husband and his family also has an important influence on the use of contraceptives. This participant mentioned that as an older woman, she is expected to fulfil her husband's desire for children. This entails for the non-use of contraceptives. She mentions that it is a norm that married women can have many children up until the end of their reproductive years.

> *In this community, you cannot be growing up and not have children. I have many children because I have never prevented. Some families, like my husband's family wants many children, so I must not prevent, as I need to have children. I will not have*

any more children now, maybe because I am growing older. Your body will stop having children when it is time to stop. (Wenziwe, 35 years)

One of the married women was in a polygamous marriage. She mentioned that there is pressure on her to demonstrate her fertility. As the second wife, she is under pressure to have many children. She emphasised that since her husband paid *ilobola* (bride wealth) for her, and she has to fulfil the wishes of her husband by having many children. According to Preston-Whyte (1999) men support the notion that *ilobolo* is the price they pay in order for their wives to bear them children This woman also spoke about the influence of other women including her sister-wife, and mother-in-law as a factor that could prevent her from using contraceptives.

For me, I am married as a second wife, so as I am in this household as not just a wife, but a second wife. It means that I have been paid lobola for and that I need to have children because my husband wants many children. I just cannot prevent and use condom you know. My sister-wife will not like that, and my husband, he can ask me why I am married if I do not want to give him children. (Thobile, 35 years)

4.7.5 Gender inequality

The study area, Ntabamhlophe is a rural area that is predominantly patriarchal which also has impact on the use of contraceptives. According to Keele *et al.*, (2005), male dominance in decision -making both in the family and in the community impedes the use of contraceptives. Most of the participants indicated that men do not appreciate the use of condoms and contraceptives.

Some of the participants believe that as women, they are not in a position to solely make the decision to use contraceptives. These women believe that they do not have the right to make the decision to use contraceptives without their partner's permission. This is so because the participants indicate that males are the breadwinner and main provider in the home. Considering that most of the participants are unemployed, they naturally succumb to their partner's desire. The women are then expected to bear children and take care of the

household while the male partners work. This can be interpreted as a manifestation of unequal power dynamics.

One of the participants assumed that the decision to use contraceptives is easier for independent women who are able to provide for themselves. This participant mentioned that having a working husband who is able to provide for children allows for the non-use of contraceptives. The participant argued that it is necessary for a woman to contribute to the household income in order to have a say on matters such as contraceptives. This participant indicated that as a woman, if you are unemployed and unable to provide for the family, then your duty is to bear children. Further, the participant mentions that she was taught from a young age that women need to obey their husbands and have children.

> *You need to be stable. If you are staying here and you are not working but your husband is working, he can provide for the children so you cannot say that you are using contraceptives.* (Lungile, 28 years)

She added

> *You are able to make decisions when you are able to provide for yourself. It is about what you can bring to the table at home. Like me, you cannot be a 28-year-old woman who is not working, who is not doing anything, but you are just not having children… With us as women here, we have been taught that you have to grow up and have a husband, then obey him and have children.* (Lungile, 28 years)

Another participant shared the same sentiments. The participant stated that it is not easy to use contraceptives if you are dependent on your male partner. This participant felt that male partners might have a problem with the use of contraceptives and that as a dependent women, she needs to be home raising the children.

> *For us it is not easy. Because you cannot just go to the clinic to prevent. Maybe your boyfriend will have a problem with it and since I am not working,*

> *I will need to just stay at home and take care of the children. If I am pregnant, my boyfriend will provide the money.* (Beauty 31, years)

One of the participants mentioned that the men in the community are predominantly Zulu and traditional. Often the men are not fond of modern way of living and the use of modern contraceptives. She indicated that traditional Zulu men do not believe in modern things such as contraceptives. This then leads to avoidance of contraceptives based on the perceived opposition of male partners.

> *Here, we tend to be in a relationship with a traditional Zulu man. Example, those who believe in Kwa Shembe. They do not believe in contraceptives. They believe in the olden way of doing things. They believe that prevention does not work for Zulu women. You cannot use the contraceptives if you know that your partner is traditional and does not believe in them.* (Nonhla, 25 years)

The gender inequality that exists in Ntabamhlophe has an impact on women's attitudes towards contraceptives and their use. Based on the participants' comments, it can be argued that the women do not have decision-making autonomy regarding contraceptive use. They will therefore not use a method because they will be perceived as disobedient and going against their partners who do not agree with the use of contraceptives.

4.8. Summary

This chapter has outlined the results from the face-to-face interviews with older women in Ntabamhlophe, KwaZulu-Natal. The results indicate that the use of contraception is low in this rural area. There are a number of reasons for the low use of contraceptives. The women displayed awareness of available contraceptive methods but only few reported knowledge of correct and consistent use of the contraceptives methods. The use of contraceptives among the women was low as only two of the fifteen participants were currently using any method of contraception. The women mentioned that the health facilities were far away from their residence and that the health personnel exhibited negative attitudes and these merged in making it difficult for this group of older women in the community to access contraceptives.

This also correlated to the stigma associated with using contraceptives in the community. The interviewed further established the fact that marriage and patriarchal ideologies barred women from using contraceptives. This results from the fact that the women in this age group were of childbearing age and were thus expected to have children.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

The findings of this study suggest that there are many components linked to the use of contraceptives. Statistics indicate that the rate of contraceptive use among women residing in rural areas remains lower when compared to urban areas (Department of Health, 2017). Research has indicated that issues pertaining to contraceptive use in South Africa have become a cause for concern. However, older women in rural areas have been neglected as far as this phenomenon is concerned. The overall aim of this study was to draw the attention of all the stakeholders to contraceptive use. The research has attempted to explain the factors that promote and inhibit the use of contraceptives among rural women.

The aim of this study was to provide deeper insights into contraceptive use among women in rural KwaZulu-Natal. The majority of the studies conducted on the use of contraceptives have focused on the use of contraceptives among younger people. However, this study has focused on older women whose ages ranged between 25 and 35 years. The study used a sample of 15 black women living in Ntabamhlophe, a rural area in KwaZulu-Natal. Qualitative research techniques are interactive and participative, thus ensuring the soliciting of detailed data by the researcher. Nonetheless, using qualitative research methods did pose limitations for this study. The study draws on the social ecological model developed by McLeroy (1988) to explore the factors that promote and inhibit the use of contraceptives among women residing in rural areas.

5.2 Discussion

The findings of this study suggest that most of the participants were aware of contraceptives and their use. The participants indicated that they possessed knowledge of contraceptives as communicated to them by the community caregivers as well as the displayed information at the clinic. This correlates with other studies that assessed knowledge of contraception among women in South Africa and found it to be high (Peer, 2012; Morroni *et al.*, 2016; Chersich,

2017). A study conducted in rural KwaZulu-Natal yielded similar results pertaining to knowledge of contraceptives (Ndinda et al., 2017). The injectable contraceptive was the most commonly known method among the participants. However, having knowledge on contraceptives does not transfer to the use of contraceptives as it has been noted that women have the knowledge on contraceptives, but this does not guarantee the use of contraceptives (Haffejee *et al.*, 2018). However, not all the participants had accurate knowledge regarding the correct and consistent use of contraceptive methods. The social ecological model that guides this study implies that intrapersonal aspects such as knowledge affects a person's behaviour. This study found that women's knowledge of contraceptives has an influence on women's decision to use or not use contraceptives. Some of the participants indicated that their knowledge on the correct use of contraceptives was low because they had never used contraceptives before. This correlates with other studies that have indicated the same trends in developing countries (Ritcher, 1996; Biney, 2011; Blanc and Way, 1998; Ndinda *et al.*, 2017). This study indicates that there is a correlation between the lack of accurate knowledge on the correct use of contraceptive methods and the low contraceptive prevalence rate.

Studies reveal a number of factors that motivate women to initiate the use of contraceptives. Women commonly use contraceptives to space births and limit family sizes. Further, health benefits accumulate from the use of contraceptives and these include the prevention of pregnancy and related risks, the prevention of cancers and HIV as well as STIs (Chipeta, 2010; Davidson *et al.*, 2016). This study investigated the perspectives of women towards the use of contraceptives. This is in line with the desire to explore the interpersonal attributes that influence women's decision-making concerning the use of contraceptives, as guided by the model propounded by McLeroy (1988). The study established that women's perspectives on contraceptives are, to some extent, influenced by a number of factors. The study indicates that some of the participants were in favour of contraceptives while others disapproved of them. The women who approved of the use of contraceptives indicated that using contraceptives is beneficial for the prevention of unwanted pregnancies and diminishing the need for abortion. In this context, this study corresponds to the literature contributed by White and Speizer (2007).

The participants who were against the use of contraceptives were mostly of the perspective that contraceptives are to be used by independent, employed and unmarried women as well as

younger women. This study found that the participants were mostly unemployed, with an education level below matric and were classified as poor due to their household income and the socio-economic background. The perspectives of the participants correlate with previously conducted studies which indicate that economic independence, higher levels of education as well as reaching desired family sizes are factors that promote the use of contraceptives among women (Buyinza and Hisali ,2014; Solanke, 2017; Obwoyo, 2018; Osuafor *et al.,* 2017, Chouhury *et al.,* 2017).

Regarding the experiences of contraceptive use, this study identified that six out of the 15 interviewed women had experience of ever using a contraceptive method. Two of the participants reported to be using a modern contraceptive method at the time of the interview. Most of the participants had experienced using injectable contraceptives because it is effective and privately administered. These findings are similar to those of a study conducted amongst women of rural areas in the Western Cape, which indicate that the injectable contraceptive is commonly used in rural areas because it can be used discreetly. Further, injectable contraceptives are favoured because the effectiveness lasts up to three months (Peer, 2012). The participants also indicated having experience with other methods including traditional methods of contraception such as the withdrawal method, as means of preventing unintended pregnancies.

The study indicates that the participants had different experiences with using contraceptives. Some of the women indicated that they experienced no problems with using contraceptives while others indicated that they experienced side effects. This study found that the women who had discontinued using contraceptives did so to evade the side effects they had experienced while using contraceptives. This resonates with other studies, which indicates that women stop using contraceptives due to the side effects. The rejection of contraceptives is based on the fear of putting their health in jeopardy (Baar, 2010; Longwe 2012; Ackerson and Zielenski, 2017). Further, the study found that some of the women were not aware of the side effects of using contraceptives prior to their own experiences.

This study mentions that educational levels have an impact on the use of contraceptives. Low education levels often translate into the low use of contraceptives, especially in rural areas.

This study discovered that nine of the women that participated in the study had not finished matric and none of the women had tertiary level of education. This can be compared to other studies which indicate that the low use of contraceptives in rural areas particularly in African countries is associated with lower levels of education (Peer, 2012; Moronkola and Fakaye, 2008; Therani et al., 2001). This study found that some of the women did not complete school because of unintended pregnancy at a young age. The women indicated that they had not been educated about contraceptives in their families and that most of the information they had possessed concerning contraceptives came from peers, health service providers and school. However, accessing these pieces of information was not easy for young women. This is consistent with other studies conducted about women in rural areas (Ndinda *et al.*, 2017; Potgieter *et al*., 2018). The model that guided this study indicates that interpersonal processes and groups have an influence on the health behaviours and decisions of individuals (McLeroy, 1988). Thus, the non-use of contraception is to some extent influenced by low levels of education and the issue of parents not educating girl children about contraceptives when they are young.

The study indicated that access to contraceptives is a problem in this community even though there is a clinic in the Ntabamhlophe area. Most of the participants stay in particular areas that are located far from the clinic. Thus, some of the women indicated that it is not easy for them to travel to the clinic to access contraceptives due to limited funds for transport, considering that most of the participants were unemployed. It is clear that there is an unmet need for contraceptives in the rural area. Worldwide, statistics for the year 2017 indicate that 214 million women were not having their contraceptive needs met (United Nations, 2017). The unmet need for contraceptives is highest in Africa's less developed countries which have difficulty in providing contraceptives to all those who need them (Morronii *et al.*, 2016; Obwoyo *et al.*, 2018). This study indicates that the limited access to health facilities that provide contraceptives in the rural area studied does inhibit the use of contraceptives for the women in the area. Public policy level relates to the policies that regulate health practices, which, in the context of this study can refer to the availability of free contraception to the women living in the rural areas (McLeroy, 1988). Hence, for this study, this model indicates that the lack of access to contraceptives for women living in rural areas has an impact on the non-use of contraceptives among women.

According to Norris *et al.,* (2011), stigma is a social process that labels and discredits an individual for an attribute that goes against social norms. This study found that there is prevalence of stigma and negative attitudes towards the use of contraceptives in the rural area under study. The participants identified stigma as a factor that inhibits the use of contraceptives among the women. This study found that some of the women who were interviewed shared similar negative attitudes towards contraceptives. The women also indicated that in this rural area, negativity towards women who use contraceptives is common. The negativity is based on the assumption that women who use contraceptives are promiscuous and have many sexual partners. This negative attitude and the stigma associated with the use of contraceptives makes it difficult for the women to access contraceptives. Reference can be made to a study that was conducted in Ghana to investigate the factors associated with reproductive health stigma. (Hall *et al*., 2018). This study found that stigma associated with the use of contraceptives is high and it was found to have consequences such as shame, social marginalisation and violence for women. The theoretical framework which guided this study (McLeroy, 1988), indicates that at the social institution level, the community's negative views towards contraceptives has an influence on women choosing not to use contraceptives. Further, the participants indicated that the health professionals working at health facilities act as an obstacle that prevents women from accessing contraceptives. The participants mentioned that health professionals hold negative attitudes and pass judgemental comments to older women who use contraceptives. This barred the women from accessing and using contraceptives and this is congruent to literature by (Wood and Jewkes, 2006)

Myths and negative misconceptions associated with the use of contraceptives are another factor that inhibits the use of contraceptives among women living in the rural areas (Eram, 2017). This study found that there are commonly known myths and misconceptions associated with the use of contraceptives in the rural area studied. Commonly known myths that were mentioned by the participants were that contraceptives affect sexual performance, fertility and that contraceptives should not be used by women who have never had a child before. Another common myth mentioned was that using a condom alters sexual pleasure and makes men to not "feel you" during sexual intercourse. Some of the interviewed women regarded these myths as true while others indicated that they were aware that these myths were untrue. This coincides with studies that were conducted in rural areas of Ghana and Malawi, which indicate that myths and negative misconceptions towards the use of

contraceptives are high in rural areas. These studies indicated common myths similar to the ones identified in this study such as the notion that using condoms causes non-erection and impotence in men (Chipeta *et al.,* 2010; Adongo *et al.,* 2014). This study found that the myths and negative misconceptions have an impact on the use of contraceptives in the rural areas.

The study found that culture as well as gender inequality and male dominance in the rural area studied inhibit women's use of contraceptives. Some of the women in the study indicated that they were not in a position to make decisions about sexual and reproductive matters. All the participants were Zulu and some of the participants noted that having a Zulu male partner who is traditional makes it difficult use contraceptives. The study found that most of the women were submissive to men. This was based on the understanding that the men are the providers at home and thus, their decisions are to be respected. These results are similar with other studies, which investigated the same phenomenon. The results indicate that male dominance in African countries prohibits women from using contraceptives. Patterns of gender inequality reportedly influence the low rates of contraceptive use in African countries (Stephenson *et al.,* 2008, Keele *et al*., 2005; Ackerson and Zielinski, 2017). Furthermore, the study found that in rural areas, a woman has to prove her fertility by bearing children. Most of the participants indicated that at their age range, married women face pressure to produce children and grow their families to the size desired by their husbands or in laws. The women indicated that this is a result of the reality that their husbands paid *lobola* for them, which entails that they are to obey their husbands wishes. Therefore, the women are then obliged to bear children and thus not use contraceptives. Studies conducted in rural areas indicate that women's oppression in decision making as far as limiting family sizes is prevalent in rural areas (Davidson *et al*, 2016). The model that guides this study indicates that family and societal influences have an impact on the health behaviours of individuals (McLeroy, 1988). In the context of this study, male dominance in households stands as a factor that inhibits the use of contraceptives in the rural area.

5.3 Recommendations

Family planning stands out as a key factor in determining sustainable development in developing countries. Access to healthcare services and the realisation of reproductive rights

for all the people is essential in fulfilling the pledge of Agenda 2030 (Agenda for Sustainable Development) which entails that no citizens will be left behind in developmental issues (United Nations, 2017). This entails intensified support for family planning through the implementation of effective government policies and programmes. The global community has committed itself to ensuring that over the next 15 years, access to sexual and reproductive health, inclusive of family planning programmes is guaranteed for all the people (UN, 2017).

Global policy makers have placed emphasis on increasing access to long acting reversible contraceptive methods such as the IUDs and sub-dermal implants. These are reportedly highly effective in reducing the need for user adherence to contraceptives and consistent contact with a health worker (Morse, 2013). Increasing the range of available contraceptive methods has been identified as a key component in ensuring that women and their partners access contraceptive services (Chersich, 2017). Having a variety of contraceptive methods allows women more opportunity to explore and identify which contraceptive methods best suits them.

Community intervention programmes that seek to provide information about contraceptives should be provided by health personnel and community caregivers stationed in the rural areas. This will aid the dissemination of information thereby eliminating negative attitudes as well as myths and misconceptions that are prevalent in rural areas regarding the use of contraceptives. Further, intervention programmes that address issues pertaining to sexual and reproductive health should be more male inclusive. This is more relevant in the context of rural areas where patriarchy and gender inequality are prevalent. In doing so, both parties are educated about the use of contraceptives and the available methods as well as their effects. Thus, this ushers in the interactive transfer of information through more open discussions about family planning and the use of contraceptives.

As a strategy of increasing contraceptive use in rural areas, government involvement is inevitable in the provision of mobile units that deal specifically with the provision of contraceptives. This will increase women's access to contraceptives, as they do not necessarily have to travel far to the health facilities to access contraceptives.

In terms of further research, more studies and literature in South Africa should focus on the use of contraceptives especially in rural areas and the study samples should attempt to focus on different age groups. This is because most studies have focused on young women. This study recommends that further research be done in South Africa to arrive at a broader understanding of the factors that either promote or inhibit the use of contraceptives among the women living in rural areas, precisely because the use of contraceptives is low in those rural areas.

5.4 Conclusion

In conclusion, the study collected data with the aim of gaining more insights into the use of contraceptives among older women in rural KwaZulu-Natal, specifically in the rural area of Ntabamhlophe. The study found that awareness of contraceptive methods was high, although knowledge on the correct and consistent use of these contraceptives was limited. The study indicated that women were aware that using contraceptives could eliminate unintended pregnancies and thus reduce unsafe abortions. Nonetheless, the use of contraception among the women under study appeared to be low. Experiences and perspectives towards the use of contraceptives were also investigated in the study. The study found that there are factors that promote and inhibit the use of contraceptives among the rural women. Factors promoting contraceptive use were identified as the desire to limit family sizes and space births. Socio-economic factors such as educational level and employment were also seen as factors that have an influence on women initiating the use of contraceptives.

The study found that the inhibiting factors were inclusive of, but not limited to gender inequality, myths and misconceptions, fear of side effects and issues pertaining to health facilities and health practitioners. The women also indicated that there is a need for them to prove their fertility once they get married, thus, this barred them from accessing and using contraceptives. Thus, the study recommends the carrying out of more research on the use of contraceptives in rural areas focusing on all the age groups. Further, more educational intervention programmes on sexual and reproductive health should be developed and implemented in rural areas and these should move towards an inclusive paradigm, thus roping in the males. Policy makers and health department’s need to increase the availability of

contraceptives in rural areas to address the unmet need for contraceptives that is prevalent in rural areas.

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Appendix I- Interview Schedules

Interview Schedule: English

Part 1: Demographic background

1.1 Age

1.2 Marital status

1.3 Highest level of education

1.4 Employment status

1.5 Number of children

Part 2: Interview Questions

2.1 What methods of contraceptives are you aware of?

2.2 Do you know how different methods of contraceptives work?

2.3 Do you feel that contraceptives are available and accessible?

2.4 How do you feel about contraceptives and the use of contraceptives?

2.5 Why do you think other women use contraceptives?

2.6 Which types of women do you think should use contraceptives?

2.7 Have you used contraceptives before?

(a) If yes, which type of contraceptive did you use?

(b) If no, why not?

2.8 What do you think is the influence behind the non-use of contraception?

2.9 What are the common effects of contraceptives that you are aware of?

(a) Do you believe that these effects are true?

2.10 Do you believe that it is risky to use contraceptives?

Uhlelo lwemibuzo yengxoxo: isiZulu

Ingxenye 1: iImibuzo yesimo sobu demographic

1.1 Iminyaka

1.2 Isimo somshado/ isimo sobudlwelano

1.3 Izinga lemfundo

1.4 Isimo somsebenzi

1.5 Inani lezingane

Ingxenye 2: Imnibuzo Yengxoxo

2.1 Yiziphi izindlela zokuvikela ukukhulelwa/inzalo ozaziyo?

2.2 Uyazi ukuthi izindlela ezahlukene zokuvimbela ukukhulelwa zisebenza kanjani?

2.3 Unomuzwa wokuthi izinto zokuvikela inzalo/ukukhulelwa ziyatholakala kalula?

2.4 Uzizwa kanjani ngezimvikela nzalo nokusetshenziswa kwazo?

2.5 Ucabanga ukuthi kungani abanye besifazane basebenzisa izimvikelanzalo?

2.6 Ucabanga ukuthi yiziphi izinhlobo zabesifazane okufanele basebenzise izimvikelanzalo?

2.7 Ingabe uke wazisebenzise izimvikelanzalo ngaphambili?

(a) Uma u-yebo, yiliphi uhlobo olusebenzisile?

(b) Uma cha, kungani?

2.8 Ucabanga ukuthi yiliphi ithonya elivimbela ukusetshenziswa kwezimvikelanzalo?

2.9 Yimiphi imiphumela evamile yokusebenzisa izimvikelanzalo oyaziyo?

(a) Uyakholelwa yini ukuthi lemiphumela iyiqiniso?

2.10 Uyakholelwa ukuthi kuyingozi ukusebenzisa izimvikelanzalo?

Appendix II- Informed consent forms

INFORMED CONSENT FROM

My name is Ayanda Mkhize, (Student number 213 517 480). Population Studies Masters Candidate from the University of Kwa-Zulu Natal Howard College Campus, School of Built Environment and Development Studies.

You are being invited to consider participating in a study that involves research on investigating Contraceptive use amongst women in rural Kwa-Zulu Natal. The aim and purpose of this research are to shed insight/light into contraceptive use among women of reproductive age in rural areas. The study is expected to enroll 15 participants in total. It will involve the use of individual semi-structured interviews with each of the participants and the interviews will be conducted by myself. The duration of your participation if you choose to enroll and remain in the study is expected to be approximately one hour for each interview.

The study may involve discomforts such as the participants seeing contraceptive use as a sensitive and private issue. It is hoped that the study will be beneficial in reducing the knowledge gap that exists and by providing knowledge on the use and non-use of contraceptives by women between the ages of 25 and 35. The benefits of this study to the participants could be the information on contraceptive use that they could gain from participating in this study. The Community Care Givers will provide psychosocial intervention in the event of potential discomfort.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/0825/018M)
In the event of any problems or concerns/questions you may contact the researcher at:

I can be contacted at:
Email: ayandamkhize945@gmail.com
Cell: 082 079 2402

Research Supervisor:
Email: Maharajp7@ukzn.ac.za
Tel: 031 260 2243

If you wish to obtain information on your rights as a participant, please contact Humanities & Social Sciences Research Ethics Administration**:**

Tel: 031 260 4557

Email: HSSREC@ukzn.ac.za

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as an individual response.
- The interview may last for about an hour or less and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research at any time. You will not be penalized for taking such an action.
- The research aims at assessing the use and non-use of contraceptives amongst older women and that is the sole purpose of this study.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.

CONSENT

I (Name) have been informed about the study entitled 'Contraceptive use amongst women in rural Kwa- Zulu Natal: A case study of Ntabamhlophe.' by Ayanda Mkhize.

I understand the purpose and procedures of the study.

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

I declare that my participation in this study is voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

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

I hereby provide consent to:

- If you are willing to be interviewed, please indicate by ticking as applicable whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		

Signature of Participant: _____ Date: _____

Print name: _____

INCWADI YESIVUMELWANO SOCWANINGO

Isibingelelo: Ngiyakubingelela lunga lomphakathi

Igama lami ngingu Ayanda wakaMkhize umfundi wezobuncwethi zePopulation Studies ophuma eNyuvesi yakwaZulu Natali, Howard College Campus. Eskoleni sakwa Built Environment and Development Studies.

Uyamenywa ukuba ube ingxenye noma ukusebenzisana nami kucwaningo lokuthola ulwazi mayelana nezimvikela nzalo kubantu besifazane abahlala ezindaweni zesemaphandleni lapha eNtabamhlophe. Inhloso yalolucwaningo ukukhanyisa ulwazi olukhona mayelana nezimvikela nzalo kanye nokusetshenziswa kwazo kubantu besifazane abahlala emkahyaya. Kulesifundo kuzoqokwa abesifzane abawu 15 abaphakathi neminyaka engu 25 kuya ku 35 ubudala. Kuzobandakanya ukusetshenziswa kwezingxoxo zomuntu ngamunye ezihleliwe futhi izingxoxo zizoqhutshwa yimina mcwaningi. Isikhathi sokubamba iqhaza kwakho uma ukhetha ukubhalisa futhi uhlale ocwaningweni kulindeleke kube cishe ihora elilodwa ukuxoxisana ngalunye.

Lesisifundo asinabo ubungozi futhi akukho lapho ozozizwa ungenakho ukukhululeka. Kuthembaka ukuthi lolu cwaningo luzozuzisa ekunciphiseni igebe lwazi olukhona futhi ngokuhlinzeka ngolwazi ekusetshenzisweni nasekusetshenzisweni kwezimvikelanzalo ngabesifazane basemaphandleni abaphakathi kweminyaka engu-25 no 35. Izinzuzo zalolu cwaningo kubahlanganyeli kungaba ulwazi mayelana nokusetshenziswa kokukhulelwa abangayithola ngokuhlanganyela kulolu cwaningo. Abahlinzeki Bokunakekelwa Komphakathi bazohlinzeka ngokungenelela ngosizo kwezengqondo lapho kwenzeka ukungahambi kahle.

Okunye okumele ukwazi ngalolucwaningo ukuthi akukho muhlomulo ngokusebenzisana nathi ngalesisifundo.

Lesisifundo sibhekiwe ngokwenkambo yobulungiswa sagunyazwa ikomide lesikhungo sasenyuvesithi UKZN Humanities and Social Sciences Research Ethics (inombolo yokugunyaza: HSS/0825/018M)

Uma kwenzeka noma yiziphi izinkinga noma ukukhathazeka / imibuzo ungaxhumana nomcwaningi ku:

Ngiyakwazi ukuxhumana nami:

Imeyili: ayandamkhize945@gmail.com

Iseli: 082 079 2402

Umphathi Wokucwaninga:

Imeyili: Maharajp7@ukzn.ac.za

Ucingo: 031 260 2243

Uma ufuna ukwazi ngemininigwane ngamalungelo akho njengomuntu oyingxenye yalolucwaningo, ungaxhumana nehhovisi loCwaningo eNyuvesi yakwaZul- Natali

Ucingo: 031 260 4557

Imeyili: HSSREC@UKZN.ac.za

Sicela wazi ukuthi:

- Imfihlo yakho iqinisekisiwe njengoba izimpendulo zakho zingeke zibhekwe kuwe ngomuntu, kodwa zibikwe kuphela njengempendulo yomuntu ngamunye.

- Ingxoxo ingahlala isikhathi esingangehora noma ngaphansi futhi ingahle ihlukaniswe ngokwezifiso zakho.

- Noma yiluphi ulwazi olunikezwa nguwe alukwazi ukusetshenziswa ngokumelene nawe, futhi idatha eqoqwe izosetshenziselwa izinhloso zalolu cwaningo kuphela.

- Idatha izogcinwa kwisitoreji esiphephile futhi ibhujiswe ngemuva kweminyaka emihlanu.
- Unelungelo lokubamba iqhaza, ungahlanganyeli noma uyeke ukuhlanganyela ekucwaningeni nganoma yisiphi isikhathi. Ngeke ujeziswe ngokuthatha isenzo esinjalo
- Ucwaningo luhlose ukuhlola ukusetshenziswa nokungasetshenziswa kwezimvikelanzalo phakathi kwabesifazane asebekhulile futhi yinjongo yodwa yalolu cwaningo.

- Ukubandakanyeka kwakho kungenxa yezifundo kuphela, futhi azikho izinzuzo zezimali ezihilelekile.

ISIVUMELWANO

Mina (Igama) ngazisiwe mayelana nesifundo esinesihloko esithi ‘Ukusetshenziswa kwezimvikelanzalo kwabesifazane ezindaweni zasemaphandleni zaseKwaZulu-Natali: Ucwaningo lwamacala eNtabamhlophe ngu Ayanda Mkhize.

Ngiyaqonda injongo nezinqubo zesifundo nocwaningo.

Nginikeziwe ithuba lokuthi ngiphendule imibuzo mayelana nalolucwaningo noma isifundo futhi ngiphendulwe ngendlela engineliseka ngayo

Mina ngiyamemezela ukuthi ukuba kwami ingxenye yalolucwaningo angiphoqiwe futhi ngingayeka noma nini ngaphandle kokuphazamisa lesisifundo.

Uma ngabe ngiba nemibuzo noma yini ephathelene nalolucwaningo ngingaxhumana nomcwaningi.

Uma ngabe ngiba nemibuzo noma ngifuna ukwazi kabanzi ngamalungelo ami ngokusebenzisana nani kulolucwaningo noma okumayelana nalolucwaningo noma ngabacwaningi ngingaxhumana nonobhalo wesikhungo esibhekelene nobulungiswa bokwenza ucwaningo.

Okwengeziwe ngemvumo okudingekayo:

• Uma uzimisele ukuxoxoswa njengenxwenye yalolucwanincgo, sicela ubonise ngokufaka uphawu ngokubheka njengokusebenza noma ngabe uzimisele yini ukuvumela ukuthi lolu daba lulotshwe yizixhobo ezilandelayo:

	Ukuzimisela	Ukungavumi
Imishini eqopha umsindo		

Sayina ukuzibophezela Usuku_____

Igama _____

Appendix III- Ethical clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

2 October 2018

Ms Ayanda Fezzie Mkhize (213517480)
School of Built Environment & Development Studies
Howard College Campus

Dear Ms Mkhize,

Protocol reference number : HSS/0825/018M
Project title: Contraceptive use amongst women in rural KwaZulu-Natal : A case study of Ntabamhlophe

Full Approval – Full Committee Reviewed Protocol

In response to your application received 2 July 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

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

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

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

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

Yours faithfully

[redacted]

Professor Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Professor Pranitha Maharaj
cc Academic Leader Research: Professor Oliver Mtapuri
cc School Administrator: Ms Angeline Msomi

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