

Women and contraceptive use: A case study of a South African urban informal settlement

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degree of Master of Social Work**

By

Susisizungu Ncube

211555563

School of Social Work and Community Development

University of KwaZulu-Natal

Durban, South Africa

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ABSTRACT

This study adopted a case study design to understand women and contraceptive use in the Diepsloot community, an impoverished urban informal settlement, north of Johannesburg. It was guided by feminist and critical theory, and made use of the qualitative research paradigm. The history of the provision of reproductive health services in South Africa has been discussed as a process that has both marginalised the participation of previously disadvantaged communities and also limited the opportunities for effective contraceptive use in the post-apartheid era. The main objectives were to understand reproductive health experiences of women and their knowledge of modern contraception in relation to the ecological environment in which they are embedded.

I used the non-probability purposive and theoretical sampling methods. The sample size was theory driven and largely determined by the type of data acquired after a series of interviews with twenty women over a five month period. Data collection ceased when data saturation was reached. Individual interviews and focus group discussions were conducted with twenty primary respondents. For triangulation purposes, primary health care service providers from the two local clinics were interviewed. Also one focus group discussion was done with a group of eight men; two traditional healers and the manager at the local Marie Stopes clinic were also interviewed for the same purpose. I used thematic analysis as the method of analysing the data. Thematic analysis moves beyond merely describing the data but identifies both the unspoken and obvious ideas within data. It was the intersectionality of contraceptive use and the unique lived experiences of disadvantaged women that had inspired the study and all methods employed were aimed at a deeper understanding of the effects of the cultural, social and economic environment on the reproductive health choices of the women.

The data were analysed according to the seven themes that emerged from the study and these were: empowerment and reproductive health decision making, level of education as a determining factor in contraceptive use, contraceptive knowledge, contraceptive dialogue as a contributing factor to contraceptive use and choice, opinions on the prevention of pregnancy, spacing versus limiting the number of births and the availability and accessibility of modern contraceptive methods. The inextricable link between education, poverty and gender inequality highlighted the need to empower women in marginalised communities. Due to poverty and lack of education, most women were powerless and not independent to make favourable reproductive health decisions. Knowledge of modern contraceptive methods was limited and the most popularly used method was the contraceptive injection.

The circumstances of the women in this study and those of the Diepsloot community speak to the broader economic issues of the country and reflect the need to prioritise women's education; to create economic opportunities for women and to enhance the participation of the poor and marginalised communities.

DECLARATION

I hereby declare that this dissertation is the original work of the author and has not been submitted in any other form to another university. Where the work of others has been cited, it has been duly acknowledged and referenced.

Durban, November 2012

Susisizungu Ncube

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CHAPTER 1

INTRODUCTION

1.1 Introduction

The chapter introduces the aim and objectives of the study, which was to explore the subject of contraception amongst women living in the Diepsloot community, an urban informal settlement. The chapter also gives a background of the study, by describing the problem situation and purpose of the study. It also includes the theoretical framework guiding the study and ends with the arrangement of the contents of the dissertation.

1.2 Rationale of the study

Reproductive rights are fundamental to women's health, development and empowerment (Knudsen, 2006). Women and the use of contraception are global issues whose urgency is being recognised world over as the world focuses at achieving universal access to reproductive health. International campaigns such as the World Contraception Day, an annual event taking place on the 26th of September every year, all seek to raise awareness on contraception and improve reproductive health education (Population Services International, 2011). Although the world's total fertility rate has declined and contraceptive uptake improved over the decades, disparities in contraceptive use are still found between the developing and developed nations (Creanga, Gillespie, Karklins and Tsui, 2010). Regionally, Sub Saharan Africa is behind on the reproductive health areas, cited as crucial for achieving the Millenium Development Goals, especially those around child and maternal health (Gribble and Haffey, 2008). Although there have been dramatic national changes in South African policies designed to improve the conditions of non-whites that were a result of apartheid, the realities of life for most previously disadvantaged South African women have not been as dramatic as a result of the vast inequalities created by the previous system (Burgard, 2004).

Women's autonomy in pursuing favourable reproductive health intentions is crucial for their empowerment and development and South Africa, like most developing nations still remains behind on reproductive health areas and those related to improving the lives of women. Consistent and correct contraceptive use is a strong determinant of intended pregnancies,

while inconsistent use or non-use has the adverse effects (Bafana, 2011). Reproductive health issues cannot be isolated from HIV/AIDS, which has greatly undermined development and affected women. According to a 2008 UNAIDS report, nearly 80% of the world's 15,5 million HIV infected women live in Sub Saharan Africa and it was also estimated that each year, these women experienced 1,4 million pregnancies and that 50-84% of these pregnancies were unintended (World Health Organisation, 2009; Laher, Todd, Stibich, Phefa and Behane, 2009). An estimated 350 000 births a year are affected by HIV through mother-to-child transmission in the region, whilst maternal mortality also continues to be exaggerated by HIV/AIDS (WHO, 2009; Kaida, Laher, Atrathdee, Money and Jansen, 2010). Between 2000 and 2009, HIV/AIDS prevalence in South Africa was at 11 236 per 100 000 people per year (National committee into confidential enquiry into maternal deaths, April 2012).

The health system is plagued by challenges in terms human resources, quality of care and management expertise and this has not only affected other major sectors of the health department but also reproductive health promotion and service provision (Stevens, 2012). An unmet need for family planning, especially amongst HIV positive women presents women with a double challenge of HIV and unwanted pregnancies. Studies done suggest an under emphasis on promoting contraception amongst HIV positive women, yet some studies show that contraception amongst HIV positive women could prevent 29% more HIV positive births than prophylactic nevirapine alone (Kaida et al. 2010). "South Africa's HIV prevention of mother to child transmission programmes seldom focus on the second focal point, the prevention of unintended pregnancies" (Stevens, 2012:1). 77 771 legal abortions were recorded in state facilities in South Africa in 2011, a 31% increase from the 2010 statistics, suggesting an unmet need for family planning (IOL, 21 August 2012).

South Africa's past population policy led to the country having a high contraceptive prevalence rate compared to other Sub-Saharan countries. However, there has been little change in available contraceptive methods and the injectable contraceptives still remain the most commonly used amongst the previously marginalised (Cooper, Morroni, Orner, Moodley, Harries, Cullingworth and Hoffman, 2004). Gaps in the implementation of the current reproductive health policy have hindered meaningful developments in women's reproductive health issues (Cooper et al. 2004).

Several authors have emphasised the importance of looking into the interrelationship between social factors such as poverty, education and housing quality, and contraceptive use. In South

Africa, apartheid institutionalised inequality. Eighteen years after democracy, the skewed distribution of resources along racial lines that existed during the apartheid era is still evident in present day South Africa and the majority of the Black population still live in dire poverty (Adebajo, Adedeji and Landsberg, 2007). An estimated 8,7 percent of the population lives in urban informal settlements, unhealthy overcrowded areas which protrude as symbols of inequality on the urban landscape (Harber, 2011; Huchzermeyer and Karam, 2006). The 2010-2011 Department of Labour annual report revealed that 73,1 percent of top management positions in South Africa are still held by whites who continue to hold the most wealth and occupy managerial positions (Sewpaul, in press). According to the 2011 South African Census, black households earn an average of R60,613, a sixth of what the average white household earns (Timeslive, 30-10-2012). A majority of the poor population still lacks basic services as 297,847 households still use the bucket system for ablution, 748,597 households have no toilets at all, and a further 1,3 million households are without piped water (Timeslive 30-10-2012; Joseph and Eyal, 2012). While the majority of Black men are oppressed and struggle reconciling male expectations with the socio-economic realities of their lives, “black women are at the bottom of the social ladder, and are, as a result of their social status, more vulnerable to both poverty and HIV” (Osthus, in press). As a result, there is a need to examine the realities of Black women and how their reproductive health decisions are affected.

Many studies in the area of reproductive health have focused on the issue of power and male domination in contraceptive choice and use. Based on gender differences, patriarchy perpetuates the ideology of motherhood, burdening and limiting women with responsibilities and activities in the home, such as rearing children and being a wife. Ray (2008:2) explains the institutionalised and legitimised male control by asserting that “while the subordination of women may differ in terms of its nature, certain characteristics such as control over women’s sexuality and their reproductive rights cuts across class, caste, ethnicity, religions and regions and is common to all patriarchies”. Many women still remain subordinate in their homes and in society and are yet to attain any real autonomy to express and apprehend their reproductive intentions (Brown, 1987).

Taking into consideration that the liberation of women’s reproductive health rights is still a global, regional and national concern, the use of contraception amongst women who are at the bottom of the social and economic ladder in urban South Africa is an area still in need of more investigation. The purpose of this qualitative study was therefore to gain an in-depth

understanding of women and contraceptive use in an urban informal settlement setting, focusing on past and present socio-economic factors affecting their reproductive health decisions. The study also aimed at exploring how power and gender relations intersect to reinforce the subordination of women, further distancing them from achieving reproductive health intentions. Apart from giving the women a voice to express and explain how they navigated everyday challenges and injustices, the study was also an opportunity to look at the realities of South African poverty through a gender sensitive lens.

1.3 Research problem

The interest in the issue of women in informal settlements and their use or non-use of contraception came as a result of many comments that I had heard being passed in various mass media and public circles, expressed as a visibly persistent problem in urban areas. There seemed to be always a question on why women in informal settlements always had children that they could not afford to adequately look after. At all times, these comments appeared subjective, uninformed and highly prejudiced. The perceived high fertility rates in these settings were often expressed as the irresponsibility of the woman and were often seen in isolation to many other historical, cultural and socio-economic factors. It was apparent that the easily taken for granted issues of gender and race with particular reference to contraceptive use in commonly patriarchal societies, were being ignored in this social phenomenon. Interesting was also the unique multiple social identities and positions held by the women living in informal settlements, which at some level colluded to render them more disadvantaged than their female counterparts in comparatively better settings. Factors such as the level of education, empowerment, decision making power and the availability and accessibility of contraception in these settlements appeared of notable concern. It is the intersectionality of contraceptive use and the unique lived experiences of disadvantaged women that inspired the study.

1.4 Research aim and objectives

The aim of the study was to explore the subject of contraception amongst women living in the Diepsloot community.

The objectives of the study were to:

- understand knowledge of modern contraception among women living in Diepsloot, an urban informal settlement.

- explore marginalised women's experiences of contraceptive use through exploring the role of the socio-economic environment on women's choices and understanding of contraceptives.
- explore patriarchal social dynamics in Diepsloot and their effects on women's autonomy with regard to contraceptive use.
- understand how the Diepsloot community values and culture impact on the women's use of contraceptives.
- investigate the availability and accessibility of contraceptive methods and the related effects.

1.5 Value of the study

The case study of Diepsloot on women and contraceptive use focused on marginalised women and their everyday experiences with contraception, in an area known for poverty and a dire lack of basic services. The study thus intended to contribute to a deeper understanding of the effects of the cultural, social and economic environment on the reproductive health choices of the women that exist within it. There are still disparities within contraceptive provision in urban South Africa and the study was aimed at highlighting the gaps that still exist in the implementation of reproductive health policies. The study was also meant to provide context bound and relevant information, attained through non-judgemental interactions, highlighting the perceptions and realities of the women as they would best describe them.

The study also aimed at providing multiple and alternative perspectives to understanding the use of contraception and hopes were to inform social and health interventions at different levels, especially within the community.

1.6 Theoretical framework

The study is guided by the feminist and critical approaches to social research. Ideology from the feminist and critical theory is comparable as both theories are concerned with historically established power structures that have led to dominance, subordination and marginalisation of certain groups of people. Both theories seek to understand and expose inequality and the ultimate aim is to empower those marginalised.

Critical theory challenges our knowledge of reality as being shaped by social, cultural, political and gender based forces that have been refined over time and preserved into social structures (Guba and Lincoln, 1994). It also contends that social realities are historically generated and that social issues are not ‘naturally’ occurring, but socially created and influenced by power inequalities (Osthus, in press). Critical theory not only recognises but goes further to challenge the existing power structures. Shermain and Reid (1994:46) explain critical theory as being “directed at the moral and political equation of the lived experience” with a “purpose of inducing new awareness and fruitful change.” Similarly, feminist theory, which is critical in nature and politically motivated, is concerned with social inequality, but most importantly begins from the standpoints of women (Brayton, 1997). Feminist research challenges social structures by documenting the lives of women, their experiences and highlighting gender based stereotypes (Hesse-Biber and Brooks, 2006).

The purpose of feminist research is to empower women and other marginalised groups, as well as encouraging social justice and social change for women (Hesse-Biber and Brooks, 2006). By reinforcing the participants as authors and experts of their own situations, feminist methods allows women to critically examine their own lived realities, potentially giving women the opportunity to safely criticize their own lives, community, organizations and circumstances (Brayton, 1997). Feminist theory strives for bringing women’s voices to the fore and aims at exposing socially and politically gendered contexts and thus, feminist research is not just “research about women but research for women to be used in transforming a sexist society” (Cook and Fonow, 1986, in Brayton 1997:1). Similarly, critical theory is empowering in nature, aimed at “consciousness-raising” through research methods that encourage dialogue and critical reflection for “an increase in self-knowledge, the reduction of illusions, the restoration of meaning or the alleviation of injustice and discrimination” (Shermain and Reid, 1994:47).

Feminists and critical theorists view knowledge as being context bound and knowledge acquisition as a dynamic process, acquired through the researcher’s constant interaction with the environment. The researcher is viewed as a competent, reflexive research instrument. Therefore, feminist and critical theory rejects the idea of researcher neutrality and value free methods of acquiring knowledge, and acknowledges the need for interpretation, subjectivity, emotion, and embodiment into the knowledge-building process (Brooks and Hesse-Biber, 2006). Brooks and Hesse-Biber, (2006:14) further emphasize that through “paying attention to the specific experiences and situated perspectives of human beings, both researchers and

respondents alike, may actually become a tool for knowledge building and rich understanding”.

On the ‘researcher-researched’ relationship, Brayton (1997) advises that the pre-existing inequality between the two may be overcome through the researcher’s unreserved association with the context, where participants may feel more comfortable in sharing information with someone who is within the situation. Brayton (1997) also explains how the hierarchical relationship between the researcher and the researched is restructured to validate the viewpoint of the participant. The equalisation of power is achieved through involving participants at all stages of the research and acknowledging that they are experts of their own lived experiences. The study on women and contraceptive use thus needed to pay particular attention to the gendered social and political dynamics of the specific environment, at the same time being inclusive of emotions and experiences as described by the women and also to inform on the existing social practises that make up these experiences.

1.7 Presentation of contents

Chapter 1 is the introductory chapter. It gives a background of the study and aims at justifying the existence of the research problem. Subsections covered are the introduction, the rationale of the study, a discussion of the research problems, the value of the study and the theoretical framework guiding the study.

Chapter 2 is the review of literature. It provides the definitions of contraception, and also focuses on the past and present provision of family planning services in South Africa and the intersectionality of contraceptive use. Other literature reviewed in this chapter looks at the cultural, social and economic factors related to the use of contraception.

Chapter 3 is the methodology chapter. The chapter describes and justifies the methods used to gather and analyse data. There is a discussion on the qualitative method as the most suitable research method and also the theoretical framework. The chapter also discusses the concepts of reliability and validity, the possible study limitations and the ethical considerations.

Chapter 4 is the analysis and discussion of findings. The chapter begins with an outline of the context of the study and also the socio demographic characteristics of the respondents. The presentation of the findings follows, grouped into themes and subthemes that emerged during the study.

Chapter 5 concludes the study and contains conclusions and recommendations made based on the findings and analysis.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The chapter begins with the definitions of contraception, both modern and traditional; followed by an exploration of theories of health behaviour that relate to contraceptive use. This section of the study also looks at the concept of intersectionality and its notions on contraceptive use. There is focus on the history of contraception in South Africa and also a look at the present reproductive health system, including the Department of Health's current policy guidelines that seek to shape contraceptive provision in addressing current reproductive health challenges. Other sections of this chapter focus on the social, economic and cultural factors that affect contraceptive use.

2.2 Definition of contraception

According to the South African Department of Health National Contraception Policy Guidelines (2000:9), "contraception is the prevention of pregnancy through temporary or permanent means."

Another term closely associated with contraception is family planning, and the two are commonly used synonymously and most service users do not differentiate between the two (Bafana 2011). In separating these terms, Hagenfeldt (1991) describes family planning as not only including contraception but also, access to other reproductive health options such as safe legal abortions, antenatal care, infertility investigation and treatment.

The World Health Organisation website on health topics (2011) further defines family planning as the means through which individuals and couples anticipate and attain their desired number of children and the spacing and timing of their births. Such is achieved through the use of contraceptive methods and the treatment of involuntary fertility. This in turn has a direct impact on the woman's health and well-being, as well as on the outcome of each pregnancy.

Contraception as defined by Stacey (July 3 2009 About.com Guide), is "the intentional prevention of conception through the use of various devices, sexual practises, chemicals, drugs or surgical procedures. This means that something or some behaviour becomes a contraceptive if its purpose is to prevent the woman from becoming pregnant."

For the purposes of this study, the definition by Stacey (2009) will be used.

2.3 Classification of contraceptive methods

Contraceptive methods are usually classified into two categories, traditional methods and modern contraceptive methods. Known traditional methods include withdrawal and periodic abstinence and a variety of sometimes undocumented folk specific practises. Modern contraception includes hormonal methods, for example, the intrauterine device, the pill, the injectable contraceptives; barrier methods such as condoms and permanent methods like sterilisation (Biddlecom, 2008).

Hormonal contraceptive methods work by stopping ovulation, thickening the mucus around the cervix to prevent sperm from entering the uterus and also by thinning the lining of the womb to prevent fertilised eggs from implanting into the wall of the uterus (Harper, Blum, de Bocanegra, Darney, Speidel, Policar and Drey, 2008).

An online Health 24 article dated 7 February 2011, classifies contraceptives methods into three types, that is, natural methods, barrier methods and hormonal methods.

- Natural methods: methods that do not use any contraceptive device or medication.
- Barrier methods: the devices that physically block the access of sperms to a woman's uterus and fallopian tubes. They include the diaphragm and cervical cap, the male and female condom, and the spermicides.
- Hormonal methods: These are contraceptives that can only be used by women and include oral contraceptives, commonly known as the Pill, as well as hormonal injections, implants and vaginal rings, all containing synthetic hormones. Their method of action is to stop the ovaries from releasing an egg each month.

2.4 Types of modern contraceptive methods

Table 1

Type of contraceptive	Description	Known risks and precautions
Oral contraceptives	<ul style="list-style-type: none"> - Pills come in packets of 28 and must be taken once daily at the same time. - These can be bought without a prescription at a pharmacy and are offered free of charge at public health care facilities in South Africa. - These contraceptives do not prevent sexually transmitted infections. - There are two main types <ul style="list-style-type: none"> i) Combined Oral Contraceptives ii) Progestogen only contraceptive pills 	<ul style="list-style-type: none"> - The hormone (estrogen) in birth control pills is known to increase the risk of heart attack in women over 35, especially those who smoke. - Pills are also known to change menstrual periods, change moods, cause weight gain, cause acne and headaches.
Emergency contraception	<ul style="list-style-type: none"> - This form of contraception is often referred to as the morning after pill and is used to prevent pregnancy after unprotected intercourse. It can be taken up to 72 hours after unprotected intercourse. 	<ul style="list-style-type: none"> - Emergency contraception is known for interrupting the menstrual cycle.
Contraceptive	<ul style="list-style-type: none"> - There are two types of 	<ul style="list-style-type: none"> - It may take many

injection	<p>contraceptive injections</p> <p>i) Depo-Provera or Petogen: given every three months</p> <p>ii) Nur-Isterate: given every 8 weeks.</p>	<p>months to begin ovulating again once a woman stops using the Depo-Provera or Norplant.</p> <ul style="list-style-type: none"> - Long term use is also linked with infertility in some cases.
Intrauterine device (IUD)	<ul style="list-style-type: none"> - This type of contraception is a small device that is put into a woman's uterus to deter sperm from reaching the egg. It is inserted by a specially trained health worker. It can be bought in pharmacies but is available at most clinics. - The IUD can prevent pregnancy for up to 5 years but it's advisable to go for a check-up every year. - This method does not protect against sexually transmitted infections. 	<ul style="list-style-type: none"> - The IUD is a foreign body that tries to stay inside the uterus and the uterus tries to get it out, resulting in heavier periods and more menstrual cramps. - It is also a relatively costly method. - This method also increases the risk of pelvic infection. It can also injure the uterus by poking into the uterus wall. - Infections resulting from use have been

		linked to infertility and complications with STIs. Until recently, it has only been encouraged for women with children.
Condoms	<ul style="list-style-type: none"> - Female and male condoms are the only known method that offer dual protection from unwanted pregnancy and sexually transmitted infections - Condoms are offered free of charge at clinics and some public venues and can also be bought at pharmacies and shops. 	<ul style="list-style-type: none"> - Some women have reported getting urinary tract infections, when they use the condom and also allergic reactions for some from latex condoms.
Sterilisation	<ul style="list-style-type: none"> - Sterilisation is a permanent contraceptive method for both men and women. Any person over the age of 18 can consent to the procedure. - The operation is free at clinics and other public health care facilities. - The operation for females is called tubal ligation. The fallopian tubes that carry the ovaries to the uterus are tied or blocked and the eggs are prevented from becoming 	<ul style="list-style-type: none"> - Some women report increased menstrual discomfort after the procedure.

	<p>fertilised by sperm.</p> <ul style="list-style-type: none"> - For males the operation is called vasectomy and the sperm tubes of the man are cut and tied. 	
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2.5 Traditional contraceptive medicines and prevalence of use

2.5.1 Definition of traditional contraceptives

Traditional medicine still plays an important role in primary health care in most developing countries (Setswe, 1999), yet most definitions of contraception only include the use of modern medicines. Johnson (2002) in an article on the modernity of traditional contraception, points out that this omission may have been caused by policy emphasis on biomedical contraception and explains how most programme oriented groups do not consider traditional methods to be contraception at all. But studies carried out around Africa and the rest of the developing world prove that traditional contraceptives are still being used and are part of the belief systems in most African cultures.

Traditional medicine is defined by the South African Traditional Health Practitioners Act No 22 of 2007:7 as “... an object or substance used in traditional health practice for:

- (a) the diagnosis, treatment or prevention of a physical or mental illness; or
- (b) any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings.

The definition of traditional contraception by some authors is sometimes limited to natural methods, methods that do not use any contraceptive device or medication, such as the rhythm and withdrawal methods. Some researchers however extend this definition to include the use of non-conventional methods, sometimes also referred to as folk contraceptive methods. According to Agadjanian (1998) these methods may include herbs, charms and amulets believed to prevent pregnancy. Robinson (1999) points out that folk contraceptive methods are usually country specific and tend to differ from one society to another. As a result, it is difficult to classify traditional medicines and provide evidence supporting its use. For the

purposes of this study, a review of literature on traditional contraceptive medicines also includes articles focusing on the use of non-conventional methods of contraception.

2.5.2 Prevalence of use

According to a 2010 report on traditional family planning methods in Africa by the American National Centre for Chronic Disease Prevention and Health Promotion, the rapid rates of modernization, and social change experienced in African countries make it difficult to determine how often traditional methods of fertility regulation are still used. However, there have been several studies investigating the prevalence of traditional contraceptives amongst women. The results vary between continents, societies and sometimes on proximate determinants of fertility, such as socio economic status, level of education, geographical location; as comparable disparities continue to be found between poor and wealthy societies (Creanga, Gillespie, Karklins and Tsui, 2010).

Traditional contraceptive methods are still being used in most parts of the world. A 2011 study conducted in Europe Moldova, where uptake of modern contraceptives methods was found to be relatively low, showed that traditional contraceptives are still commonly used especially by older women even when they have been exposed to modern methods (Lynos-Amos, Durrant, Padmodas, 2011). Most studies done in Africa, especially in Nigeria show that the use of traditional contraception is more popular amongst women with less education, unfavourable economic circumstances and those with limited access to primary health care facilities. An example of one such study is one conducted amongst Yoruba women in Nigeria in 1990, where traditional contraceptive prevalence was 7.1 percent of the 1400 women who participated. Use of traditional medicines for contraceptive purposes was found to be more common amongst women with little or no education and knowledge on the available types of contraceptives was found to be universal (Jinadu, Olusiso and Ajuwon 1997). A similar study in the same country, suggests that traditional contraceptive methods are also common amongst men, although now becoming less popular due to competing female modern methods (Adebisi and Bello, 2011). The study was conducted in 2011 in South Western Nigeria to determine patronage of traditional healers for unconventional contraceptives by males and 26.7 percent of the male interviewees admitted to having consulted a traditional healer for contraceptive purposes (Adebisi and Bello, 2011).

Whereas available data from some parts of Africa shows that traditional contraceptives are widely known and prevalence sometimes rivals that of modern methods (Agadijanian 1998),

these findings have not been consistent with the rest of the continent. The 2003 South African Demographic Health Survey reported that use of traditional contraceptive methods were at a low 0, 7 percent amongst the South African population. This low use of the traditional methods was attributed to the high effectiveness of modern contraceptives as compared to the traditional methods. The high use of modern contraception was taken as an indication that South African women normally have good access to family planning services and that they trust modern contraceptive methods to achieve their goals of either spacing or limiting their total number of children.

Most research shows that the availability and accessibility of contraceptives varies according to socio demographic characteristics (Agadijanian, 1998). As a result, some studies conducted suggest that traditional contraceptives are most likely to be used in rural and marginalised settings, where there is very little or no access to primary health care facilities. As cited earlier on, research done in Nigeria shows that traditional contraceptive medicines are more popular amongst the rural population. The use or non-use of contraceptives, be they traditional or modern, is a complex subject and the following section focuses on theories of health behaviour that have been used to inform health interventions.

2.6 Theories of health behaviour

There are several social and behavioural science theories that have been used to explain and guide public health interventions, including contraceptive use. The theories seek to understand health behaviours starting at the individual level and incorporating other various determinants of health at different levels. Maddox-Brown (2011:1) defines these “social and behavioural science theories” as the consolidation of health and social science approaches and methods, designed to improve health behaviour and outcomes. According to Warriner (2012), a better theoretical understanding of contraceptive behaviour is necessary for improving use and is of greater significance when targeting certain populations or groups of people where contraceptive use is still relatively low. The three inter-related theoretical perspectives that are pertinent to this study are: social cognitive theory; the social ecological perspective and the health belief model.

2.6.1 The social cognitive theory

The social cognitive theory rests on the premise that people not only learn from their personal experiences but also through observing the actions of other people and the results of those

actions. Based on Bandura's social learning theory, this model proposes that there is reciprocal interaction between the personal factors, behaviour and environmental influences and "triadic reciprocal causation" is the term introduced by Albert Bandura, to explain the interrelationship between these factors (Eysenck, 2004:473). According to Maddox-Brown (2011:12), concepts of the social cognitive theory that are relevant to health behaviour change are, "observational learning, reinforcement, self-control and self-efficacy." This necessitates an individual acquiring knowledge of the health dangers and benefits associated with behaviour change; developing self-assurance on one's ability to change health behaviour; and determining outcome expectations (Michie, Jonestone, Abraham, Lawton, Parker and Walker, 2005). Contraceptive research framed by this theory accepts the possibility of contraceptive use or non-use as being learned behaviour; based on how a person perceives and reacts to environmental changes/influences. The person's reaction to contraceptive will then be also determined by personal factors.

2.6.2 The social ecological model

The social ecological model is based on the premise of constant interaction between the person and the environment. The theory is founded on the belief of a correlation between the environmental conditions, human behaviour and well-being (Stokols, 1995). Emphasis is on the multiple levels of influences to the social environment and these are; the individual or interpersonal, organisational, community and public policy (Maddox-Brown, 2011). Thus, the "health promotive environment is understood, not simply in terms of the health effects of separate environmental features, but more broadly as the cumulative impact of multiple environmental conditions on the occupant's emotional and social well-being, over a specified time interval" (Stokols, 1995:285). Simply put, the theory is centred on the belief that people's behaviours shape and are also shaped by the environment. Also, another central idea to this model is that the human health is not only affected by the environmental features, but also by personal attributes such as psychological predispositions, behavioural patterns and genetic heritage and thus recognises the dynamic interaction between situational and personal factors (Stokols, 1995). With regard to health promotion, the central principle of the social ecological model is that, "creating an environment conducive to change is important to making it easier to adopt healthy behaviours" (Maddox-Brown 2011:18). While an individual might have the knowledge and skills to make the right reproductive health decision, that intention might be disrupted or reinforced by the social networks at the interpersonal level, the environment at the organisational level and the cultural values and norms at the

community level. Also, environmental conditions like broader macro level structural determinants of poverty such as race, class and gender may also affect the level of compatibility between the individual and their reproductive health intentions.

2.6.3 The health belief model

The constructs of the model emphasize that people's beliefs on a health risk directly relates to their perception of the issue and influences their reluctance or readiness to take preventive action (Maddox-Brown, 2011). According to Hall (2011:77), contraceptive behaviour explained through the health belief model is determined by an individual's "desire to avoid pregnancy and value placed on not becoming pregnant; nonspecific stable differences in pregnancy motivations and childbearing desires; and the perceived ability to control fertility and reduce the threat of pregnancy by using contraception."

The constructs of contraceptive behaviour according the health belief model are:

Perceived threat: relates to the individual's supposed likelihood of falling pregnant and in that eventuality, the consequences of such. Perceived threat is influenced by other factors like demographic and social variables such as age, ethnicity, peers, personality and social pressure.

Cues to action: relates to incitements that prompt awareness of the perceived pregnancy threat and encourage deliberation of using contraception to alleviate the perceived threat. The cues to action can include mass media campaigns and concerns raised by partner.

Perceived barriers: the undesirable consequences of contraceptive use. These sometimes relate to changes in weight, mood swings, and the inconvenience of regular visits to the clinic (Maddox-Brown 2011). Perceived barriers can also be social in nature especially social environments that support high fertility. According to Peterson, Oakley, Potter and Darroch (1998) what women perceive as potential disadvantages of using contraception, does actually inhibit them from using contraceptives.

To further explain contraceptive use and choice at the individual level, some literature identifies four aspects of contraceptive use as contraceptive choice, accuracy of use, consistency of use and contraceptive switching (Jacard, 2009). According to Jacard (2009), contraceptive choice refers to the decision to use some form of protection from pregnancy and also to the specific type of primary contraceptive method chosen. Choice is further

determined by formal resources like, adequate public health facilities, informal structures such as social interactions and the receptiveness of individuals and communities to birth control (Agadjanian, 1998). The effectiveness of the type of contraceptive method used then depends on how accurately and consistently an individual uses the method of contraception. Most women tend to switch methods based on the desirability of the method chosen. Jacard (2009) points out that the period in-between switching two methods is usually characterised by non-use, further placing a woman at risk of an unwanted pregnancy. Furthermore, switching highlights reasons for change and the implications it has on contraceptive knowledge. According to Lewis and Salo (2009), the public health system has greatly ignored the need for education and informed choice of contraceptive, which in turn leads to method mix, inconsistent use and eventually discontinuation.

2.7 Intersectionality and contraceptive use

Intersectionality is the view that societal systems and cultural forms of oppression collude at different levels, contributing to social inequality. Hill-Collins (2000:299) defines intersectionality as an “analysis claiming that systems of race, social class, gender, sexuality, ethnicity, nation and age, form mutually constructing features of social organisation, which shape black women’s experiences and in turn, are shaped by black women”. Originally developed in the United States by black feminists, intersectionality has been extended and is being used to understand diverse and marginalised positions in society (Crenshaw in Knudsen 2006:63). The key intersectional systems of society include gender, class and race. Also, they do not stand independently of one another, but relate to create multiple forms of discrimination (Hill-Collins, 2000). According to Stunaes (in Knudsen, 2006:62), the concept of intersectionality “can be a useful analytical tool in tracing how certain groups of people get positioned, as not only different but troublesome, and in some instances, marginalised.” It further highlights the complexity of lived experiences by viewing them from a social context, rather than an individual as the primary point of focus (Odum, 2004).

Hancock (2007: 64) further explains intersectionality as “the relationship between socio-cultural categories and identities” and “a content specialisation in populations with intersecting marginalised identities.” As a result, identity is particularly important to intersectionality as it is through the multiple identities that women are deprived of access to rights and opportunities (Symington, 2004). Also, it is through these multiple identities that intersectionality creates different kinds of inequalities, leading to different kinds of realities

and lived experiences (Hill-Collins 2000). Cherrera (2006) states how feminists have argued on the interesting position occupied by black women, where gender and race merge, and both are equally prevalent systems of oppression. According to Knudsen (2006), ethnicity, disability, sexuality, social class and nationality are categories that add to the intricacy of intersectionality.

Due to the intricacy of the concept of multiple identities, Hill-Collins (2000:28) states the importance of recognising that no “homogeneous Black woman’s standpoint exists”. There is however, “commonality within diversity”, common themes that emerge as a result of simply living as a black woman, so much that even if a Black women’s collective standpoint exists, it is characterized by the tensions that come about as a result of different reactions to common challenges (Cherrera 2006:5, Hill-Collins, 2000). This “commonality within diversity” is explained further by Cherrera (2006:5) who points out that, “even though individual Black women may respond differently, based on different cross-cutting interests, there are themes or core issues that all Black women can acknowledge and integrate into their self-identity”.

Sewpaul (in press) explains intersectionality within the distinctive South African context, whose uniqueness is a result of apartheid. Sewpaul (in press) highlights that “the complexity of race dynamics is such that with a relative disregard for the imperatives of intersectionality, there is a taken for granted assumption, that *all* Blacks are disadvantaged and *all* other designated racial groups, are advantaged.” To this the author encourages an understanding of disadvantage and privilege, not only in relation to race but also to take into account a combination of intersecting social categories; class, gender and nationality. The underestimation of the situational attributes in race and gender matters, with particular focus to the South African environment may lead to intersectional invisibility, a phenomenon where individuals with intersecting subordinate identities are made invisible (Cadwell, 2010; Sewpaul, in press). Purdie-Vaughns and Eibach (2008:377) explain intersectional invisibility as resulting from “androcentric, ethnocentric, and heterocentric ideologies” that cause people who have “multiple subordinate group identities to be defined as non-prototypical members of their respective identity groups.” While all Blacks are seen as disadvantaged in the South African context, at a more concrete level “it is still the Black woman who remains at the bottom of the social stratification system and experiences the greatest onslaught of poverty and of oppression” (Sewpaul, in press).

Power is a major determinant in intersectionality. Knudsen (2006) proposes that power goes beyond suppression to contain or reinforce aspects of exclusion and inclusion. The concept of intersectionality emphasizes how “different power relations affect each other by reinforcing or weakening, supporting or competing against each other in a dynamic interplay” (Anderson and McCormack, 2010:7). An identity or category thus carries with it certain views and power dynamics, that can either lead to an advantaged or disadvantaged position.

The issue of power in intersectionality is further explained by Hill-Collins (2000) through what she terms ‘the matrix of domination’, which is defined as the general organisation of power in any society. Hill-Collins (2000) further enlightens that any matrix has two features. Firstly, any particular matrix has intersecting systems of oppression, and these power arrangements are context specific, and also historically defined and justified. For example, the oppressions of an educated, black, foreign female cannot be similar to those of a foreign, illiterate, unemployed single mother. Although both are foreign nationals, they have different identities resulting in different lived experiences. Furthermore, their identities and categories are further specified by the social organisations in which they find themselves. Secondly, intersecting systems of oppression are believed to be specifically organised through four interrelated domains of power. One of the four domains is the interpersonal domain, which further identifies determinants of social class as “age, culture, disability, ethnicity, gender, immigrant status, race, sexual orientation, social class and religion”. According to Hill-Collins (2000), the interpersonal domain influences everyday life as it is made up of dialogues and everyday conversations that create social identities, which in turn influences the ways in which individuals as members of certain categories express themselves. Social identity construction in this regard is briefly discussed below. As discussed in this chapter, there is an inextricable link between intersectionality and reproductive justice.

2.7.1 Social identity construction

Deaux (2001) defines social identity as the process by which we view ourselves in positions and categories that we share with other people. Most people are members of several groups, but it is through the most meaningful groups that they are able to define themselves and self-definition is shared with people who share the same categorical group. Symington (2004:2) emphasises that the multiple identities that complicate the lives of most marginalised women are “derived from social relations, history and power structures.” Symington (2004) elucidates further by stating how these multiple identities should not be analysed as

increasing the burden of those subjected, but rather as creating different experiences. Due to the different identities, some women are pushed to the margins and experience discrimination, while others may enjoy a few privileges due to their different positions.

Identity formation and gender socialization processes begin at an early stage in life as “parents start to project expectations of gender specific behaviours towards their children” (Chae 2001:56). According to Chae (2001), female identity formation revolves around who she can be in relation to others and more especially around the society’s expectation of a woman. As with most patriarchal societies, women’s expressions of femininity and opportunities are limited to reproductive and domestic activities. Sewpaul (in press) affirms the normalised prescriptive nature of societal standards on how women ought to behave by asserting that “on the basis of biological manifestations, people have attached to them social descriptors and cultural extensions that have come to be widely accepted and naturalised.” As a result, “a woman’s sense of self is contingent upon her successfully resolving issues of connecting with others in ways that satisfy herself as well as those in her communal context” (Chae, 2001:56). Socio-cultural expectations and environmental factors are contributing factors in female identity development, for example, the definition of womanhood. Other factors that influence social identity construction are empowerment, knowledge and self-definition (Cherrera, 2001).

2.7.2 Reproductive justice

Linking intersectionality and contraceptive use lies in the reproductive justice concept. Advocates of this concept recognise that women’s reproductive health is linked to and affected by circumstances in their lives that are shaped “by their socio-economic status, human rights violations, race, sexuality and nationality” (Ritzer 2007:204). Hence, in contraceptive use, intersectionality may refer to interlocking social structures that affect reproductive health choices and other oppressions that restrict women’s abilities to pursue reproductive health strategies.

Ross, Hardee, Mumford and Eid (2006) in an article on understanding reproductive justice, state that women cannot have autonomy over their reproductive health unless these discriminatory conditions created by society are properly addressed. Odum (2004) further suggests that social categories such as gender, race and class have implications on the conceptualisations and definitions of motherhood and therefore it becomes necessary to understand how they interlock to affect reproductive health choices.

Examining the intersections of contraceptive use is of great value as gender inequality is often worse in poor societies, and more particularly for poor women in informal settlements, as is the case in this study. Most of the literature on contraception reviewed in this study, centres around social structures and how these patterned social arrangements have affected reproductive health choices of many women in society.

2.8 The history of contraception in South Africa

According to Maharaj and Rogan (2007) the evolution of reproductive health policy between 1974 and 1994 can be described as a process that, partially as a result of its ideological implications, has both marginalised the participation of communities and limited the scope for contraception use in the post-apartheid era. The South African population was officially classified into four racial groups, that is, Whites, Blacks, Indian and Coloured in terms of the Population Registration Act No 30 of 1950. Before 1994, the four groups were geographically separated according to racial lines in terms of the Group Areas Act No 41 of 1950. Burghard (2004) explains how the National Party institutionalised discrimination through allocating basic services according to membership to one of these groups. Separate development that favoured Whites over the other racial groups meant very limited access to basic services such as education, health and employment opportunities.

Chimere-Dan (1993) notes that historically, family planning services in South Africa have been offered by private agencies, particularly, the Family Planning Association of South Africa, subsidised by the Department of Health. The funding was however very limited and contraception was not very effective, as Moultrie and Timaeus (2003) state that during the 1950s, fertility was at an average of 6-7 children per woman amongst Africans. Swartz (2000) elaborates on the growing fear of African overpopulation by pointing out that as early as the 1960s, there was a nationwide fear from the apartheid government that rapid population growth would undermine South African prosperity and development. There were also concerns that the fast growing African population would engulf the much smaller number of whites. As a result, by 1963, there was substantial government funding for private and public family planning.

In 1974, the National Family Planning Programme was established in South Africa. According to Kaufman (2000) this came after the 1974 World Population Conference which attempted to find ways of curbing population growth worldwide as there were growing fears of future inadequate resources due to rapid overpopulation in most of the nations. Cooper,

Morrone, Orner, Moodly, Harris, Cullingworth and Hoffman (2004) argue that although South Africa was not a part of the conference, like the rest of the world, it caught the fear of inadequate resources due to population growth and established the National Family Planning Programme in 1974, with the goal of integrating family planning into health services. Also at the time, there continued to be calls from academics within the ruling party to curb population growth and there were generalised White concerns about the African population growth. Coupled with the growing international support for the family planning movement, the South African government felt encouraged to launch its National Family Planning Programme in 1974 (Moultrie, 2001). Mostert (cited in Moultrie 2001:19) further argued that, “while the public face of the campaign might have suggested that the programme was demand led, the National Family Planning Programme was most definitely not simply a response to that demand.” Government officials continued to defend the decision to introduce the programme by highlighting that the goal was to make contraception available to all South African women, driven by a growing nationwide demand for contraception and was not aimed at curbing the population of any racial group.

The National Family Planning Programme of 1974 was viewed with a lot of suspicion from the Black political leaders who believed it was meant to control the fertility of the Black population whilst increasing that of the white South Africans (Wolf, 2005). There were however links between the family planning programme and the white fears of the growing black population. Moultrie (2001: 22) also notes that the new family planning programme which was based on fertility reduction through the provision of family planning services was a way of “resolving the incompatibility between apartheid policies and the ability of modernisation to deliver rapid fertility decline among Africans.” Kaufman (2000) however argues that the government did not implement the programme on racial basis but services were free to any woman who sought them. There was a growing need amongst South African women for contraception. However, racial residential segregation was a major determining factor in the type of contraceptive services. Black women got an inferior quality of family planning services and largely used the injectable contraceptive, oral pills and IUDs, with a larger proportion of the Black users relying on the Depo Provera (Kaufman, 1997; Burgard 2004).

The programme had expanded swiftly across the country after its official approbation in 1974. In urban areas, the drive mainly targeted ‘urbanised Blacks’ living in White areas, as white women had long enjoyed the privileges of contraception (Chimere-Dan, 1993). By

1977, there were more than 2 700 clinics in the white areas where modern contraceptives were available, and these clinics were developed to extend and promote family planning services to black women living the urban areas (Wolf, 2005). An estimated 250 000 black women were visiting these clinics every month (Mostert, 1978). However, due to the separate development policy, the expansion of contraceptive services was mainly experienced in the White areas. According to Kaufman (1997), control over health services including family planning was part of the plan for the homelands and some of these homelands were granted self-governing rights within their borders. To avoid stepping into the political turf of the homelands, the 1974 programme was never fully implemented in the homelands by the government. To address the demand for family planning, mobile clinics were introduced in these areas and sometimes clinics were organised around areas frequented by Black women, such as shops (Kaufman, 1997). The rapid expansion of family planning clinics in modern areas previously referred to as White areas, still accounts for present day differences in contraceptive prevalence between the urban and rural areas (Mostert, Hofmeyr, Oosthuizen and van Zyl, 1998).

Critics of the 1974 Family Planning Programme highlight that although there were notable successes in terms of contraceptive uptake even amongst the Black women, the programme failed to recognise the link between reproductive health and socio-economic status of the user, and in this case, the harsh and discriminatory conditions that Black women were living under (Burgard, 2004). Kaufman (1997:4), comments that there were three notable tensions over reproductive controls: “the evolution of national politics of population; the transformation of gender relations within a racially discriminatory society; and the proscriptions of everyday life for black women.” Also, research has shown that the intensity of the programme did not immediately translate into a rapid decline in the levels of African fertility, nor did it have a visible effect on women’s fertility intentions. According to Moultrie (2001) the conditions of African women’s lives under apartheid created no desire among African women to limit their fertility. As a result, the family planning programme did not offer any social or political stability as anticipated by the government and population in the homelands did not decrease in line with the larger socio-political context of racial domination (Chimere-Dan, 1993; Kaufman, 1997). While women did adopt modern methods of contraception, this was in an effort to delay the timing of subsequent births as an economic and social survival strategy.

The provision of family planning had very little regard for people's choice and as a result, the injectable contraception was the most common form of birth control, often administered without the knowledge of clients (Kaufman, 2000; Moultrie, 2001). The long term side effects of the injectable contraceptives were unknown to a majority of the users, but its imposition on Black women simply served the government's aims of controlling the fertility rates, especially amongst the Africans, where the fertility rates had remained significantly high. Black women were not seen as capable of making their own decisions with regard to reproductive health, and services were definitely not intended to empower women to make favourable reproductive health choices, but were rather delivered as a means of control. Also, taking into consideration the limitations to access of contraceptives faced by most Black women, the women also had very little choice but to opt for the contraceptive injection a longer lasting method. As a result, family planning provision came with a lot of human rights violations as nurses were even permitted to deliver services without any authorisations from a physician (Kaufman, 1997).

Although the programme was riddled by suspicion and faced resistance especially from the Black South Africans, it was relatively successful in enabling the decline in fertility by increasing family planning services and contraceptive use amongst women in general. By 1976 contraceptive prevalence in South Africa was higher than that of any other country in Sub-Saharan Africa (Burgard, 2004). According to Swartz (1998), by 1983 over half the eligible women in the country were using contraception.

In 1984 the National Party introduced the Population Development Programme. Similar to the previous 1974 contraception policy, the 1984 Population Development Programme aimed clearly at reducing the national population growth rate due to fears that the country's resources would not sustain the prevailing high rate of population growth (Chimere- Dan, 2003). The Population Development Programme however also tried to integrate other factors that have an impact on fertility such as, primary health care, education, and housing. However, very little was done to address women's empowerment among the African females (Swartz 1998).

Contraceptive provision continued to have racial undertones, where the long lasting injectable contraception was promoted amongst the non-Whites and the pill, a less severe form of contraception was encouraged amongst whites (Cooper, Meyer, Bracken, Zweigenthal, 2004). According to Swartz (1998) the programme fell short of its original

objectives by continually neglecting other primary health care related issues and only focusing on establishing as many contraceptive clinics as possible. By 1994, there were over 65 000 contraceptive points in the country. Cooper et al (2004) notes that, “the extensive availability of contraceptive services was in contrast with all other primary level health services including all other reproductive health services.” Maternal health was poorly serviced, characterised by understaffing, overcrowding and remained inaccessible to most women. Other issues such as cervical screening for non-Whites, termination of pregnancy, HIV/AIDS and gender based violence were still ignored by the Population Development Programme.

The Population Development Programme was a relatively successful programme as family planning and contraceptive services became popular during the decade that it was in effect, despite its political agenda. Swartz (1998) suggests that African women adopted contraception due to the unfavourable social, cultural and political circumstances that they lived in. The total fertility rate per woman reduced significantly between 1986 and 1990 from 4,6 to 4,1 respectively (Chimere-Dan 2003). According to Klugman (1990), while apartheid family planning and contraception policies can still be credited for the high use of contraception in present day South Africa, they set a wrong precedent for ‘client-provider’ choice as most health providers still wield enormous influence over the choice of contraceptive method used by most women in public health care facilities.

Since 1994 the South African government has set out to thoroughly break down the apartheid system and to build a democratic society based on the principles of fairness, non-racialism and non-sexism (Bafana, 2011). In 1994 the primary health care approach was adopted by the Department of Health as a more holistic approach to health care. According to Cooper et al (2004), the approach emphasised health as a human right, impartiality in resource distribution, expanded access, and decentralised services aimed at promoting local health needs while promoting preventative and promotive health care. Also, two significant economic and redistribution policies were adopted by the government as part of correcting the structural inequalities fostered by the previous government and these have had a great effect on efforts to reconstruct the distribution of income, resources and economic opportunities. These are the GEAR and the RDP policies.

The GEAR strategy was a macro economic strategy adopted by the Department of Finance in June 1996 and its broad aims were strengthening economic development, broadening of

employment and redistribution of income and socio-economic opportunities in favour of the poor (Adebajo, Adedeji and Landsburg, 2007). The 1994 Reconstruction and Development Programme was the basic social development policy. It was people centred in nature and was meant to address needs such as housing, land, health, education and other related social services. However, Adebajo, Adedeji and Landsburg (2007:53) highlight the conflicting nature of the two policies in that GEAR was more economist in nature and superseded the RDP. GEAR was all about liberalisation and marketization of the economy, before human centred development. As a result, a vast majority of the population has remained trapped in poverty. Sewpaul and Holscher (2004) elucidate on this further by pointing out that “although South Africa’s policies contain a political rhetoric of reflecting correct values of justice, equality and human centred development, its market related discourses have become dominant in the practical spheres of life.”

Although the South African government has taken great strides in providing basic services to a large number of previously disadvantaged areas, arguably better than any other post-colonial government in Africa, the majority of the black population still lives in inequality and deprivation (Harber, 2011). At the domestic level, marketisation and globalisation have meant reduced state intervention, reduced subsidisation and increased privatisation (Adebajo, Adedeji and Landsburg, 2007:53). Rather than address the past inequalities and to deliver the promises of restructuring the South African economy, strategies adopted by the government have heightened poverty and marginalisation (Sewpaul and Holscher, 2004). The fanatical concern with growth economics at the expense of a more people centred development strategy has borne a message that people are irrelevant (Adebajo, Adedeji and Landsburg, 2007). As a consequence, the skewed distribution of resources along racial lines that was synonymous with the apartheid government and hampered the successes of family planning programmes has been perpetuated into the post-Apartheid era. The link between social structures and reproductive health issues cannot be separated and thus, the successes of the current family planning programme remain relative.

2.9 Family planning in South Africa in the context of the Millennium Development Goals

To further achieve the RDP objectives, in 2000, the South African government pledged to promote equality and eradicate poverty through the Millennium Development Goals (MDGs). According to the UNDP website, the Millennium Development Goals are a set of eight goals

designed to free people from extreme poverty and multiple deprivations. These goals were adopted by 189 nation leaders as part of the Millennium Declaration at the 2000 United Nations Millennium Summit, in an effort to help the international community end poverty, hunger, and health and gender inequality by the year 2015. At this summit, world leaders from both poor and rich countries committed themselves to help eradicate extreme poverty. Poorer countries vowed to improve policies and governance and increase their responsibility to their own citizens and the wealthy countries pledged to deliver the means. (United Nations Report on Sustainable Development, Mozambique 2008).

All the goals are interlinked and failure in achieving any one of the goals adversely affects efforts to achieve others. However, family planning has been recognised as the most crucial in achieving the MDGs as rapid population growth continues to pose a major challenge in achieving any of the goals by 2015 in most African countries (USAID June 2009). As a result, slowing population growth is a major focus in development efforts in support of the eight goals. Cates and Burris (2010) states that women's access to family planning and contraceptive services plays an essential and undeniable role in meeting each of the MDGs as it is one of the most cost efficient development investment. In 2007, a new MDG target, 5b, was added and it called for the provision of universal access to reproductive health services and included the 'contraceptive prevalence rate and unmet need for family planning as key indicators for meeting this target' (USAID June 2009). According to the World Health Report: Making Pregnancy Safer (2007), improving maternal health, reducing child mortality and eradicating extreme poverty requires that women have access to safe and effective methods of fertility control.

As part of South Africa's efforts to redress the disparities of the apartheid government in the health sector, the government has aimed to reduce inequity in health and health services by reorienting services towards primary health care. In reproductive health care, user fees were removed for maternal and child primary health-care services, abortion was legalised, and more than 1300 clinics were built (Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes, Flisher, Mayosi, Tollman, Churchyard and Coovadia, 2009). More initiatives aimed at addressing the socio economic determinants of health have included improved pensions, a growing number of social grants, and a social expenditure programme to build low income houses, and provide clean water, sanitation, and electricity to the majority of the population (Chopra et al. 2009). However, development has been slow and uneven, and macro structural determinants of poverty such as inequality, class and gender are still hampering the delivery

and accessibility of these health services in present day South Africa. As discussed earlier on, the country's major economic policies have not been supportive of people centred development and according to Adebajo, Adedeji and Landsburg (2007:56), "it is doubtful that South Africa will meet all the 18 MDG targets, unless of course, it dumps GEAR and its neo-classical economic framework."

Another area of focus of the MDGs is to combat HIV and other related diseases and this goal is also closely related to the provision of family planning services and modern contraceptive methods. According to Cates and Burris (2010), contraception is the best HIV prevention method as well as it limits the number of unwanted pregnancies, therefore reducing the risk of transmitting the virus. Cates and Burris (2010) further states that preventing unwanted pregnancies amongst HIV positive women is three times more effective as a prevention strategy than ARV treatment. As a result of the focus on reproductive health as a way of achieving the Millennium Development Goals, family planning needs in South Africa have been mostly addressed in the context of HIV/AIDS and child mortality. South Africa has partnered with international organisations such as USAID and the UN in implementing effective family planning programmes (Williamson et al. 2009). According to the USAID South Africa update report in 2010, USAID in partnership with the National Department of Health currently supports activities in five provinces and eight districts to improve family planning and reproductive health in public health care facilities.

According to Sewankambo and Katamba (2009) none of the MGDs seem likely to be achieved in Sub Saharan Africa by 2015 despite improvement in supportive policies and the availability of cost effective and feasible interventions. The major reason found is the failure by most African governments to give sufficient consideration to gender issues that have been found to be intricately linked to maternal and child health and other communicable and non-communicable diseases that still burden the region.

2.8 Empowerment and reproductive health decision making

Although the definition of women empowerment goes across a broad spectrum of issues related to gender, more often such issues encompass "options, choice, control and power" and usually relate to a woman's ability to make life choices that affect her well-being (Schuler and Hashemi 1994:5). Women's empowerment has therefore been described as a multifaceted and broad term with many inferences, influenced both by women's personal attributes and by the cultural norms of different groups, making it relative and context

specific. The concept of women empowerment is defined by Malhotra, Schuler and Boender (2002:27) as referring to “decisions that influence a person’s life trajectory and subsequent ability to exercise autonomy and make choices”. Examples of such choices cited by the authors include marriage, education, employment and child bearing. While empowerment borders around the process of resisting control over one’s life, autonomy is the ability to do certain things without any hindrance (Dixon-Mueller, 1998), and in linking the two concepts Basu and Koolwal (2005:16), suggest that “an empowered woman is presumably an autonomous woman”.

Empowerment can be understood at many levels; most research done on gender issues identifies household and interfamilial relations as the central points to women’s empowerment and disempowerment (Bogale, Wonderfrash, Tilahum and Girma, 2011). For the purposes of this study, only literature focusing mostly on ‘household level’ was examined. Household level empowerment includes the following aspects:

- i) Household economic empowerment: women’s control over the income, relative contribution to family support, access to and control of family resources
- ii) Household familial/interpersonal empowerment: participation in domestic decision making, control over sexual relations, ability to make child bearing decisions, use of contraception, control over spouse selection and marriage, freedom from domestic violence.

In the family planning context, the concept of women's empowerment comprises a range of elements that include, the women’s ability to discuss freely about their family planning needs with their partners, access to modern contraceptive methods, ability to make child-bearing decisions and, control over sexual relations (Malhotra, Schuler and Boender, 2002; Bogale et al. 2011). Such ability in many contexts would mean freedom from spouse abuse, as fear of domestic and partner violence have been identified as one of the many barriers to effective contraception use (Williams, Larsen and McCloskey, 2008). Due to the patriarchal nature of some societies and the uneven balance of power in most sexual relationships, taking control of one’s reproductive health through the use of modern contraceptive methods may be seen as challenging the authority of the male partner and in other cases may lead to suspicions of infidelity (Do and Kurimoto 2012).

Studies done in developing countries on empowerment and reproductive health decision making have produced varying results. Do and Kurimoto (2012) investigated women's empowerment and choice of contraceptive methods in selected African countries. Although the results varied across different countries, on the whole, strong associations between contraceptive use and dimensions of women's economic empowerment were found. A similar study was conducted in rural Bangladesh on women's empowerment and contraceptive use; household level empowerment was found to be positively associated with the use of contraception. Empowerment was measured on the woman's physical mobility, economic security and ability to make household economic purchases on her own. A positive effect was found on women who fell under the empowered definition in the study, when compared to their less empowered counterparts (Schuler and Hashemi 1994). A 2010 USAID research paper in SubSaharan Africa explored whether women's empowerment had an effect on the ideal number of children. In the study, empowerment was measured by participation in household decision making and the women's attitude towards wife beating and refusal to have sex with a partner. Contrary to the Bangladesh study, the results indicated that the ideal number of children and the use of contraception was most likely to be determined by social norms and practices that supported high fertility more than the woman's empowerment. Also greater household decision making was found not to be consistently associated with a lesser ideal number of children (Upadhyay and Karasek 2010).

The subject of contraception is universal knowledge thus making it a norm in most societies. Mahotra, Schuler and Boender (2002:20) explain this further by suggesting that because of individual-community intersectionality, empowerment should be measured as a function of the distance between the individual's behaviour and the community norm. Several authors argue that women's empowerment in relation to reproductive health decisions requires systemic transformation in not just any institution, but fundamentally in those supporting patriarchal structures (Malhotra, Schuler and Boender, 2002). The next section of the review focuses specifically on African women and their levels of autonomy in the use of modern contraceptives.

2.11 African women's autonomy and contraceptive behaviour

In most developing nations, decisions to practice contraception are hugely influenced by culture and religious traditions (Campbell, Sahin-Hodoglugil and Potts, 2006). Studies done in most African countries show that most African women are still not free to choose or use

the available different types of contraception methods. Du Guerry and Sperberg (1993:37) in a study on the interrelationship between gender relations and the HIV/AIDS pandemic, suggest that men are involved in reproductive decision making and, in societies characterised by an unequal balance of power, they may exert considerable influence over their partners' sexuality and reproductive health decisions. The study concluded that men frequently dominate in decisions about family size, whether to use contraception, and the type of family planning method used. Hogan, Berhanu and Hailemariam (2008) studied factors affecting women's contraceptive behaviour in Ethiopia, and conclusions were made that household organisation and women's status have an impact on the use of contraceptives and basic contraceptive knowledge.

Ndwamato (2009) investigated beliefs and practises of women using contraceptives in a Tshivenda speaking community in South Africa. This qualitative study included women from the local churches, traditional healers and care workers. Amongst some of the reasons cited for non-use was strong spousal disapproval, with some women reporting that they had to covertly use contraceptives to control and space child bearing as their husbands still wanted large families, a tradition still popular in some Tshivenda speaking communities. However a study done in South Africa in KwaZulu Natal by Maharaj (2001), used men as primary respondents and had a different conclusion. Unlike the other mentioned studies, the use of men as respondents could have consequently led to the divergent conclusion. The study was on male attitudes to family planning in the era of the HIV/AIDS pandemic, and the focus was on how their attitudes might have an impact on fertility decisions and family planning. The study was conducted in an urban and a rural setting, both relatively impoverished areas. There was found to be a general strong approval of the use of contraception as a method of fertility regulation, and the costs associated with raising large families were cited as reasons behind motivation for family planning.

Some studies have suggested that the type of contraceptive method used by a woman can also be a reflection of the amount of autonomy she has over her reproductive health. In a 2008 report by the Southern African Regional Poverty Network on South African post-apartheid contraceptive use and fertility trends, 'the high use of contraceptive injection was taken as an indicator that many women were still not free to discuss reproductive health matters with their husbands or partners, further suggesting that the reproductive rights of many of South African women were still in the hands of men. However a similar but different opinion is offered by Dr Northup in an article by Amanda Whitehouse in the August 2011 Shape

Magazine, when she suggests that inasmuch as choice of method may be affected by the degree of partner involvement, women may opt for a particular method because they view it as being relatively easy to follow, therefore suggesting a certain level of autonomy in contraceptive use and choice. The article further proposes that most women who opt for the pill do so as other forms of contraception require them to acknowledge and interact with their fertility as well as involving their partners. The author explains that “women still don’t have conscious dominion over their fertility, don’t appreciate their fertility cycles and aren’t in partnerships that respect these cycles either” (Amanda Whitehouse Shape Magazine, August 2011:53).

Due to the patriarchal nature of African cultures, most decisions affecting females and their reproductive health are in the hands of males, leading to some women covertly using contraception without the knowledge of their spouses. Biddlecom and Fapohunda (1998) investigated the prevalence, motivations and consequences of covert contraceptive use in Zambia, amongst married women and their husbands. The study found that covert use is usually prevalent in instances where contraceptive prevalence is low. The study highlighted the discrepancy between the contraceptive needs and intentions between husbands and wives. A similar study in Ethiopia by Tensou, Hailemen and Reniers (2002) came to similar conclusions as it was found that in patriarchal societies decisions related to reproductive health were made by men and women had opted to covert use of contraceptives. Of the 47% of married women in the study who admitted to using contraceptives, only 8,7% admitted to using contraceptives with the complete or partial knowledge of their partners.

Studies done in parts of South Africa and other parts of Africa reveal that the violation of women’s sexual and reproductive rights have not only been violated by men that they live with, but in some instances, also by health care service providers. In 2008, several women tried to sue the government for violating their rights after it had emerged that some women had been sterilized without their consent. According to a study on the same issue by Mallet and Kalambi (2008), the 13 recorded cases of these women only represent a small fraction of women who had faced similar degradation in the hands of health providers. Similar incidences have also been reported in South Africa over the years, according to an IRIN news article dated 30 August 2010, which highlighted that several women were coming forward with stories of forced sterilisation after testing HIV positive. One of the women interviewed for the article informed that she was made to sign a form she had not read just as she was about to give birth, only to discover four years later that she had been sterilised. Most women

never knew that they have been sterilised until they tried conceiving again. Cases of coerced sterilisation have been mostly reported in parts of Southern Africa (Jalubana, 2009). It is primarily poor Black women who are subject to enforced sterilisation, again highlighting the intersection between race, class and gender and, reproductive rights violations.

A study by McDevitt, Adlakha, Fowler, and Harries-Bourne (1996) focused on examining the attitudes of health care policy makers and service providers towards reproductive decision making among HIV infected service users. Despite many studies showing that HIV positive women still desire to have children, the results from this study showed that little attention was being given to their family planning intentions and their reproductive health choices. The researchers further state the crucial role that health care providers play in determining access to reproductive health services when working with HIV infected women. They recommend further research on the issue and a clear health policy that will clearly recognise reproductive choice for HIV infected individuals.

2.12 Male knowledge and attitude towards contraceptive use and family planning

Closely linked to the autonomy of women with regard to issues relating to their reproductive health, are male attitudes towards contraceptive use and family planning. Due to the patrilineal nature of most African societies, studies done on family planning continue to show that men dominate decisions on family size (Duze and Mohammed, 2006). In a study conducted in Northern Nigeria by Duze and Mohammed (2006), on male knowledge and attitude towards contraception, knowledge was found to be relatively high amongst the respondents yet inconsistencies were found in relation to family size. The respondents in this study were willing to use contraception to space births more than to control the number of children. Ezeh (1997) suggests that in many instances where a large number of children is desirable due to societal norms, the men are usually not bothered by the child bearing implications or the reproductive well-being of their partners, as the physiological aspects of child bearing and the rearing is always the woman's responsibility.

Some studies in this area have suggested that male support of family planning may increase the initial and continued use of contraception (Du Gerry and Spoberg, 1993). Onwuzurike and Uzochukwu (2001) investigated knowledge, attitudes and practise of family planning amongst women in a high density low income urban area in Nigeria. It was found that common reason for non-use by most women was rejection of contraceptive methods by the husband. Although women were found to be educated, the socio cultural influence of men on

their wives was found to be a major stumbling block to the use of modern family planning methods. The study concluded that there was still a greater need to educate and encourage male involvement in family planning programmes.

Research around male contraceptive knowledge suggests that an average sexually active male knows of at least one modern contraceptive method, but also that there are several other societal factors that hinder approval and use (McGinn, Bamba, and Balma, 1989). A study conducted in 21 Sub Saharan African countries, examined whether the discussion of family planning between couples improved male attitude towards contraceptive use. The study found that partner discussion led to an increase in contraceptive knowledge, which did not necessarily translate to contraceptive approval and use (DeRose, Dodoo, Ezech and Owuor, (2004). The findings are similar to those of a study by Duze and Mohammed (2006), which suggest that the level of education of the male partner had a direct effect on contraceptive use, more than the effect of contraceptive knowledge. McGinn, Bamba and Balma (1989) conducted a study in Burkina Faso on male contraceptive knowledge and attitude. They found that almost all the men in the study knew of a contraceptive method and that most of those that did not approve of contraceptive use cited religious reasons, ill-informed health risks and fear of infidelity. It is interesting that level of education - across all studies it seems- emerges as a major factor amongst both men and women for openness to contraceptive use. In terms of the MDGs we cannot have effective and increased uptake of contraceptive use without greater access to education for women and men, highlighting the inter-relatedness across the MDGs.

2.13 Religion, sexuality and contraception

For the purposes of this study, it is important to explore the various ways in which sexual meanings are created, changed and modified by society and religion; and how these interpretations and meanings later relate to the use of contraception. Issues on religion and sexuality are still fervently discussed around the world. According to Villanueva (1997), it is difficult to look into sexuality without also focusing on religion as both subjects fall within certain social constructs. Plavet and Molednjick (1999) propose that cultural and religious negative sexual messages collude to make it difficult for women to develop a high perception of their sexuality and as a result, most women are said to experience internal conflict when it come to their sexuality.

There is no exact definition of religion as it is a hugely varied and multifaceted phenomena and the word 'religion' is usually defined from many different angles and disciplines (Roger 1988). According to the Wikipedia online dictionary, religion is a belief system that is entirely based on faith and is usually regarded as a person's relationship to a supernatural power or being. Although most worlds' religions are very different in nature, Roger (1988) suggests that there is some commonality in that all religions are conceptual, performative and social in nature.

Characterised by conservatism, some religious traditions are seen as houses of patriarchy, with powerful pronatalist norms and gender groupings (Ellingson 2002). In a discussion on religion and sexuality, Caplin (1987:106) suggests that "the depiction of an Abrahamic god as essentially male is a reflection of the realities of cultures that had long been patriarchal." As noted by some studies, specific assumptions on human sexuality made by most religions put the burden of sexual morality on the woman. Most faiths prescribe a strict adherence to a moral code and sexuality, often encouraging abstinence for the unmarried and unhindered procreation for the married.

Like religion, sexuality is a broad subject relating to a number of variables such as gender, class, and power. Sexuality is a central aspect of human existence and is expressed in thoughts, beliefs, practices, roles and relationships. Sexuality is further influenced by the interaction of biological, social, economic, political, cultural and religious factors (World Health Organisation Draft working definition of October 2002)

The regulation of human sexuality through religion is "an institutional and universal way through which religious groups demonstrate power and exercise social control over their members" (Ajo, 2005:4). In explaining what he describes as the powerful link between religion and sexuality, Ellingson (2002:2) states that, "sexuality occupies the attention of many religions because it is a powerful way to organise human beings. Thus many religions attempt to tame sexuality, to force it to conform to the boundaries that have been established to contain it. Sexuality then is a central element in the construction of religious meaning."

While individual choices are not totally disregarded, the liberty to choose is often weakened by the scriptural instructions on sexuality. Those who confirm themselves as members of religious groups are assumed to have dedicated their whole being including their sexuality, to be inclined to the teachings and norms of the groups (Ajo, 2005). Religious leaders sometimes back their anti-birth control stance by suggesting that it undermines the AIDS

agenda as young people seem to be concerned about pregnancy more than HIV and as a result, some religious leaders are viewed as counter reproductive to public health.

A research conducted by Keele, Forste and Flake (2005) on the acceptance of contraception in the church found that 80 percent of the religious leaders approved the use of contraceptives. Sometimes, the subject is simply avoided in the church except in communities hugely afflicted by the AIDS pandemic. For the purposes of the study, the literature review on religion will focus on Christianity and Islam, the two most popular religions in the African content (Haynes, 1995).

2.13.1 Christianity and contraception

Christianity, as a religion, has presented many differing views on contraception amongst the different denominations. The Roman Catholic Church has been known for its opposition of artificial contraception, its views on sex as a unitive and procreative process and promoting natural contraception, such as the rhythm method (Farell, 2011). As a result of similar Christian views, studies conducted in Africa show that congregational leaders yield a certain amount of influence in contraceptive use and are sometimes described as key impediments. In a 2005 study in rural Malawi, congregational leaders were found to be more significant than denominational laws in the use of contraceptives (Farell, 2011). The same study suggests that women in Africa do not necessarily look to the church for guidance in family planning as it was found that Catholic women were most likely to use contraception due to their relatively higher level of education. The majority of religious leaders were also found to not speak frequently about family planning, therefore neither endorsing it nor offering advice on birth spacing to their congregates. The study concluded that views of most religious leaders were to a greater extent shaped by the community where they come from rather than by a centralised religious edict.

A similar case study in Zimbabwe that focused on the Apostolic Sect investigated how religion influenced health services. Religious leaders were found to have a considerable amount of detrimental influence over their female church members (Mapuranga, 2011). The apostolic sect is one of the largest Christian groups in Zimbabwe with a clearly anti contraception position for all its members (Kambarami, 2006). Results from this study further showed that a lot of health misconceptions were viewed from a spiritual context and all decisions including those of health were made by the prophet for every member. Noted as well were other factors such as the low education level of the female church members who

usually only go as far as the primary school level and are married by the age of 15, mostly into polygamous relationships.

2.13.2 Islam and contraception

Similar to most religions, the Islamic faith does not approve of premarital sex, and likewise, Islamic jurists who approve of the use of contraception, state that it is only for married couples. Although some Muslim countries have established successful formal birth control for their countries, there are however some extremist Muslim groups who are against the use of contraception, even within the confines of marriage (Boonstra, 2001). Not only do differences exist between the different countries, but also between the different societies as well (Holt, Lambton and Lewis, 2004). Studies of contraceptive use amongst Muslim societies, found birth control very low in rural agrarian societies, where levels of education for females remain very low and men still have disproportionate decision making power. As a result, contraceptive use remains high even in some Muslim countries that have established formal birth control policies (Boonstra, 2001). What emerges from the different studies is that the education of women and greater gender equality promote the use of modern contraception. Women's greater education and equality promotes openness to new health encounters and experiences.

In explaining rural-urban differences, Holt, Lambton and Lewis (2004) argue that the persistence of high birth rates in some Muslim societies is not due to religious prohibitions but rather to a tradition that has not encouraged its use. The author further asserts that in rural societies, children are inexpensive to rear and become economically productive, whereas in the cities, status is determined by education, income and one's ability to adequately provide for the children.

Studies done in some West African Islamic societies show that religious leaders are very vocal in terms of their position on contraception. Many conservative Islamic leaders have campaigned against condoms and other forms of contraception as promoting promiscuity and being against God's will of procreation. One such Islamic movement in Africa has been the Izala, an Islamic reform movement born in Nigeria (Best, 1999). According to Masquelier (2009:105), "...the Izala preachers loudly advertise their anti-contraception stance in their sermons insisting that birth control goes against God's wishes and is altogether un-Islamic." An earlier East African study in 2003 had shown that amongst several factors found to

influence contraceptive use in rural Tanzania, were the strong Muslim beliefs in that community (Keele, Forste and Flake, 2005).

Religion has a significant impact on the use of contraception as evidenced by the Niger in West Africa, a strong Muslim area that has the highest fertility rates in the world, with an average of eight children per woman (Holt, Lambton and Lewis, 2004). Public health officials from this area reported that they found it very difficult to encourage family planning and often “...euphemistically speak of birth spacing more than birth control to emphasize the benefits of this strategy and to avoid bruising conservative sensibilities” (Masquelier, 2009:106). Religion thus affects contraceptive use at many different levels as in some communities the decision to use contraception or not appears to be a personal choice whilst in others it appears to be dictated by religious edicts.

2.13.3 African traditional religion and contraception

There is very little that has been written on Traditional African religion and its views on contraception. While it may be relatively easy to define and identify some the traditional methods of contraception, the views of the religion directly referring to contraception are limited, owing to the complex and diverse nature of the faith. Often referred to as ‘religions’, the African Traditional Religion has come in many different forms due to the many different cultures that exist throughout the continent (Awolalu, 1972). Also, it has been infused and affected by influences of modern religions, leaving its definitions and prescriptions in the hands of those that practise it. African Traditional Religious practices often encompass multiple beliefs (Farrell, 2011), making it difficult to comprehend and give one voice. Awolalu (1972) explains that there are however many similarities in these African religions, that give it a qualification of single religion, such as the belief in the existence of a God, the concept of divinities and also the ancestral cult. Unlike other religions, it is not written on paper but based mainly on oral transmission, inscribed on peoples’ minds and hearts and is commemorated through rituals and religious functions. “The declared adherents of traditional religion are very conservative, resisting the influence of modernism, heralded by the colonial era, including the introduction of Islam, Christianity, Western education and improved medical facilities” (Awolalau, 1972:2). Even so, family planning and contraception can vary widely within a religion as discussed earlier on with Christianity and Islam.

2.14 Links between family planning services and fertility

As suggested by most of the theories, reproductive intentions do not always translate to contraceptive use and are influenced by various social, economic and cultural factors. The quality of family planning services provided in a specific environment also has a considerable amount of influence on the use of contraception. When investigating whether the quality of family planning services had an effect on the current contraceptive use by women in Peru, Mensch, Arendis-Kurrenning and Jain (1996) found that after taking into account personal and household characteristics, the quality of services had a significant effect on contraceptive uptake and continuation. Jain (1989) suggested a hypothesis that links the quality of family planning services and fertility. The author's presentation, shown in Figure 1 (page 42), shows the six elements of quality and how they affect fertility.

The ***choice of contraceptive methods*** refers to “the number of methods offered on a regular basis and their inherent variability that adequately accommodates all subgroups within a community” (Jain, 1989:2). A look at contraceptive choice through the equity lens and highlights that there is still a large disparity between the poor and the rich in terms of contraceptive use, a consequence of the unavailability of choice. The poor, especially those in informal settlements and mostly rural areas still do not have the access to necessary life-saving and healthy interventions compared to the wealthy.

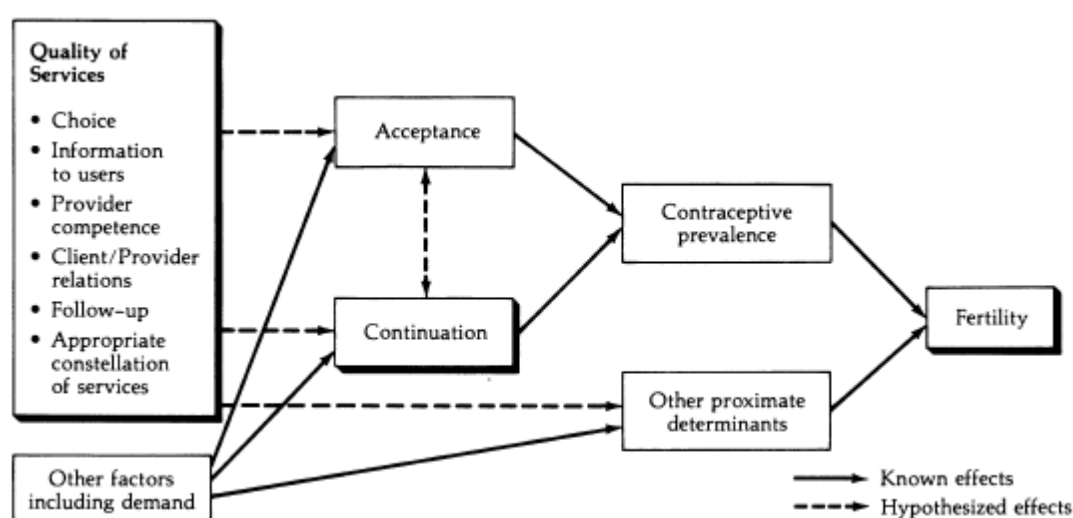
Information given to users refers to knowledge given to clients about contraindications, risks and advantages of certain methods; information on how to use a method, the side effects and ways of managing the side effects; and information on what service users can expect from service providers regarding support, advice and supply. Many studies have reported higher rates of discontinuation amongst those given less information about side effects, especially on the contraceptive injection (Jain, 1989). The type information given to users also relates to ***provider competence***, which refers to the skills and expertise of service providers such as nurses, doctors and other health care professionals. Provider competence in the South African context is discussed later on in this chapter as barrier to effective contraceptive use.

Client-provider relations refer to positive feedback from service users, in particular with the health personnel with whom they relate with (Jain, 1989). Wood and Jewkes (2006), affirm this as they found “scolding nurses” to be a major barrier of effective contraceptive use in a study focusing on adolescent girls and contraception in South Africa. The family planning programme's ***follow up*** mechanisms seek to ensure continuity and client satisfaction with

offered services. Finally, the *appropriate constellation* of services, which refers to the grouping of comprehensive reproductive health services, such as maternal and child health facilities, is also important in influencing fertility. In South Africa, the efforts at grouping reproductive health services informs the 1994 Primary Health Care approach, which was adopted by the Department of Health as a more holistic approach to health services and this is discussed in this chapter in the section on MGDs in South Africa (Cooper et al, 2004; National Contraception Policy Guidelines, 2002).

The figure below by Jain (1989) illustrates how elements of family planning supply and quality of the service environment can affect contraceptive use and continuation.

Figure 1



Graphic presentation of the links between quality of family planning services and fertility
 Source (Jain; 1989).

The solid lines illustrate evidence that is adequately held by empirical evidence while the broken lines represent theorised relationships that do not have sufficient empirical evidence (Jain, 1989). Other factors that lead to acceptance and continuation as illustrated in the diagram include availability, proximity and also the cost of contraception. Jain (1989) further suggests that the other proximate determinants are mostly demographic and socio economic factors, such as the fertility intentions of a couple, individual motivation to regulate fertility marital status, level of education, and the woman's age. These approximate determinants are

not usually consistent across countries and studies but they all have an effect on the fertility of a given population (Blanc, Curtis and Croft 1999). The following sections of the literature review focuses on some of the identified determinants, mainly choice and client-provider relations.

2.15 The availability and accessibility of modern contraceptive methods in South Africa.

Whereas some studies conducted show that great improvements have been made in South Africa in terms of the availability of contraceptives, there are some studies that suggest that accessibility is still a challenge in some areas. Restrictions on contraceptive choice constrain the users from acquiring methods that suit their individual needs and this results in lower levels of contraceptive prevalence (Ross et al. 2002). Improving the reproductive health of women requires access to safe and effective contraceptive methods and most developing countries are still behind in this regard (Williamson et al. 2009). Bafana (2011) in a study on factors influencing contraceptive use and unplanned pregnancy in the South African population found that there was high knowledge but a relatively lower use of contraception in some parts of the country. The study concluded that the socio-economic status of women has an effect on the type of contraceptives and the likelihood that they will stay on a contraceptive method. In a survey carried out in 2003 by the Southern African Regional Poverty on Financing of family planning services in Sub Saharan Africa, 93,4% of women and 96,4% of men in South Africa between the ages of 15-49 years knew about different contraceptive methods. However, in the same year the Department of Health Demographic and Health Survey (2003) showed that 65% of all sexually active women use a contraceptive method, clearly showing that contraceptive knowledge has not yet translated to use.

According to the South African Health Policy Plan of 1993, contraceptive use remained relatively low in many cities and inaccessibility or poor quality services were often given as reasons. There was still a need for improved contraceptive accessibility and quality by strategic planning, recognising the marginalised nature of many of the urban poor and the economic constraints under which most of them operated. The quality and availability of family planning services seem to have however changed since then as later studies show an improvement. In a study on South African Women's experiences of contraception and contraceptive services, Gready et al. (2008) found that the quality of contraceptives offered at public health facilities and those offered in the private sector was the same. The public

facilities were however found to be characterised by long waits in queues, provider hostility and limited choice of contraceptives.

2.16 Service provider attitude and knowledge as a barrier to effective contraceptive use

Some studies have suggested that the attitudes and knowledge of reproductive health service providers have an impact on the adherence and proper use of contraceptives. In a study by Campbell et al. (2006) on improving adherence to family planning guidelines in Kenya, the researchers found that although there were clinical guidelines to service rendering, most health care service providers had never seen or gone through them and that the same service providers had a somewhat limited understanding of all modern contraceptive methods. As a result, service users' choice of contraception heavily depended on the amount of information that the service provider had on the particular product. Similarly, a study on pharmacists' knowledge and perceptions of emergency contraception, pharmacists around Johannesburg showed that most pharmacists erroneously believed that repeated use of the emergency contraception posed health risks. They also had different views on who should and should not be given the emergency contraception pill.

Some research has proven that service providers sometimes deny service users access to a family planning method as a result of their own preconceptions about the method or its delivery system (Campbell, et al. 2006). Service provider attitude was cited as one of the barriers to contraceptive use amongst adolescent girls in South Africa in a study carried out amongst adolescent contraceptive users in Limpopo. According to Wood and Jewkes (2006), there was general consensus amongst the adolescents that, nurses often attempt to stigmatise their sexuality by treating them harshly and often scold them in public and openly show their unwillingness to acknowledge teenage girls as contraceptive users. These attitudes are believed to be undermining the effective use of contraception by young girls. A recent report by News 24 dated 2011-09-13, where Cape Town preteens were given birth control injections as a measure of preventing pregnancy in case of rape, raised a lot of concern from the public on this unethical and uninformed practise by public health care providers, who it seem were oblivious of the possible harmful effects of administering the drug to children who have not reached puberty. Many people responded with outrage at the incident and expressed their disappointment in the public health care system.

According to Gready et al.(2008), apartheid has had a lasting impact on contraceptive services as evidenced by the noticeable difference in services offered by the public sector and

the private sector, with regard to client information, choice of methods, and privacy and respect. Most women going to the public sector clinics for contraceptives report are still being subjected to health worker hostility and some have reported getting sterilisation procedures without their full knowledge. Women who receive an unwelcome reception at any health care facility are most likely to avoid it whenever possible or never to return to the clinic for services. Gready et al (2008) further state that the experiences of South African women on contraception and contraceptive services show that the prime factor that weakens the quality of care of contraceptive services in South Africa is not the lack of resources usually experienced by developing many countries worldwide, but rather the universal and erroneous assumption by health workers that they have the power to make reproductive health decisions on behalf of service users, usually done without providing enough information on contraceptive method choice or an atmosphere in which women will feel empowered to take responsibility of their fertility.

2.17 Conclusion

This chapter examined relevant literature relating to the study of women and contraceptive use. The background of contraceptive services in South Africa provided a historical context of the current provision of reproductive health services. Part of the discussion included ways in which societal structures such as patriarchy, religion, culture, class, gender and other socio economic factors have an impact on the of contraception amongst African women, and how they relate to the study of contraceptive use. The following chapter is on the methodology used to conduct the study.

Chapter 3

Methodology

3.1 Introduction

The chapter describes and justifies the methodology used to gather and analyse data for the research. It begins with a discussion of the data collection techniques, relevant to the guiding theoretical framework. There is a discussion on the qualitative approach as the most suitable method. The chapter also offers a detailed account of the data gathering process, the data analysis method employed, reliability and validity, the study limitations and also the ethical considerations.

3.2 Research method

Guided by the feminist and critical theory, the study of women and contraceptive use in the Diepsloot community was a case study. I used the qualitative design mainly due to the exploratory nature of the research.

Because contraceptive use is such a multifaceted phenomenon, sometimes open to many subjective interpretations, it was one of the main aims of the study to detail the perspectives of the participants and their first-hand accounts of their experiences, exploring the meanings that they give to their own situations. My inclinations were towards the constructivist view that realities are multiple, subjective and constructed according to one's standpoint – a personal reality that is self-created (Rodwell 1998).

Rodwell (1998:8) emphasises the importance of understanding the “*context bounded nature of reality*” as being crucial in the research process and how assessment and investigation cannot be fully carried out except through field based methods, taking into perspective the local context. Taking into account the notion of multiple realities and the importance of conducting research in a natural setting or context, a case study was then chosen as a more adaptable research method, with an advantage of uncovering the contextual conditions related to contraceptive use, thereby providing a thick detailed description of the experiences of the respondents (Baxter and Jack, 2008).

It was also relatively easy for me as a researcher to do a case study of Diepsloot, due to my previous engagements with the community and the ease with which I already had with access

to the women, who were potential respondents and also to other community structures that I found relevant to the study. I also had the advantage of having worked at the community centre as a social worker for over a year and although the life experiences and social circumstances of the women were not the same as mine, I considered myself to be an ‘outsider within’; after all, I spent a great part of my day in this community. However, feminist theoretical proposition that women are in a better position to do research on other women due to their shared experiences as females was particularly difficult to comprehend at first. I was overwhelmed by the prospect of being a young woman; interviewing mostly older women, on sensitive matters which involved the exploration of their sexual lives, a process that I found initially to be very uncomfortable, but after building a connection with the women on what the research process entailed, the asking and answering of questions easily became an informal process and the interviews took a more conversational tone.

Marshall (2006) explains how the qualitative research design is essential in studies that seek to understand a phenomenon as experienced by a specific group of people as it goes beyond simply understanding the surface meanings attached to particular actions but further exposes the researcher to an understanding of the meanings that everyday activities hold for people, thereby gaining a richer detailed understanding of the subject. Also, because gender, a social category closely linked to contraception, is created by culture it became important that the definitions of gender and other categories linked to it be defined and investigated through first hand experiences of the women in the study. As such, qualitative methods such as in-depth interviews allow for exploration of meanings from the point of view of those being investigated.

Qualitative methods which include interviews, focus group discussions and naturalistic observations are methods that recognise the social context, and also enable a thick and rich description of a phenomenon by “encouraging participants to speak freely and understand the investigator’s quest for insight into a phenomenon that the participant has experienced” (Tuli 2010:100). Neumann (2005) further expounds on the naturalistic observation by describing how the qualitative approach seeks to comprehend any phenomenon within its full context by focusing on understanding the people studied in terms of their environment and their perception of their context. Qualitative research thus allows researchers to interact with subjects to obtain data as the aim is to explore “socially meaningful action through the direct detailed observation of people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social worlds” (Neumann, 2005:68).

In qualitative research, meaning is constructed and there are multiple realities. Therefore, the use of qualitative methods such as in-depth interviews was better suited to explore and study meanings, practices, and processes in the women's lives. They give the participants the opportunity to relate their experiences in their own words and also to attach meanings to these experiences within their social context (Villanueva, 1997).

Critical theory assumes that what is known to be reality as we know it is shaped by social, cultural, political and gender based forces that have been refined over time and preserved into social structures (Guba and Lincoln, 1994). Harvey (1990:2) expounds on this when pointing out how a critical perspective then attempts to "dig beneath the surface of historically specific, oppressive social structures". Therefore, to fully understand any social phenomenon requires an investigation that focuses on the historical, social and political context of the issue and how such a background influences our knowledge of reality.

According to Harvey (1990) the aim of critical research is to provide knowledge that engages the prevalent social structures. The most dominant of these structures are class, gender and race. This became very pertinent in the development of the methodology for this study as it sought to capture the unique experiences of disadvantaged women living in a marginalised area. Critical theory places value in how the researched describe their own realities, thus calling for methods that allow for exploration and description (Kincheloe and MacLaren 1994). Knowledge is viewed by critical theorists as a dynamic process, aimed at moving towards an understanding of the world and of the structures that frame our perceptions of that world (Harvey 1990). Critical theory thus suggests a scrutiny of social processes "in order to reveal underlying practices, their historical specificity and structural manifestations" (Harvey 1990:3).

According to Creswell (1994) critical theory further acknowledges the interactive link between the researcher and the environment as a way of gaining in-depth understanding into a particular phenomenon. This 'researcher and the researched' relationship is further elucidated by Haynes (1995:58) when he explains how the feminist model works on the "theoretical proposition that women, due to their personal and social experience as females, are in a better position than men to face and understand the world of women". The basics of feminist theory are those of critical theory, making the feminist paradigm a critical approach, studying the social conditions of women from a socially unjust and patriarchal point of view (Haynes, 1995). The study on women and contraceptive use thus needed to be pay particular

attention to the dynamics of the specific environment, at the same time being inclusive of emotions and experiences as described by the women and also to inform on the existing social practises that make up these experiences.

3.2.1 Advantages and disadvantages of qualitative research relating to this study

Table 2

Advantages	Disadvantages
Focus is usually on a relatively small sample, allowing for an in-depth investigation into a phenomenon. (Niemann, 2005). The method was thus relevant in this study as contraception is a very complex subject and similarly, experiences are as varied.	The sample sizes are generally too small for generalizability of the results (Babbie and Mouton, 2001).
Allows the researcher to view the behaviour of participants within natural settings, giving room for contextual detail in a study (Guba and Lincoln, 1994).	The subjectivity of the process of analysing and interpreting what is observed behaviour can lead to researcher bias. Different researchers may gain different understanding of the same happening(Kawulich, 2005)
Qualitative studies provide multifaceted documented descriptions of how people experience a given research phenomenon as emphasis is on understanding and creating meaning of the phenomenon studied (Tuli, 2010).	Findings only help in explaining a single phenomenon based on a particular social setting and time. Qualitative studies are thus often difficult to replicate and therefore validate (Meyers, 2000)

3.3 Sampling

3.3.1 Definition of the population

The aim of the study was to explore the subject of contraception amongst women living in the Diepsloot area. According to the 2006 South African census, there is an estimated population of between 150 000 and 200 000 people in Diepsloot and efforts to access the actual percentage of women from this number was futile. The sample was drawn from a population of women living in the area for more than two years and focus was on sexually active women

between the ages of 18 and 45. Over the years, Diepsloot has become a place of refuge for people migrating into Johannesburg, from rural areas within the country or from other neighbouring countries, as it is very easy to rent an affordable space and erect a shack upon arrival (Harber, 2011). As such, Diepsloot is a heterogeneous community, with many of its members leading nomadic lifestyles. A significant number of the South African official languages are spoken in Diepsloot but the most commonly spoken and understood are IsiZulu and SeSotho. The number of years that the women have lived in Diepsloot thus became an important defining factor of the study population, as an effort at getting valuable insight on the social context of the community from the participants.

Participants in the study, had to be adult sexually active females, able to understand the aims of the study as explained to them and also to independently consent to participation. The ages of 18 and 45 were chosen as those in this category are more likely to be still in the process of family planning and decision making with regard to the use of contraceptive. Children under 18 were excluded due to the sensitive nature of the issues discussed and the ethical considerations of interviewing children that are more complex than interviewing adults.

Another population group in the study were the traditional healers residing in Diepsloot and church leaders from the various spiritual denominations around Diepsloot. The Diepsloot Traditional Healers Association has 37 registered traditional healers. After consulting with the head of the association for permission to conduct the research, the head informed that all traditional healers approached for the study would participate in their own individual capacity. Based on earlier research findings on the influence of the church on contraception and family planning, there was also initially a plan to involve leaders from the local churches for verification of the information provided by the primary respondents, as would be with the traditional healers. However, none of the study participants interviewed expressed their religious leaders having an influence on their choice of contraception, and hence, this group was left out of the research process.

3.3.2 Sampling technique

The sampling technique used for the study was the non-probability purposive and theoretical sampling methods. Selection was purposive because of the exploratory nature of the subject. There was a specific criterion such as the age, residence in Diepsloot for more than 2 years, sexually active and willing to participate in the study. According to Reid and Smith (1981:173), this type of sampling allows “cases to be included because they are thought to be

typical to what one is interested in studying” and is best used in exploratory studies. The sample was drawn from women that came to the Diepsloot Wings of Life Community Centre whom I had previously worked with or was currently working with. The purpose of the research was clearly stated to them and that it had nothing to do with my social work activities with them. Those who declined due to their relationship with me were not coerced into being a part of the study.

3.3.3 The sample size

Determining the sample size in the study did appear a particularly difficult process considering the demographic characteristics of Diepsloot. It is a relatively small but densely populated area, with its population haphazardly spread across its 13 Extensions. Ideally, the sample would accommodate every ethnic group, every extension and most of the diverse demographics specifics of the community. Even amongst the women who came to the Centre, there were many potential respondents. However, a somewhat large sample which would obviously yield large amounts of data, posed a threat of prohibiting a deep descriptive case analysis that is synonymous with qualitative and ethnographic research (Sandelowski, 2007). Hence, the sample size was theory driven and largely determined by the type of data acquired after a series of interviews with 20 women over a 5 month period. In supporting the relatively small sample sizes associated with qualitative research, Marshall (1996) argues that generalizability is not the common goal of all good research and suggests that a good sample size is one that sufficiently answers all the research questions. Accordingly, at the initial stages of the research, there was no definite sample size; as the study was guided by theoretical sampling, which requires building interpretive theory from emerging data (Marshall, 1996:523).

The sample was made up of 20 women, which was considered most representative of the population and also guided by the non-probability purposive and theoretical sampling methods. This might appear a small number to represent the population described earlier on, but after over 60 interviews with 20 women, the information provided adequately answered the research questions and data saturation was reached. Qualitative research is principally directed towards theory construction with emphasis being placed on seeking in-depth information from the people experiencing the phenomenon under investigation and as such, theoretical data saturation during the study was based on the concept of continued sampling and collections of data until no new theoretical insights emerged (Law, Stewart, Letts,

Pollock, Bosch and Westmoreland, 2001; Bloor and Wood, 2006). Time was also a determining factor in the sample size as the amount of data gathered was to be conveniently handled and analysed within the specified research time period.

Only 2 traditional healers were interviewed for the study. The number was determined by the small fraction of participants who admitted to consulting a traditional healer for contraception. There is a Diepsloot Traditional Healers Association, which I approached at the initial stages of the study. I had to explain to them the nature and aims of the research and also my desire to involve them during the course of my investigations. I was advised by two ladies representing the association that there were many traditional healers in the area, and most of them were ‘unskilled crooks’, unknown to the association. They also made a recommendation to the trusted practitioners that I could approach. I could approach any of the traditional healers. The Association representatives also explained that the traditional healers that I was going to interview were free to respond in their own capacity, and therefore, there was no need to request written permission to conduct the interviews from the Association.

There are several doctors’ surgeries operating privately in Diepsloot and it was very difficult to establish the exact number. These were left out of the study mainly because very few women in the study mentioned occasional consulting the doctor for contraception. Due to the sporadic nature of the cases seeking services with the private medical practitioners, attention was directed towards larger centres providing contraceptive services and these were mainly the clinics and a Marie Stopes centre. There are only two primary health care facilities in Diepsloot, one in Extension 2 and the other in Extension 7. From the clinics, the two Operations Managers were interviewed for the purposes of data triangulation and also to increase the credibility of the research. Permission to do the interviews was requested through an application letter, sent to the Gauteng Department of Health in Midrand, clearly stating the goals of the research project and the involvement of the two clinics (see appendix 1). Consent was granted for the interviews (see appendix 5).

From the Diepsloot Marie Stopes Centre, an application letter was also sent to their head office in Cape Town and permission to interview the Centre manager was also granted (see appendix 2).

3.4 Data collection

For data collection, I conducted multiple individual interviews and a focus group session with some of the women that I had interviewed initially. Although the research method was flexible in nature, a standard interview procedure was developed at the beginning of the research. According to Boyce and Neale (2006), developing an interview protocol ensures uniformity between interviews and increases the reliability of findings. Specific focus around this planning was on the actual preparation on how the interview was to be set up, introducing and concluding the topic of discussion, the method of recording the data and the process of analysing each session at the end of the discussion.

3.4.1 Individual interviews

In-depth interviewing, a qualitative data collection method was chosen as it provides more detailed information on the person's thoughts and perceptions around a subject, therefore giving detailed contextual information (Boyce and Neale 2006). In preparation for the interviews, an interview guide with a set of 9 questions was developed at the beginning of the study (see appendix 3). The questions were drawn from the objectives of the study and designed in line to answer the research questions. These questions were not strictly adhered to; the interview took on a conversational and discursive style allowing the women to speak freely and with ease and comfort.

20 women were interviewed on three occasions and a total of 60 interviews were conducted. The interviewing process began by inviting the respondents in groups of 4 for a briefing session. Four was considered to be a moderate number, leaving the women comfortable enough to ask relevant questions. The sessions were held at the Wings of Life Community Centre, where the aim and objectives of the research were discussed and the participants were given the opportunity to seek clarity on the process. Other issues discussed at this stage included visiting them in their homes and conducting the subsequent interviews in their own spaces. The participants were then requested to sign the consent form and subsequent appointments were then made.

The interviews were all held in the respondent's own homes. Interviewing participants in their own homes was to increase the likelihood of the respondents opening up more and communicating freely as they are likely to feel safe and relaxed in their own spaces. Each interview session lasted between 30 to 45 minutes and a maximum of three individual

interviews were held with each respondent. Most of the interviews were done on weekends as the women informed on being available on Saturdays. Time was however a determining factor on the length of each interview session as weekends was also for performing household chores and socialising for the respondents. Villanueva (1997:28) notes “that in order for knowledge to be non-oppressive, it has to emerge through dialogue rather than one sided questioning”. Interviewing was conducted in the respondents’ spaces in an effort to encourage the participants to feel unrestricted in their environments, often resulting in the occasional interruption to attend to a child or a knock on the door. Using this study’s methodology, the interviews were made to be very conversational and non-hierarchical in nature and the participants were viewed as experts of their situations and co-creators of the data creation process.

To allow for a complete and accurate detail of the information provided by each respondent and also to create a better rapport between the interviewer and interviewee, an audio voice recorder was used in every session to record the interview. The use of a voice recorder allowed me to listen and respond more rapidly by eliminating the difficult process of manually recording lengthy answers. According to Tuli (2010), sometimes respondents may become anxious with the use of a voice recorder. To avert this, the purpose and use of the voice recorder was clearly explained to the respondents and did not appear to present any difficulty or discomfort during the interview process. Apart from voice recording the interviews, brief notes were also taken during the interviews, to aid in recalling the most important questions and areas to further probe on.

The recorded interviews and notes were reviewed at the end of the interview, to identify any major questions that might have been missed during the interview, and these were marked down for further exploration in the subsequent interviews.

Taking of field notes after the interviews was also another method used to complement the data from the interviews. According to Wolfinger (2002:88), field notes are reconstructions of observations, events and conversations that take place on the field. The field notes were useful in the observations and analysis. As the taking of field notes is largely an interpretive process that is determined by knowledge of our surroundings, the notes that I recorded could have been determined by prior knowledge that I had of the place, acquired through my two years of work in the area. The strategy used for taking the field notes was what Wolfinger (2002:89) calls “comprehensive note taking”, the aim of which is to “systematically and

comprehensively describe everything that happened during a particular period of time, e.g., a single trip to the field.” All notes were systematically recorded in a field diary.

Field notes were very useful even in noting informal discussions. For example during one of the briefing sessions, the women began actively discussing various forms of unconventional contraceptive methods amongst themselves, and this not only shed light on the commonality of the topic amongst the women but also helped the researcher shape some of the interview questions from the cues picked up.

3.4.2 Focus groups

Three focus group discussions were done as part of the study’s data collection process. A focus group is defined by Guba and Lincoln (1994) as a group of individuals carefully chosen and gathered by the researcher to discuss and comment from personal experience on the topic of discussion. This method of data gathering relies on the interaction between the group members for data and is useful for ascertaining diversity within a group. Osthus (2011:83) notes that “focus groups give insight into the differences between participants and diversity within the population group”. The focus group discussion was done after the individual interviews and was meant to complement the other data collection methods and also became useful as a validity check.

For the first group session, 8 of the 20 primary respondents were selected by the researcher to partake in this group discussion. To keep the discussion goal directed and also to afford everyone the opportunity to freely express themselves, only 8 participants were chosen. Free interaction was possible as most of the women knew each other, having met at the Centre before. The group was carefully selected to represent the primary respondents. Although each woman’s story had been different and uniquely expressed, similar factors like age, marital status, partner involvement, level of education were taken into account and given consideration when selecting the focus group.

The second group session came at a later stage of the research, during the data analysis. The group served two main purposes at this stage, firstly as a reflective process with the women and also as a way of formally negotiating the results of the analysis. Rodwell (1998:164) advises the enquirer to follow the empowering traditions of both social work and constructivism, by taking steps in aiding the powerless regain a control of their lives, through making sure that all voices have been heard in the way the meaning has been constructed.

The second group session thus allowed me to report back my findings, verify the analysis with the participants and also discuss ways and methods of gaining more control of their lives through making informed and favourable reproductive health choices. Eighteen out of the 20 women were part of the second group.

In order to avoid bias, it became important at a later stage of the research to include the men in the study. During this stage of the data collection process, men were not seen as a symbol of patriarchy, but rather as useful informants in the understanding of the information shared by the women. Due to issues of time, only one group made up of 8 men was interviewed. The main aim of the group was hear their opinions and views on contraception and to understand if their views were in harmony with those expressed by the women.

3.5 Validity and reliability

Reliability in research refers to the extent to which “a questionnaire, test, observation or any measurement procedure produces the same results on repeated trials” (Miller 2003:1). Validity is the extent to which a research instrument measures what it purports to measure. Although validity and reliability have been more aligned to quantitative than qualitative studies, (DeVos 2005), the two terms are still very relevant for use in qualitative studies as well. For effective use in qualitative studies, De Vos (2005) further argues that the concepts of validity and reliability should be redefined for use in the qualitative paradigm and suggests the use of alternative qualitative judging terms proposed by Guba. These are credibility, conformability, dependability and transferability, suggested equivalents of the quantitative reliability and validity terms. To achieve these mentioned equivalents, Guba and Lincoln (1994) suggests the use of verification strategies. Verification strategies employed by other qualitative researchers are “methodological coherence, sampling sufficiency, developing a dynamic relationship between sampling, data collection and analysis, thinking theoretically, and theory development” Guba and Lincoln (1994:87). The most important of these is methodological coherence, which refers to the ensuring a correlation between the research question and the methods applied. The research questions, the methodology including the analysis of the data should all coherently point towards the goals of the research. The methodology employed in this study was aimed at addressing the research questions through thick and detailed descriptions on the life experiences of the women in the study. To ensure correlation, a qualitative research design was adopted, as this was the best of method for answering the research question.

Credibility refers to how consistent the results are with reality, from the perspective of the research participants. Credibility is described as an equivalent of internal validity (Shenton 2003). Some of the methods described in maximising credibility include having a good knowledge of the community before beginning the data collection process (Squares, 2009). Before I began the study, I had been working in the Diepsloot community for over a year as a social worker, working with survivors of gender based violence. My work in this community gave me the basics in terms of understanding the culture and other social dynamics of this community. Data triangulation was also another method employed in this study to increase the credibility of the research as other informants were also interviewed to verify the information.

Transferability or applicability is an equivalent of external validity in quantitative research. It refers to the generalizability of the study, the extent to which the research findings can be applied to other contexts or to the rest of the population. Firstly, the sample size of the study, although fitting the qualitative method, was small for generalizability to the entire population (Babbie and Muoton: 2001). Secondly, the transferability of findings to other contexts outside the study situation in qualitative research was difficult to achieve as the aim of the research was to provide a thick description of a phenomenon within its context (Niemann 2005). According to the qualitative paradigm, there are multiple realities and the research subjects are experts of their own realities, which are created and defined according to context. Hence every study becomes unique and context specific, making generalizability a challenging undertaking to achieve.

Dependability refers to the repeatability of the study, a suggested equivalent of reliability (DeVos 2005). Reliability assumes that if the study is repeated with the same participants, same context and the same methods used, it would yield similar results (Squares, 2009). However, with qualitative research, there are multiple realities presented by the respondents and according to Squares (2004:71) “the changing nature of phenomenon scrutinised by qualitative researchers renders such provisions problematic in their work”. Squares (2009) suggests that in addressing the issue of reliability in qualitative work, a clear description of the research design and implementation, a detailed data gathering process and an insightful evaluation of the entire research process be provided so as to enable the readers of the study to have an complete understanding of the methods and effectiveness. I have done that in this study.

Confirmability refers to the extent to which the results are confirmed or validated by others. Confirmability emphasizes that the results should reflect the experiences and information provided by the respondents and not the inclinations of the researcher. Krefting (1991) identifies data triangulation and spending more time with the respondent as some of the suggested methods of increasing the confirmability of the study. As mentioned earlier on in this chapter, triangulation was one the methods used in verifying the information provided and quality time was spent with the respondents throughout the study.

3.6 Data analysis

I have used thematic analysis as the method of analysing data. Braun and Clarke (2006:6) describe thematic analysis as a method that pays attention to describing both the implicit and explicit data, through a thorough process of identifying, analysing and reporting pattern (themes) within a data.” Thematic analysis was chosen as the most preferred method as it moves beyond merely describing the data but identifies both the unspoken and obvious ideas within data (Guest, McQueen and Namey, 2011). Data from the secondary sources, that is, the clinic staff, the traditional healers, the Marie Stopps Centre and the men, were not discussed separately but integrated into the discussion on the primary sample of respondents, to provide a holistic picture of the issues under investigation and also used for the purposes of triangulation.

Bryman, (2004:93) states that this method of analysing data involves two processes, “the mechanical and the interpretive component”, both inextricably linked. The mechanical process refers to the physical activity of reading and rereading the data in search of key words, trends and themes that will help shape the analysis before any analysis takes place (Guest, McQueen and Namey, 2011). The interpretive component of the analysis occurs when the researchers immerse themselves in the data, looking for the unspoken and attaching meaning to it, based on the broader picture presented by the findings (Rodwell, 1995). As a result, thematic analysis is taken to be a rather subjective and flexible method of analysing data. At the explicit level of analysis, it is the raw subjective voices and opinions of the respondents that are taken into perspective, giving room for presenting their lived experiences and realities as they know them (Mays, Pope and Popeye, 2005). Thematic analysis becomes a flexible method of analysing data when it permits an integrated analysis of data collected using different qualitative methods. I used several qualitative methods of data collection that I

have explained prior in this chapter and the use of thematic analysis enabled a concise but thick and detailed exploration of the data gathered.

The identification of patterns and the construction of themes was an on-going process of the data analysis that started soon after the initial 20 interviews. For example, the information given by the primary respondents was used to confirm theoretical explanations in the interviews with the key informants and where significant patterns had been identified, the topics were revisited in the subsequent interviews, also allowing me to check and verify my constructions of their reality with them. Terre Blanche, Durkheim, and Painter (2006), suggest the preliminary understanding of the context and meaning of data as one of the initial stages of theory formulation. As proposed by Eisenhardt (1989), no theories or propositions with regard to the research questions were made at the beginning of the research so as to avoid bias and limiting the findings. As a result, themes are not predefined but emerged from the data. However, some of the themes that emerged during the study were those that had been also been identified in during the review of relevant literature.

Braun and Clarke (2006:13) suggest two levels of analysing data using thematic analysis, ‘the explicit level and the implicit level’. The explicit level deals with surface meaning, taking in what the client has said and looking for anything beyond, whilst the implicit level “attempts to theorise the significance of patterns and their broader meanings and implications, often in relation to previous literature” (Braun and Clarke, 2006: 13). While both levels of analysis are of equal importance, some qualitative authors further suggest staying close to the data and analysing it from an empathic understanding as being key to providing a thorough description of the characteristics, practices, transactions and the setting that constitute the phenomenon being studied (Terre Blanche, Durkheim, and Painter, 2006; Braun and Clarke, 2006; Babbie and Mouton, 2002). Terre Blanche, Durkheim, and Painter (2006:322) point out that this type of interpretive analysis results in a “compelling account of the phenomenon being studied; close enough to the context so that other people familiar with the context would recognise it as true, but far away so that it would help them to see the phenomenon in a new perspective.”

Thematic analysis was also chosen as a method of analysis as it accommodates constructivist leanings in data interpretation, which was key in this study (Terre Blanche, Durkheim, and Painter, 2006). Goldstein in Shermain and Reid (2006:43) points out how in essence, social work practice is constructivist in nature in that critical enquiry shares the same philosophical assumptions with social work practice through an interest in understanding people and their

predicaments and “finding meaning in their thoughts, behaviours, language and life circumstances”. The case study of Diepsloot required an understanding of the socio-cultural and economic dynamics of the community and therefore multiple levels of analysis. In linking social work practice and ethnographic research, Goldstein in Shermain and Reid (2006:43) states that: “If, in practice, we intend to keep the dialogue going, our duty would be to fathom the meaning - and there are many meanings - embedded in a client’s narrative. We would need to take an intersubjective and interpretive disposition of mind, one that is responsive to the nature of idiom, culture, symbols and antecedent circumstances concurring within the context of the relationship...here we are not technicians generating data; we are people engaged in reconstructing meaning.” The link between ethnographic research and social work practice described by the author here, reaffirmed my inclination was towards being interpretive and critical of the dialogical processes, the interactions, the culture and meanings attached to certain behaviours in the Diepsloot community and how this related to contraceptive services and use at different levels.

Thematic analysis emphasises the importance of acknowledging the researcher’s position within the data and analysis process. What counts as a theme in thematic analysis, is something that has been concluded as resting largely on the researchers’ judgement (Braun and Clarke, 2006). In supporting the researcher as the main tool in theme identification, Rodwell (1998:162) expounds that themes and “theory that grows from these data is really the enquirer’s cognitive map of the data”. Typically, a theme highlights something of significance in the data, in relation to the research question. However, the question on identifying themes in qualitative research has been on the issue of theming based on prevalence or simple presence of a particular aspect in the data. Rodwell, (1998:162). suggests that “the ‘keyness’ of the theme is not dependent on quantifiable measures but should be viewed in terms of capturing something important in relation to the overall research.” Theme identification in this study was based both prevalence and simple presence.

3.7 Possible study limitations

As mentioned earlier on in this chapter, the interviews were conducted in SeSotho and IsiZulu, the most commonly spoken languages in the area. The recorded interviews were then translated and transcribed into English. According to Squires (2008), poorly translated concepts or phrases pose a potential limitation of misrepresenting emerging themes from the

analysis and may not reflect what the participant actually said. Although great care was taken into efficiently capturing all the details of the information provided, some of the details might have been lost in the interpretation, an inevitable happening when translating between two or more languages. An interpreter was used throughout one of the interviews for one woman who felt that she wanted the questions clearly interpreted to her in XiTsonga, although she was able to respond in SeSotho, a language I understood. However, the subsequent interviews were conducted in IsiZulu and SeSotho as she informed that she had a clear understanding of the research aim and felt that she no longer needed the questions interpreted in XiTsonga. A possible limitation in this case could have been the loss of some detail through interpretation.

Another possible limitation in the study was cultural bias. Diepsloot is made up of people from many diverse cultures and some of the actions of the respondents might have been misinterpreted during the data collection and analysis. However, to avert this, clarity on the possible different interpretation of any behaviour or action was sought from the respondents at every stage of the research process.

3.8 Ethical considerations

Social work as well as general research ethics shaped the ethical considerations during this study. Peled and Lechtentritt (2002:146) list the ethics of social work with regard to research as encompassing,

- i) Respect for the individual person
- ii) Promotion of the person's self determination
- iii) Promotion of social justice
- iv) Work for the interests of others.

Also, the research ethics that directed the study were further guided by the UKZN's Research Ethics Committee that promotes minimising potential harm and stress to respondents, the autonomy of respondents to withdraw at any stage of the interview if they so wish, protecting the anonymity of the respondents and treating all information provided with confidentiality. As part of the requirements of the study from the university, an ethical clearance was obtained from the University of Kwa Zulu Natal Research Ethics Committee (See appendix 4).

According to May (1993) ethical considerations should not be defined by what is advantageous to the research project, but rather by what is correct and just to all research participants.

A consent form plainly stating the objectives and processes of the study was created (See appendix 5). The consent form was written in English as the study population had diverse languages. To ensure a complete understanding of the contents of the consent form, I translated in IsiZulu and SeSotho, commonly spoken languages in Diepsloot. In the event that the respondents needed translation into one of the local languages that I do not speak, an interpreter was brought in. This happened twice during the study, when two of the respondents requested interpretation in XiTsonga and TshiVenda. The consent form was signed before the interviewing began.

The research objectives and process were repeatedly explained to the participants before and during the study and throughout all the stages of the data collection process, the purpose of each interview was clearly stated to the respondents.

Penad and Lechtentritt (2002:146) advise that another level of ethical consideration should be given to the community or social setting where the research is being conducted by suggesting that “a community is assumed to have common moral values and these are to guide the research conducted in its domain”. Thus, social science researchers are required, as moral individuals, to make and adapt their moral acts “through a non-hierarchical dialogue with research participants within the social contexts in which the research is conducted” (Penad and Lechtentritt 2002: 147). As mentioned earlier on in this chapter, the value and input of the respondents as individuals was respected and all interviews were designed to be non-hierarchical and conversational in nature, respecting the respondents’ opinions as experts of their own experiences.

During the focus group discussion where 8 people were sharing confidential information in one room, all the participants were encouraged to keep all the information shared as confidential. All data obtained from the group meeting was treated with anonymity. In cases where direct citations from the interviews and focus groups are provided, pseudonyms are used.

3.9 Conclusion

In this chapter I have described the research methodology and discussed how the theoretical framework guided the methods utilised. Also discussed is the qualitative research design, the ethical considerations given in the study, the sampling methods, the data collection process, issues on reliability and validity, and the possible study limitations. The next chapter is on the analysis and discussion of the research findings.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESULTS

4.1 Introduction

In this chapter I provide my analysis and a discussion of the findings. The chapter begins with an outline of the context of the study, presented through a detailed description of Diepsloot in accordance with the case study methodology adopted in this research. This is followed by the socio-demographic characteristics of the twenty key respondents who participated in the study. Thereafter is the presentation of the findings, grouped into themes that emerged during the study. Pseudonyms were used in place of the real names and direct quotations from the respondents are italicised. Data from the focus group with men, and from health practitioners and traditional healers are also included in the thematic discussion.

4.2 The case-study of Diepsloot

Diepsloot Township is an informal settlement, situated north of Johannesburg. It lies between the outskirts of Johannesburg and Pretoria. Diepsloot is located in the middle of three busy highways, making it well connected to the city and other surrounding areas. On the north side of Diepsloot is the N14 highway, the R511 on the East, and the Ben Schoeman Highway on the west.

Being in this community, I found a few landmarks that make it easily identifiable. To the south of Diepsloot is a municipal waste area, which gives out a disturbing stench of human waste throughout most days. Two buildings next to the R511 highway stand out. First is the Diepsloot mall, a tiny shopping centre at the entrance of the settlement and as you proceed towards where the R511 and the N14 highways merge, is the massive multi storey structure of an incomplete police station that has been under construction for the past 6 years. Centred in all this are dense clusters of what appears to be shack settlements, grouped into different sections. It is one of the 182 such settlements around Johannesburg and 1700 around South Africa (Harber, 2011)

According to the City of Johannesburg records, the Diepsloot settlement was established in early 1995 as a transit camp for people who had been moved from Zevenfontein, a peri-urban settlement, not far from Diepsloot. Back in 1991, a court had ordered the eviction of a small community that had been renting this private land, which resulted in a long political and court

battle. Because there was no land readily available to place people from this community, they were temporarily moved to an adjacent piece of land, owned by the Rhema Church. At this time, there were about 45 families and less than 300 people. People were to stay in this camp until land became available. While the people were placed in this transit camp, they were joined by others, coming from all parts of the country, seeking opportunities in Johannesburg. The numbers began to gradually increase. The Transvaal Provincial Administration, which was then the local authority, set up a commission to look into this land matter. After a series of reports and presentations on possible solutions, the Provincial Administration took a piece of land from the Diepsloot farm. Landowners protested and took the Provincial Administration to court, further delaying matters. With appeal after appeal, the case was dragged through different courts and was thrown out of the High Court in 1994.

Initially, the Provincial Administration had plans to develop the plots into 1 324 serviced residential sites. However, in early 1995, after getting tired of waiting, the 'Rhema people' as they were now known, decided to move in and occupy the land appropriated for them. By then, the numbers had swelled to more than 8 000 people.

In 1996, the Diepsloot people were joined by another group, moved from the Far East Bank, an area in Alexandra affected by floods. The piece of land had to be enlarged through a court approved land appropriation. The expansion, coupled with the new government promises on equality, development and economic growth made Diepsloot a magnet for people seeking refuge, people being evicted or coming from other similar settlements, foreigners and those coming into the city from the rural areas with high hopes of securing opportunities and free government housing (Harber 2001; CoJ 2006).

People who initially came from Zevenfontein were put in 1 124 serviced plots in Diepsloot West, with no housing but just water and other basic services. Diepsloot Extension 1, also known as the reception area was used to place more landless people that had been moved from the Rhema Church land, and later on the people from Alexandra who had been moved due to flooding. There were no services in this area and people were only meant to stay here until land became available for them to be permanently placed in other parts of Diepsloot. The reception area later became the dumping ground for people who were being cut off from their areas. In 2001, a further 4 552 people were moved from Alexandra and placed in Diepsloot. The government was prioritizing urban renewal in Alexandra and in order to pave way for such developments to take place, the city officials had to get rid of the 'excess'

people in some of the Alexandra squatter camps. These people were placed in the already overcrowded and unserviced reception area.

According to the City of Johannesburg website, in 2005, Diepsloot was home to an estimated population of between 150 000 and 200 000 people living in an area of just 5,18km². The unemployment rate was then estimated at 54% and 73 % of the residents lived below the poverty line.

Although a symbol of poverty and inequality, Diepsloot is right next to Dainfern, one of the wealthiest suburbs in Johannesburg. Harber (2011) comments that it is starkly contrasted with its surroundings, which are all high income private sector residential and commercial developments. Other such areas in close proximity with this settlement are Northgate, Fourways, Sunninghill and Midrand.

Once the focal point of the 2008 xenophobic attacks in South Africa, it has been described as not being a product of apartheid but that of the transition period, a phenomenon of the new South Africa, bearing an imprint of the past (Haber 2011). In a period of 15 years, it has developed from an empty farmland to a settlement of over 200 000 people (Mail and Guardian, 26 May 2011). Harber (2011:223) gives a perfect summary of this unique community when he concludes that, “Diepsloot has much to offer as a microcosm of the country’s political and social dynamics at the cutting edge of service delivery issues. It includes some of the most deprived areas of Johannesburg, and it sits alongside conspicuous wealth. It is a post-apartheid settlement, which is unusual. It is volatile, having seen at least six violent outbreaks in the last two years. It has been a centre of xenophobic attacks. It hosts the ANC’s branch of the year for 2009. It has seen some development, but not enough. And it is accessible.”

4.2.1. Housing and infrastructure

There are three types of housing in Diepsloot, namely; shacks, RDP and bond houses. There is a very small section of bond houses in Extension 3, also known as Tanganani. This was the first attempt by the government to turn the informal into formal by allocating 700 serviced stands to the Mayibuye Housing Project (Harber 2011). The area is well serviced compared to the rest of the other extensions and there are tarred roads and less trash lying on the streets.

The second type of housing is the RDP houses which stretch over extensions 2; 4 ;5 ;6 ;7 ;8; 9; 10 and 11. Although the city council has taken great steps to try and formalise parts of the

settlements through building RDP houses, according to a report by Kwanele Sosibo for the Mail and Guardian dated 4 February 2011; “the backyards of RDP houses are a maze of shacks that far outnumber the formal structures in whose shadow they stand.”

The third type of housing and by far the most common in Diepsloot are the shacks. Shacks in Diepsloot are usually dense and congested. Extensions 1; 12 and 13 have shacks only and there is shared water and sewage facilities and no electricity (Harber 2011). According to the 2001 census, over 70% of the people in Diepsloot live in shacks. These are 3m-by-2m, wall-to-wall shacks made from scrap metal, wood, plastic and cardboard. Due to the shortage of space, the shacks are built closely together, usually separated by a footpath. In August 2008, a fire burnt down 23 shacks and left over a hundred people homeless, (Harber 2011). Also common among the shack dwellers is the practise of ‘shack farming’, an enterprise explained by Harber (2011) as socially a created process where land bosses emerge and illegally assert control over an area, start selling access and protection to those desperately in need of land. The result is severe overcrowding which is very evident in the Reception Area where most residents are tenants and not shack owners. Another problem faced by those living in shacks especially next to the local stream, is the flash floods that wash away their homes every rainy season.

In a 2005 study by the University of Johannesburg Centre for Social Development in Africa, Diepsloot came 5th as the most deprived ward in Johannesburg and is the 65th most deprived area of the 420 wards in the Gauteng province. Most families lack access to basic services such as running water, sewage and rubbish removal. Residents use paraffin stoves and coal for cooking, and candles for light.

Although the city of Joburg website informs that all the other Extensions, except extension 5 have tarred roads, a drive or simple walk through this community tells a different story.

Types of housing found in Diepsloot



Picture 1



Picture 2



Picture 3



Picture 4

Picture 1 shows a shack settlement in Diepsloot Ext 1, also known as the Reception Area. Shacks are a common feature throughout all the extensions but the main shack settlements are Extension 1, 12 and 13. The bucket system type of toilet (the green plastic structure), showing in the picture is more common throughout Extension 1 and one toilet is shared by a countless number of households.

Picture 2 shows the bond houses in Extension 1, also known as Tanganani. There are only 700 such houses.

Picture 3 shows some of the houses that people built for themselves, especially in areas where they were settled in serviced stands. These areas have communal tap water and a flushing toilet per household. The picture was taken in Extension 12.

Picture 4 shows the RDP type of housing. This type of housing is common through Ext 2, 3, 4,5, 6, 7, 8,9,20 and 11. However, they are densely surrounded by shacks so much that they are almost invisible. Most of these extensions have are a mix of shacks and RDP housing, with shacks being the most predominant.



A picture of the uncollected litter and sewage next to the shacks from the New York times dated 29 June 2009

4.2.3 Schools

There are now 6 primary schools, including two low cost private schools, and only one combined high school in Diepsloot (Judy Lelloit, Times Live, 28 January 2011). Some of the schools are built with prefabricated material and lack basic services such as running water, electricity and ablution facilities. There is a booming business for early childhood development where most parents are required to pay a minimum amount of R200 for day care. Most of these crèches operate even in shacks and a large number of them are unregistered with the relevant authorities. According to the Johannesburg News Article by Ndaba Dlamini dated 27 July 2005; there are not enough schools in Diepsloot and learners are constantly being forced to travel long distances to neighbouring schools. Also, the levels

of truancy are alarming in this area and most children at the local high school usually get to school well after 10 am (Gauteng Education MEC Creesy's address on 14 June 2011 in Diepsloot). Most children have to commute to neighbouring schools every day as the schools in Diepsloot cannot cater for the ever increasing number of the population.

4.2.3 Primary health care

There are only two primary health care facilities in Diepsloot. The O R Tambo clinic was built in 1999 in the Diepsloot West area and in 2008; the Diepsloot South clinic was opened. Both clinics are congested and patients have to queue from as early as 0500hrs in order to receive medical attention. There is a doctor that comes every day of the week for four hours and the nurse-patient ratio at each of these clinics is 60 patients per nurse, compared to the normal ratio of 30-45 patients (Bodibe 2006). More often, patients have to commute to the neighbouring Witkopen Health and Welfare Centre and to hospitals over 45kms away in the Johannesburg city centre. Services in these clinics include; antenatal and postnatal clinic, adult patient care, HIV and TB clinic, family planning clinic and immunisations. There are no ambulances in the clinics and there have been reported incidences of women giving birth by the side of the R511 road, waiting for transport to the hospital in Johannesburg (Khopotso and Njamela: 2006).

The HIV/AIDS prevalence rate in South African squatter camps is twice as high compared to the rural areas and data on HIV incidence show that a large amount of HIV infections take place in informal settlements (Hunter 2005). Diepsloot is no exception with a sizeable percentage of its population being affected by HIV/AIDS. Because the two clinics cannot adequately provide services, there are many non-governmental organisations around the area that train and support home based caregivers, who assist the chronically ill with counselling and physical assistance.

4.2.4 Crime

Diepsloot has made headlines in South Africa and internationally mainly for service delivery protests and crime. In 2008, it became the focal point of the xenophobic violence which led to murders of scores of immigrants whilst leaving many displaced (Harber 2011). There is a satellite police station, which has four patrol vehicles and the closest police station is in Emmarentia, 16kms away (Minnar 2010). Before the SAPS satellite station, it was only the Community Policing Forum which handled issues relating to crime and initiated kangaroo

courts where sentences were delivered accordingly. Harber (2011) vividly describes the Community Policing Forum activities, explaining how the police are outnumbered and outgunned by the local criminals and even relates of no-go areas where the police fear to patrol. According to Barry Bearack in an online New York Times article dated 29 June 2009, the Diepsloot citizens have lost faith in the ability of the police to control crime, leaving them defenceless and the result of this is the rampant mob justice associated with the area where sometimes innocent individuals, mostly foreigners, are viciously beaten or killed upon any suspicion of wrong doing.

It is against the above ecological backdrop that the current study was undertaken.

4.3 PERSONAL PROFILES OF THE WOMEN

Manxiweni

Manxiweni is a 34 year old mother of three. She is from the Limpopo province and moved to Diepsloot in 2002 to live with her long term boyfriend and father of her 3 children. She and her children live in a rented shack in Extension 1. She is a Christian, a member of the Zion Christian Church. The place is visibly small for the young family and she talks of sending the older children to her rural home as soon as they finish the primary school level of education. Her boyfriend has had difficulty keeping a job over the past 2 years due to a drinking problem and as a result, the family survives on a monthly income of R1700, a combination of her earnings as a domestic worker in a neighbouring suburb and the child support grant. Although she is currently not using any form of contraception, she informs that she has no desire for any more children.

Hemina

Hemina is a married 42 year old woman. She has been with her husband and father of their four girls for over 22 years. She is already a grandparent and jokingly complains how these 'kids of today' will make you age faster. Although she is still married to her husband, he lives somewhere in Johannesburg north and comes and goes as he pleases. Hemina, her children and her grandchildren live in a RDP house in Extension 5. None of her children are employed and the younger 2 are still in school. Hemina has a part time job doing domestic work in Fourways. She earns R400 a month as she only goes to work once every fortnight. The bulk of the family's monthly income is collected from tenants renting the 6 shacks in Hemina's

yard. On the use of contraceptives, she occasionally alternates between the Depo Provera and the contraceptive pills.

Thandeka

Thandeka is 25 years of age. She has five children, from 3 different fathers. She had her first child at the tender age of 14 while still in primary school in rural Eastern Cape where she was living with her grandmother. She moved to Diepsloot in 2003 to live with her mother after she was chased away by her grandmother for bringing shame to the family. Her mother lived with her boyfriend in Tanganani, a much wealthier part of Diepsloot, but Thandeka explains that she did not like things there. She left her first child with her mother and moved in with her new boyfriend who lived in Extension 1. She describes all her pregnancies as unplanned accidents and admits being a bit reckless in her 'younger days'. She recently got sterilised after the birth of her 5th child. She does not ascribe to any particular faith and now makes a living working as a cleaner at a local NGO where she earns R1300 a month.

Helena

Helena is a 42 year old mother of three. She has several certificates in the field of early childhood development and works as a Grade R teacher at a preschool in Diepsloot. She has been married for the past 20 years to her husband, whom she describes as an irresponsible man. All her children are in school and the youngest is 12 years of age. The couple has an income of R5000 a month and live in an RDP house that they have now extended to 3 bedrooms, a kitchen and a lounge. Helena is from the Limpopo province, and a member of the ZCC church. She informs that she has no desire for more children but also stopped using contraceptives many years ago after a messenger of God appeared to her in a vision and told her that contraceptives were not good for her health.

Sihle

Sihle is 42 years of age. She was born in Zimbabwe, and moved to South Africa after the death of her husband. She is a Christian, affiliated to the Roman Catholic Church but also practises the traditional rituals whenever necessary. She has been living in a rented shack in Extension 1 since her arrival in 2004. She lives with her 3 children and her current boyfriend. She used to work at a doctors' surgery back home after getting her secondary school certificate and has a good knowledge of modern contraceptive methods. She works as a primary health caregiver at a local NGO and earns R1500 a month. Her boyfriend, also from

Zimbabwe, works for a security company and also earns the same amount. The couple has no desire for any more children and Sihle is on the contraceptive injection but also uses condoms every time to protect herself from STIs.

Samina

Samina is 36 years old and is a mother of five. She has been customarily married twice in her life and is separated from both previous partners. She is currently dating a married man, whom she recently had her 5th child with. She was raised in rural Mozambique, by her grandmother, where she only went as far as grade 2 with her schooling due to unfavourable financial circumstances. She cannot remember the exact year she moved to South Africa with her first husband, but remembers that she was one of the Alexandra residents moved to Diepsloot and placed in Extension 1 where she still lives. She lives in a spacious, decently furnished shack, which was donated and built for her by a humanitarian group of Europeans. She explains never using contraceptives all her life at the advice of her grandmother and previous partners. She earns R1300 a month working as a cleaner and also gets R250 a week in child support from her current boyfriend.

Mary

Mary is a 32 year old married mother of 3 children. She lives in a relatively big shack Extension 12, portioned into 4 little rooms. She completed her secondary schooling and works a till operator at one of the retail supermarkets in neighbouring Randburg. Her husband works at a construction company and together they have a joint income of R4500. Mary is of the Christian faith and her husband is a deacon at their church. She makes an effort not to miss her appointments at the family planning clinic; especially after she accidentally fell pregnant a year ago and had to secretly terminate the pregnancy.

Samkelo

Samkelo is 34 years old and is a mother of 3 children. She comes from the North West province and moved to Diepsloot with her then husband and father of her children. She got divorced from her abusive husband of 10 years, about 2 years ago. She now rents a backroom in Extension 5, where she lives with her children and she pays R550 a month in rent. She completed her secondary level of education and explains how her grades were not good enough for her to proceed with further education. She earns R1500 a month working as a lay counsellor at one of the NGOs and gets a further R440 a month from the child support grant.

Although she is now in a new relationship, she is not using any form of modern contraception and relies mainly on unconventional methods learnt from friends over the years.

Sibonelo

Sibonelo is a 34 year old mother of 7. She is married and had two children with different fathers prior to her marriage. She was raised in rural Zimbabwe and managed to complete the secondary level of school. She has been married for the past 14 years and has had 5 more children since. The family of 9 live in Extension 1 and they are lucky to own the piece of land where they have built their shack and so they do not pay rent. The shack is partitioned into 2 relatively large rooms, the kitchen area and the sleeping area. Her husband has been in and out of prison for different sorts of crimes, and last had a job a few years ago. Sibonelo works at a kitchen of a local NGO and earns R1400 a month. To supplement the income, she is an illegal money lender (popularly known as *umatshonisa*) and makes a profit of R600. She also talks of sending the 5 older children to her rural home when she has saved enough money. She explains that she is struggling to make ends meet and thinks things will get better when she is left with only 2 children. Sibonelo explains that contraception never works for her as she has reacted badly to a 'couple' of methods that she has tried. She is currently not on any method and has been contemplating sterilisation.

Zinhle

Zinhle is a 34 year old mother of four. The family of 6 lives in a shack in Ext 12. She only completed the primary school level of education and moved to Diespsloot from Mozambique in search of employment ten years ago. Upon arrival, she met and moved in with her current boyfriend and father of all her children. She is unemployed and her boyfriend earns R1 900 working for a construction company. She is occasionally on the contraceptive injection but usually forgets her appointments.

Zandile

Zandile is a mother of five. She is 34 years of age and is from the KwaZulu Natal province. She explains how she dropped out of school when she fell pregnant in grade 9. She comes from a well-to-do family and they have taken in her 4 children and are not aware of the fifth one. She works for a retail supermarket and earns between R1600 and R2000 a month. She informs that she was never exposed to shack life and as a result most of her money is spent on rent. She lives in Extension 6, where she rents a room in a flat. She has been on and off the

contraceptive injection, which she associates with weight gain and has tried the COC, which she says have failed her.

Candice

Candice is a 22 year old mother of two. She grew up in Diepsloot, raised by both her parents. Her oldest child is 2 years old and she also unexpectedly had twins, now 5 months of age. She is a single mother and the father of the twins recently deserted them. She also had to move out of home after constant fights with her mother. She now lives in a rented shack in Extension 1. She is unemployed and receives the child support grant for all three children. She also receives monthly child support money from the father of her first child. The money is little but she tries to make ends meet. She is currently on the contraceptive injection.

Sibonile

Sibonile is 38 years old and is a mother of 7 children. She has been customarily married for the past 18 years and all her children are from her husband. She speaks affectionately of her children, most of who were unplanned. Three of her children live with her in-laws in the Eastern Cape. She never completed any level of education in school. She and her husband strongly believe in traditional African healing and consult with traditional healers whenever necessary, even for contraceptive purposes.

Silindile

Silindile is 30 years old. She is married and has 4 children, one from her previous relationship. She was born and raised in Lesotho and moved to Diepsloot 6 years ago to live with her husband, also from Lesotho. She has been married for 7 years, and has had 3 children in that period. She is of the Christian faith and attends church whenever possible. Her husband is a self-employed mechanic and does random jobs around Diepsloot, making an income of approximately R2000 a month. The family rents a shack in Diepsloot Extension 1. She is on the contraceptive injection and the couple does not intend to have any more children.

Balosi

Balosi is a 35 year old single mother of 6 children. Her children are from 3 different fathers, a circumstance she dismisses as being unlucky in love. She was raised in a Christian family in Mozambique and is of the Roman Catholic faith. She currently lives in a shack in extension 1, with her last born child. The other children are with her mother back in Mozambique. She works as a cleaner at a local NGO, earning R1 300 a month. She can barely read and write and dropped out of primary school after she repeatedly failed grade 3. She is not on any contraceptive method at the moment, as she is not in a relationship. She wants one last child, which she will have when she meets a responsible man. She comes from a small family of three and feels that her many children will be there for each other and all work together to look after her in old age.

Jalubana

Jalubana is a 45 year old married mother of 6. She is a soft spoken woman who never completed the primary school level of education. Her first marriage was arranged and she was forced to marry a mentally challenged man so that she and her in-laws could access his disability grant. The marriage failed after 4 years but resulted in the birth of her eldest two children. Her second husband died in a mine accident after 6 years of marriage, leaving her with three more children. Currently, she is in a polygamous union and has one child with her husband. She lives with 5 of her children. She works part time for the municipality, picking up litter on the streets of Diepsloot three times a week. She earns very little, making under R1000 a month. She receives an extra R250 a week from her husband, who visits the family once a week. She has had health problems with contraceptives all her life, headaches and severe weight loss, and currently, she is breastfeeding and not on any method.

Nothando

Nothando is a married 33 years old and a mother of two young boys. She has secondary school education and works as a class assistant at a local preschool. Her husband is a self-employed taxi driver and business is seasonal, and as a result the family's total income is R3000. The couple doesn't want any more children and Nothando respectfully follows all her appointments at the local family planning clinic. The family lives in a 4 roomed home in Extension 5, upgraded from what used to be a RDP structure.

Zenzile

Zenzile is a 26 year old single mother of one. She is from the North West province, where she was raised by both her parents. She has a diploma in Community Development and moved to Diepsloot 3 years ago to work as an administrator at one of the NGOs. She earns R4700 a month and rents a backroom that she shares with her daughter and helper, in the Tanganani area of Diepsloot. She is on the contraceptive injection since the birth of her young child and has no desire for more children.

Mashudu

Mashudu is 24 years old and is a mother of three. She lives in a shack in Extension 1 with her boyfriend and father of her two children. She successfully completed her secondary level of school and was raised in Alexandra, then in Diepsloot, by both her parents. She works at a supermarket in Randburg and earns R1700 a month. Her boyfriend teaches computers on a part time basis at a nearby school and earns R1300 a month. Mashudu is on the contraceptive injection, and attends the local family planning clinic.

Princess

Princess is a divorced 43 year old mother of two. She was raised by her grandmother in rural Limpopo and only went as far as grade 5 in primary school, when she had to drop out due to unfavourable financial circumstances. She lives in a shack in Extension 1. She is self-employed and runs a tavern on a rented piece of land next to her shack and makes a profit of approximately R2000 a month. Contraceptives do not play an important role in her life as she found the use of unconventional methods more reliable and with less side effects. Such methods include the consumption of certain amounts of vinegar and coca cola after intercourse. Also, she believes having unprotected sexual intercourse multiple partners prevents pregnancy.

The socio demographic data is presented in table 2, followed by a discussion

4.4 Socio-demographic characteristics of the 20 participants

Table 3

Characteristics	Number of women
Age group	
19-25	3
26-35	10
36-45	7
Educational level	
Primary	6
Secondary	7
Post-secondary qualification	2
None	5
Marital status	
Single	3
Married	8
In a relationship or cohabiting	7
Divorced	2
Religion	
Christian	17
African traditional church	2
None	1
Number of children	
1-2	3
3-5	13
6+	4
Total household income	
R 1 200 – R 2 000	13
R 2 100 – R 3000	4
R3 100 – R 5000	3

4.4.1 Age

Although Diepsloot is home to people of all age categories, as discussed earlier on in chapter 3, the ages selected for the study were 19 to 45. However, 50% of the respondents fell between the 26 to 35 age categories. The women in this age group informed that they had been raised elsewhere and explained arriving in Diepsloot in their adult life, reflecting heterogeneous socio cultural dynamics. Only two of the women in the lesser age group, explained having been raised in Diepsloot and both having had children during their teenage years, a common trait throughout all the age groups in this study. The ages of the women also became important in determining the value placed on marriage and its association with childbirth. Although studies show that most women now have children prior to first marriage,

the age at first marriage is still considered a key characteristic of population dynamics as it is usually a predisposition to child birth (Garenne, 2005).

4.4.2 Marital status

There was a difficulty in drawing distinction between married women and those in live-in relationship as most women cohabiting with their partners identified themselves as ‘married’ even if the relationship had not been formalised or recognised by family. Cohabitation is in principle not a marriage and in the study, marriage was reserved for couples that had been formally unionised by an authorised marriage officer or customarily recognised, which in most African traditions constitutes the payment of lobola. Marriage is considered an important institution in most African societies and child bearing is usually expected to happen with the confines of marriage. Only nine of the women in the study were married while three reported being single, two were divorced and seven were live in relationship with their partners.

It was the older women, all above the age of 30 that were married. Although it was the older women that fell in the ‘married’ category, age at marriage was between 19 and 22 years of age and it was mostly those with low levels of education. Of the ten women who had been previously married or were still married, six fell in the categories of those with only primary school education and those who had not completed any level at all. The low level of education and early age at first marriage corresponds with findings of other studies in Africa. The effect of education is that the longer girls go to school, the more likely they are to delay marriage (Garenne, 2004). Higher levels of education, income and urbanisation are identified as factors delaying first age at marriage, however, due to the smaller number of respondents and no conclusions could be drawn on the associations between urbanisation and late marriage. Also, cultural factors such as lobola, a relatively lengthy and costly process, also plays a huge role as to whether or not people marry and when.

4.4.3 Level of education

Only seven of the participants had gone as far as the secondary level of schooling. Of 9 women that had completed secondary and post-secondary, level of education, 4 reported that their studies had been disturbed when they had to drop out of school as a result of pregnancy or lack of funds. There was a strong awareness for the need of education amongst the respondents, as ten of the women interviewed had previously attended or were still attending

Adult Basic Education and Training (ABET) classes, a free government service for all, commonly referred to as ‘night school’ by the women. The desire for self-improvement did not go unchallenged by the men, especially amongst married women. Nothando expressed with a tone of rage and annoyance, how her husband and father of two had tried to frustrate her efforts to get more education.

“Bheki did not want me to go to school... for what I do not know! He just wanted me to be at home with the kids! All women are out there are getting school... I need to pass two more subjects to do a new ‘course’. So one time I left the kids with him at home and he decides to bring them to the class because he wanted to go drinking. The teacher said I could let them stay till the end, but the boys were noisy running around and disturbing everyone I had to leave...! It was ‘nt easy at the beginning, I had to fight...but now he understands a little...as long as I cook and bath the kids first.”

It was only the five women who had not completed any level of education that seemed oblivious to the need for basic education.

Only two of the women had successfully completed a post-secondary qualification. Of the five respondents who reported that they had not completed primary school level, four were foreign nationals. The level of education amongst the respondents was a reflection of similar findings made by some studies which show very low levels of education among squatter camp dwellers, where a large fraction of the population only has primary school education, a few with secondary education and also a group with no formal education (Okech, Wawire, Mburu, 2011). The relatively low level of education among the respondents directly relates to unfavourable economic and social circumstances in which most of the women find themselves. Kraus and Keltner (2008) explain that higher levels of education in women are associated with better incomes, physical and psychological well-being, and independent decision making. Low levels have the adverse effects.

4.4.4 Religion

Religion did not appear to play much of a role in the lives of the respondents. Seventeen of the women reported that they believed in the Christian faith though most were not affiliated to any particular church. Most of these Christian women were not dedicated members and were not living within the confines of the faith, but explained how they were Christian by virtue of being raised in the faith. Christianity was equalled with the mere belief of the

existence of a God by a large fraction of these Christian women. Weekends, the time for most churches, was set aside for doing household chores, attending *stokvels*, burial societies, part time domestic jobs and being with the family. The low levels of commitment to religion amongst the respondents did not appear an odd occurrence. Even during those times that I interviewed the women in their homes during weekends, they always had an aura of being occupied, never relaxed but seemingly calculating how to go about the endless list of weekend activities, and spiritual edification rarely featured on that list.

4.4.5 Number of children

Most of the women in the study had an early onset of childbirth with most reporting that they had a first child in their teenage years, while still in school. The ideal and the actual number of children is discussed in detail later on in the chapter. Literature reviewed indicates education to be a powerful factor in determining the use of contraception and number of children and this was evident in this study. Amongst the respondents, it was however both the level of education and marital status that appeared to have an impact on the number of children. Five of the women who were married or had been previously married had five or more children, yet also, women with lower levels of education, regardless of their relationship status had more children when compared with those with a post-secondary school qualification. Garenne (2004) also comments on the relationship between level of education, marital status and the number of children by explaining that although a greater proportion of women now have children outside marriage, marriage also increases susceptibility to childbearing and determines the dynamics to family formation.

4.4.6 Household income

With the relatively low level of education, the majority of the respondents had a total household income of between R1200 and R2000. In most cases, there was only one person employed in the family and the total household income included the social service grants which some individuals were receiving. Sources of income included menial jobs such as cleaning at local non-governmental organisations, primary health care work, hairdressing, domestic work and one of the respondents relied solely on the child support grant. It was surprising to note the low basic income paid for full time employment by some of the organisations around the community. Several of the women earned R1 200 a month working an eight hour a day job, five days a week. Most domestic work was in the neighbouring high income areas of Dainfern, Fourways and Randburg. The few respondents with a higher

household income were mainly those that did part-time domestic work on the weekends and lived with employed partners. Most of the women within the R1200 and R2000 income range were single parents, or breadwinners, living with unemployed partners. The circumstances of the women were a true reflection of a 2011 report by the Affordable Land and Housing Data centre which showed that the unemployment rate was at 54%, estimated the average household income to be at R19 100 per year, with more than 70% living below the poverty line.

4.4.7 Housing characteristics

Thirteen of the respondents lived in the reception area, the most densely populated shack area in Diepsloot. The shacks were tiny roomed spaces and occasionally partitioned into two spaces, especially by those respondents with children. Many people in the reception area own the spaces they live on and do not pay rent, as was the case with some of the respondents. However, some of the women in this group were renting the spaces for between R150 and R200 a month. The usually green or blue mobile toilets were shared between several households, with waste collected weekly by the city council. The water source was a communal tap, purposefully located several metres from the hives of shacks. There is no electricity and the source of energy for all the households in this study was paraffin, for cooking and lighting. Only a few households had the luxury of using solar power. Asked on how they felt about living and raising their families in such an environment, most women were indifferent, showing that they had grown accustomed to the life, not out of choice but due to circumstances. It is a common feeling in Diepsloot, among men and women alike, that living in the reception area is a guarantee of getting a RDP house, as the area is a government priority in terms of relocations. The women in the study shared this notion. As much as they acknowledged the area being a hazardous and an unfriendly environment, optimism at being relocated gave them hope, a rather unrealistic expectation given the government's current woes with providing decent housing for the poor. Also noted was that the women with the most number of children lived in this area. Three of the respondents lived in Ext 12, also a squatter settlement. However, they lived on serviced stands which were more spacious in comparison. Although sharing a communal tap for water, each of the households had their own toilet with a flushing system in place. Only two of the respondents lived in areas with the RDP housing.

4.5 Empowerment and reproductive health decision making

One of the aims of the study was to investigate the contraceptive behaviour of women living in the Diepsloot community, and one of the themes that emerged was the unequal balance of household power. The socio economic circumstances of the respondents were analysed to determine the relationship between household power and reproductive health outcomes in this setting. Although the dynamics of male-female relationships were sometimes too complex, it appeared the norm among the women that the man was expected whenever possible to make a financial contribution in the running of the household, no matter how casual the relationship might be. Although sometimes subtly expressed by the women, male provision appeared an important aspect of male-female relationships, being in a relationship had to come with a financial gain. The transactional nature of relationships was evident during focus group discussions, both with the men and the women. During the women's group, Balosi, an uneducated single mother of six commented: *"he cannot just come (to my place) and expect to find me clean and bathed, a meal ready for him...so that he can just have sex with me! Never! He must bring the money!"* This bold expression of expectations was applauded by the younger group members, while two of the older married women shook their heads in what appeared to be disappointment.

On the other hand, the men certainly did not feel any obligation towards financially supporting a woman that they were not 'committed' to, to which I presumed - although not explicitly expressed so - that they would be more willing to support women they were married to or in a living arrangement with. Their reluctance to play the provider role could have been a frustration indirectly resulting from the harsh socio economic climate and high unemployment rates that the men have to grapple with (Osthus, in press). Siyabulela commented during the focus group with the men, *"we all came to find jobs in Jo'burg, these girls come here, they sit around and don't look for work and next thing they want to trap you with a baby...Basile lababafazi (these women are devious)!"*

More than Siyabulela, Balosi appeared to be perpetuating the traditional idea that women's duties or roles were to be *"clean and bathed"*, cooking, sex and baby making.

Previous studies indicate that due to the patriarchal nature of most African societies, women still do not have much autonomy in making decisions affecting their reproductive health. The balance of power in household and sexual relations has an impact on the use of health services and reproductive health outcomes (Do and Kyrimoto 2012). It became apparent during this study, as highlighted in the following subsections, that financially contributing to

the household came with a certain level of autonomy, later translating to relative independence of contraceptive use and choice. Do and Kyrimoto (2012) further explain how different aspects of women's autonomy in relation to reproductive behaviour is not always consistent across or within populations and this was reflected in the different types of household relationships that emerged during the study. A view of the balance of power in household relationships as determined by the level of contribution to the household income and women's say in the house was used.

4.5.1 Household economic decision making

Three types of household relationships emerged during the study and these are discussed below.

i) Women with an income and a say in the house

Some of the women perceived that financial independence on their part came with a certain level of autonomy in terms of making basic household decisions and later on reproductive health decisions. Women falling in this category felt that just because they contributed to the household income, they had to have a say in the running of the relationship. When asked about decision making power in her relationship with a boyfriend of eight years, Manxiweni expressed that *"I also have a job, he cannot tell me what to do"*, indicating that her ability to contribute to the household income gave her a certain amount of decision making power in the relationship. Her views were also shared by Samkelo who said, *" Ya, he is stubborn sometimes...but we both bring in money, we both buy food and support the children, he knows he cannot just do as he wants here"*

In a community with high levels of unemployment, the actual amount contributed in comparison with what their partners earned appeared irrelevant for women who shared this notion. Also, the 'say in the house' was expressed with a lot of aggression, giving the impression that the man had no power sharing desire, especially in the running of the house as such decisions are traditionally viewed as the man's responsibility. The type of power brought about by economic independence was however very limited as a majority of the women later proved that they had little autonomy in terms of the number of children they had with their partners.

ii) Women with an income and no say in the house

The notion that financial independence came with a degree of autonomy in household decisions was however not consistent with all the women. The other group of women was made up of women who contributed to the total household income and still had very little contribution in the running of the major household decisions. Mostly, these were women who felt that they had a duty to support their partners or boyfriends by making a financial contribution to the relationship. Although making a financial contribution came with a level of pride for these women, they did not perceive their positions as giving them power over their male partners or autonomy to make major decisions. 42 year old Hemina has a full time job as a learning centre assistant but recalls how her husband almost runs the household single handedly by making all major financial decisions. Although not forced into giving him all her monthly earnings, she explained how it was easier for him to run errands and make sure that everything is taken care of as *“he is a man and knows what we have to do with the money...”*

James, a 45 year old caretaker at a local primary school felt that earning an income did not justify women’s participation in decision making and expressed this during the focus group discussion. *“Even back home (referring to the rural areas), women have a duty, to look after the children well, work in the fields and do this and that to make things work in the home..., men don’t always do everything! But have you ever heard of them sitting down together and making plans? No! That’s a man’s job... so what’s different about these town women? The house cannot have two men!”* James maintained that it was the man’s role to provide for his family with the help from his wife and make decisions on their behalf. Women are viewed as helpers to their husbands and not equal partners to be consulted in decision making. His views approve the subordination of women and are reflected in findings of similar studies where “men are always considered as the head of the household while women are subordinates to men. Therefore a woman is not allowed to equate her husband when it comes to household decision-making” (Ratele et al, in Osthuis, in press).

iii) Women without an income or say in the house.

There was only one woman who had no source of income and depended on the Child Support Grant. During the discussions, it was clearly expressed by some of the women that it was difficult to earn the respect of a man without any source of income. Interestingly, even those women who had an income and little decision making power in their relationships also felt that an income guaranteed some form of respect.

4.6 Level of education

Most of the literature reviewed show the level of education as one of the major indicators of empowerment, especially in developing nations. An educated woman is assumed to be an empowered woman as a person's level of education is usually associated with knowledge of one's rights and greater self-efficacy. In most studies done around the issue of level of education and contraception, low levels of education have been found to be one of the major barriers to effective contraceptive knowledge and use. The relationship between the level of education as an empowerment measure and the use of contraception was explored in this study. With regard to the level of education, focus was also on the differences in contraceptive uptake between the group with primary school level and below, and the group with secondary and post-secondary school level.

Contraceptive use was extremely low amongst the less educated women, that is, those with primary school level and no education at all. Almost all the women in the study explained never having used contraception before the birth of their first child, and only being initiated onto contraceptives at the clinic after the first birth. However, the less educated women did admit to not going back for the follow up appointment or reinjection. During one of the individual interviews, Jalubana shared that she had only been injected with the contraceptive after the births of her first two children.

Jalubana: It was only when I lived in the village that I let the nurses inject me, otherwise they wouldn't have looked at my babies, but now I never go there. I take my baby to the clinic and then the nurse tells me to go join the family queue, but I run away and go home...the injection is not good for me or the baby, I just don't want it.

Me: But did you ever ask for something different?

Jalubana: Have you ever been to these clinics? Do you think the nurses have time to listen to me...?

Me: And you were not worried about falling pregnant?

Jalubana:(she first shrugs her shoulders and lets out a sigh)Then I wasn't worried, but now they are too many. I'll see as soon as I stop breastfeeding this one.

Although both groups of women had low adherence to a particular method, the more educated women in the study were more likely to switch methods according to perceived

need and suitability, thus showing a level of awareness for the need to prevent unwanted pregnancy whenever possible. Nothando, an assistant teacher in a preschool was one of the more educated women in the study who appeared to understand the importance of controlling fertility, and not only understood it as her right but also her responsibility. *“My boss is a woman, she understands, she has to! I ask to take the morning off every now and again to go to the clinic and if the clinic is busy, I look for R50 to go to the smaller clinics in pharmacies in Fourways. I just cannot have another child.”*

The less educated group appeared to have left pregnancy to fate by not using any form of birth control, even when aware of the risk of pregnancy.

4.6.1 Concern over physical well being

When compared to the women with secondary education, the less educated women also appeared to show very little concern over their own reproductive health and physical wellbeing with regard to the strain of childbirth. Thandeka one of the women with only primary school education, explained that she knew she needed to get on a contraceptive method after she kept having children every 18 months. But she never found a method that she ‘liked’ and was left with no choice other than not using any form of protection. *“These babies kept coming, one after the other, as soon as I stopped breastfeeding I’d get pregnant again. My husband was also concerned...but you know men, he didn’t mind, since I kept giving him boys (She pauses and chuckles a little). It was almost killing me, but nothing seemed to work! I kept forgetting to take the pills, and the injection made me very sick so I just stopped going to the clinic.”* Her helplessness came with a certain level of pride at being able to bear five sons for her husband and there was a tone of what could have been reluctance at some stage to take charge of the situation. She only decided to sterilise after the birth of her 5th child at the doctor’s insistence, and concerns over her health after her last 3 children were delivered through caesarean section.

4.6.2 Perceptions on gender roles

Some of the literature reviewed in Chapter 2 showed how the recognition of gender equality was an important indicator of women’s empowerment. In this study, the women’s attitudes and perceptions of their gender roles were explored as previous studies have shown that there is a relationship between how women perceive themselves and their roles and their likelihood of using contraception. The perception of gender roles was closely linked to the household

economic decision making and the level of education. On average, the level of education was relatively low in this context, even for those women who had successfully completed secondary schooling and this might have contributed to the women perceiving their roles as being lesser than that of men. As previously noted, women with decision making power viewed themselves as almost equal with their partners while those with very little or no contribution in the running of the household perceived themselves as being inferior to the men in their lives. Interestingly, the level of education which has been found to increase knowledge on gender equality by some studies was not directly associated with a better view of the self in this community. Amongst the respondents, there were only two women who had post-secondary school certificates.

While it may be clearly understood that a woman with no decision making power in the relationship, occupies a lesser role, there were sometimes no clear cut associations between household decision making, the level of education and the attitudes towards gender roles in some cases. An example of such inconsistency was Helena, an early childhood development teaching assistant, also one of the two ladies with post-secondary schooling. During the interviews, she complained about how irresponsible her husband was, often disappearing for months and showing up at home whenever he felt like it. On decision making power, Helena confidently expressed making all the major decisions of the house. It then came as a surprise one of the Saturday mornings when Helena called off a scheduled interview to explain that her husband who did not like her talking to people he did not know, had unexpectedly come home and she feared that he would be suspicious and possibly aggressive if he saw her talking to a stranger in the house. Although making all the decisions in the house, Helena later proved to only have such power in the house in the absence of her husband but that all the power was diminished whenever he was present. Also, her education appeared to be of little significance with regard to how she viewed her independence to associate and also her role as a woman. She however did assert decision making over reproductive choices: *“I decided a long time ago that I will only have three children...I think he also wanted three because he never complained... and back then I always used the pill or the injection. Luckily, this man of mine is now interested in other women, he doesn’t bother me anymore and so there is no need for me to be on contraceptives”*

4.7 Contraceptive knowledge

I explored contraceptive knowledge in relation to the most preferred methods, why they are the most preferred and the characteristics of the women using the preferred methods.

4.7.1 Types of contraceptives

Studies done around Africa on contraception, show that unintended pregnancies for most women are a result of little or no education on sex, reproductive health and also contraception (Indongo and Naidoo, 2008). All the women who participated in the study knew at least one type of contraceptive method. Whilst most studies have found that significant differences are inherent in the types of methods preferred by women of different ages and races, the injectable contraceptive method was the most commonly known amongst the women in this study. Literature reviewed has shown that the contraceptive injection is still the most popularly known and used **method** of contraception amongst Black women and mainly those from poor socio-economic backgrounds, a precedent set by the country's past reproductive health policies (Burgard, 2004; Cooper et al, 2004)). It would appear that the poor socio-economic background of women in Diepsloot was a common binding factor that made the injection the most popular method across all ages.

For the majority of the women, knowledge of the different types of contraceptives was only limited to the injectable, the Pill and condoms. Only Sihle, a foreign national who had worked at a doctors' surgery for 14 years before moving to Diepsloot four years ago, was aware of all the modern methods available at the primary health care facilities.

A question on the women's understanding of the term contraception elicited the same response from almost all the respondents. '*Ukujova*' (a Zulu verb meaning 'to inject') was the term used to define all modern contraceptives by the respondents and as a result, the contraceptive injection was taken synonymously with all modern contraceptives. As a result, it became of utmost importance throughout the study to regularly verify with the respondents if they were talking of the contraceptive injection or other forms of contraception. '*O, you mean the injection, there are different types that I know*' was the response given by Samina when asked about her understanding of the word contraception. However further talk with Samina revealed that the 'types' she was referring to in this instance was not the types of the injectable contraception but rather the different types of contraceptive methods that she knew of.

4.7.2 Method choice

All the women in the study had used the injectable contraception at least once in their lives, and for many of them, this was after the birth of their first child. For the Diepsloot women, the most commonly used type of the injectable was the Depo-Provera, reportedly given immediately after birth or at the clinic when taking their new born child to the ‘two week’ check-up. All the women knew of both types of the injectable and differentiated them using the different time frames, and often called them ‘*the Depo and the eight weeks one*’. Despite the popularity of this form of contraception amongst the respondents, only two women in the study managed to accurately name and describe the two types.

This postpartum administering of the injectable contraceptive also highlighted that this form of contraception was more of a prescribed method for all new mothers, rather than a choice. Zinhle highlighted the lack of method choice when she explained that, “*When you take your baby to the clinic for the two weeks check-up, the sister tells you to go for the injection next door so that you can properly raise the child before falling pregnant again...they do it everywhere, back home and even here in Diepsloot clinics.*”

The above assertion also brought up the element of coercion into taking the injection, and the women were aware of it, but at most times powerless to resist. When the issue was explored further in the focus group discussion, most women thought it was mandatory that they be given the injection two weeks after giving birth. Samkelo also added, “*It’s a rule; every woman who has a child knows that!*” The commonality of the injection as the most prevalent contraceptive method of choice amongst Black South African women (South African Contraception Policy Guidelines, 2002), was therefore challenged. Women, as in this study, are sometimes given no choice. The assertions by the women also brought out the power imbalance between the women and health care service providers, who are “deemed experts of women’s bodies” (Committee on Women, Population and the Environment, 2002:3).

In an interview with the clinic Operations Manager at the Extension 2 clinic, she dismissed the ‘rule’ allegation expressed here by Samkelo and explained that they merely encouraged the women at the baby clinic on contraception and did not force them. “*We just use the baby clinic as an opportunity to spread the word... we still face a lot of resistance from the women anyway; if we forced them wouldn’t there be a significant reduction in fertility around this area?*”

The second most commonly known but less used contraceptive method was the pill. At the time of the study, none of the women was using this method. The women who had used it

previously were able to give a detailed description of this method although they had limited information on how the method worked. However none of them knew of the different types, that is, the combined oral contraceptive pill and the progestogen only contraceptive pill. In confirming the lack of knowledge around the contraceptive pill and justifying the role of the local clinic, the Operations Manager at the OR Tambo clinic in Extension 7, informed that the clinic encouraged the use of the injectable contraceptive above other methods due to the low levels of education and the nomadic nature of most of the service users.

“Most of the women who come to the clinic claim to be first timers, in fact 50% of them do not have their retainer cards, they lose them and they lie a lot about their contraception history... most of them are foreign nationals, they travel a lot and are most likely to miss their next appointments so we encourage them to use longer lasting methods, plus, most of them are not educated and a pill is likely to be too demanding for them to take daily.”

She further explained how common it was for the less educated woman to be less committed to this method and easily forget return dates and times to take the pill, which needs to be taken at the same time every day. Also, she highlighted the fact that most Diepsloot community members, especially those from the squatter areas are forever in transit and move a lot between places, therefore making it more difficult to visit the family planning clinic every month. As a result, the injectable contraception, a longer lasting method was promoted and thus more prevalent in this community. This legitimate promotion of the contraceptive injection, a longer lasting method over other all forms of method was a hindrance to women fully practising their reproductive health rights. They were seemingly, left with no choice, based on their unfavourable social and economic circumstances. The clinics were focused on prioritising prevention over health. Taking into consideration the concerns expressed by the women in this study over the side effects of the contraceptive injection, they either had to be prepared to face the incapacitating side effects of contraception or to face the consequences of a possible unplanned pregnancy.

The manager at the Marie Stopps Clinic however had a different account to method choice, and her explanation was more of a ‘willing buyer-willing seller’ transaction. *“Our services are not for free and when women come here they already know exactly what they want...The injectable contraceptive is the most popular but that’s because it’s their choice, unless if they ask for advice, consultation is free and we also have a range of other contraceptive methods available to women.”*

Condoms were also found to be popularly known but not used to prevent pregnancy and sexually transmitted infections. From the individual interviews, only one woman admitted to using it every time she had intercourse with her partner as a way of protecting herself against pregnancy and infections. From the focus groups, there was a common belief among women that condoms were not a reliable method of contraception as they were not liked by men. During one of the focus group discussions, Mary a 32 year old single mother informed that *“I’ve never met a man who wants to use condoms, if he says so, he doesn’t trust you and is afraid you have AIDS...men will only ask you if you are preventing and if you say yes its ok”*. All the women seemed to be in total agreement with this statement during the two focus group discussion.

Me: *Are you not afraid of catching STI’s?*

Mary: *AIDS is all over, one way or another you’ll catch it, your good boyfriend can bring it home and you die...*

Zinhle: *Ya that’s a difficult one, there’s little you can do...these men are so difficult.*

Sihle: *Ladies you have to learn to say ‘no’...! Men are difficult, yes...but don’t give him (sex)! You’ll get pregnant plus AIDS, who will look after your other children when you dead?Do you think I tell him that I’m on the injection? No! Because he will not use a condom...*

The indifference of the women in this discussion on extra marital affairs and their boyfriends having multiple sexual partners is a reflection of women’s subject positions in their relationships, and another expression of male domination, normalised by society’s acceptance of gender inequality. Osthuis (in press) discusses how multiple partners and unsafe sexual practises were “found to be normative vehicles for establishing the manhood of boys and men in several studies across South Africa.” With extra marital affairs and the sexual objectification of women being dominant and supported in the highest level of politics in the country, women are perpetually being relegated into subordinate positions at all structural levels. The continuation and normalisation of gender inequality also leads to a state of helplessness and fatalism, expressed here by the women in relation to HIV prevention. The assertions made by these women suggested limited power in negotiating safe sexual practices with their sexual partners. In a study on HIV risk factors in South Africa, Johnson and Budlender (2002) explained that most women from poor socio economic backgrounds use

sex as a source of income and financial support, and as a result they forfeit their negotiating power with regards to condom usage. Sewpual (in press) asserts that “it is critical that everyday life experiences become the context for learning, deconstruction and action”, and Sihle’s dissenting voice in the conversation is not only empowering but also highlights the value of group discussion in deconstructing deep rooted patriarchal ideologies.

Men however denied not wanting to use condoms, both for preventing pregnancy and STI’s. The group was made up of mostly younger men in their late twenties and thirties, who in my opinion, more involved in casual sexual relationships and were more aware of the risks of sexually transmitted infections.

Themba: *who are these women that you’ve been talking to? Unless you want to die of AIDS, then you won’t use a condom, there’s lots of AIDS out there!*

Simphiwe: *hey, and I don’t trust a woman who says she is preventing, I use a condom, always!*

While Themba’s statements referred to condom use as a way of preventing STIs, Simphiwe spoke in reference to pregnancy prevention, meaning that men were also generally aware of the dual purposes of condoms. However, both statements were said in casual, light-hearted tones and were followed by bouts of laughter and agreement from the rest of the group, several responded with “*Ya you die man...*” It was only Lucas, the only married man in the group, who felt that condoms were not necessary when married but that it was the responsibility of the woman to prevent pregnancy. Previous studies have shown the association of unsafe sexual practises and perceived masculinity as being dominant in most patriarchal communities and also that the awareness of STIs does not necessarily translate into condom use (Committee on Women, Population and the Environment, 2002; Chandran et al, 2012). As a result there was a possibility that some of the statements echoed here reflected group bias.

On condom promotion and redistribution, the Operations Manager at the Extension 2 clinic clarified that “*a condom is not a method, its mere protection against pregnancy, although we distribute a lot of condoms, we do not consider it to be a method.*” Although condoms are less popular amongst the older people and the less educated, (Johnson and Budlender, 2002), they are still a critical method in reproductive health issues. Some research studies on STIs have cited that the Depo Provera can be an independent risk factor in the transmission of

STIs, including HIV, especially amongst the poor, less educated women. (Mostad, 1998; Smith, Baskin and Marx, 2000). Given that most studies show that women from poor socio economic backgrounds are the most affected by HIV, and the seriousness with which the virus has affected the country, I got the impression that there was little concern amongst the women, the men and health care providers about the connections between HIV and sexual and reproductive health.

4.7.3 Adherence and contraceptive switching

Contraceptive adherence refers to sticking to a particular chosen method of contraception, while contraceptive switching refers to alternating between contraceptive methods (Jaccard, 2009). None of the women interviewed in this study reported adherence and consistency in use, rather, they had all got ‘tired’ at some stage and would take long breaks and resume use whenever they thought it necessary, even when they were in sexually active relationships. General dissatisfaction with a contraceptive method, especially menstrual disturbances caused by hormonal side effects, did appear as a major factor in determining adherence and continuation with a particular method. Mashudu: *“it’s not normal for a woman not to have periods; it’s a sign that something is wrong, where is all the blood going? It has to come out, so I usually stop for a while...and the pills make me sooo thin. You get tired of all these things in your body...you want to feel yourself again, that you are still a woman...!”* It did appear inexplicable that the women had a lot of problems with the injectable contraception, yet it still remained their preferred choice of contraception.

In a study on strategies to improve adherence to hormonal contraceptive methods, Halpbern, Grimme, Lopez and Gallo (2011:3) suggest that the “wide gap between theoretical and actual effectiveness” of some contraceptive methods is a result of human factors. Most of the women interviewed reported to have been alternating between the contraceptive injection and the pill. The majority of the women in the study did not adhere to a specific method of contraception and most cited side effects as their main reason for non-compliance.

Samkelo explained how she regularly alternated between the Pill and the injectable contraception, all because of side effects. She clarified that, *“the injection is easier, so I just go back to it every now and again; the Pills are good but complicated.”* Like Helena and several others, she believed that menstruation had detoxifying effects on the body. As a result, when she did not see her period for a long period of time, she would then resort to the Pill as she was guaranteed to see her menstrual cycle. After ‘seeing her period’, she then goes

back to the injectable contraceptive, which she describes as a less stressful method. Helen justified alternating between two methods: *“When the blood comes out of your body every month, it cleans your system...even your skin looks better. When I don’t see my period, my stomach grows big...then I have to use the Pill and it brings out all the blood...”*

The absence of periods appeared to be a concern to all women, even during the focus group discussions. The Operations Manager at the Diepsloot Extension Two clinic was aware of these concerns and cited lack of education amongst the women as the main reason for failing to understand how the contraceptives worked: *“the injectable contraceptives stop ovulation, it’s simple biology...there is no blood trapped in the stomach...But how do you explain ovulation to a woman who has never been to school?”*

4.7.4 Consistency in use

For any form of birth control method to be effective, the user must use it as prescribed and should also consistently use it.

Discontinuations also came without the proper consultation of a health care professional and common feeling among the women was that it was their choice and decision to discontinue using a method if they pleased. For example, Manxiweni, of the Zion Christian Church, resorted to using the *“church tea”* to detoxify her system of the contraceptives. *“I use the tea they give us at church to make my system clean again; Depo is very strong and stays in your blood for a long time”*. The local family planning clinic therefore was not viewed as a place of knowledge and consultation with regard to discontinuation and satisfaction of a contraceptive method, but rather seen as a walk in centre whenever contraception was seen as necessary.

The inconsistency was also echoed by the Operations Managers at two clinics in Diepsloot who explained that they had a problem with ‘habitual first-timers’ at the clinic. When the women attend the family planning clinic, they are presented with a clinic card with the next appointment date. However, because most of the women miss appointments for various reasons, they never bring their old appointment cards and have to be issued with new cards at every visit, making it difficult to track adherence and continuity. She further explained how the women who miss appointments and discontinue use for long intervals return to the clinic and pretend that they are new clients and deny ever being issued with cards before.

While Zandile admitted during the individual interviews that *“even if you go late, they never ask many questions, they just help you”*, some women felt and gave differing opinions during the focus group discussion. *“The nurses will shout at you in front of everyone and really make you feel like a baby, to avoid embarrassment; I never take my old card if I’m late”* was the explanation given by 22 year old Candice. The women in the group agreed that the nurses were very rude and reprimanded you for *“little mistakes”* in full view of other service users. Princess interjected and indifferently declared *“I’ve only been to that clinic three or four times since I came to Diepsloot, my shack is small and a little clinic card easily gets misplaced, is that my fault? ...they also have no problems giving us new ones!”*

4.7.5 Accuracy of use

According to Halpbern, Grimme, Lopez and Gallo (2011), COCs, the Pill, the injectable contraceptive, the vaginal ring and the patch are some of the hormonal methods that hugely rely on repetitive and correct use for success. With the contraceptive injection, which was the most popular amongst the women, accuracy of use would refer to timeously going for a reinjection after the specified period had lapsed. Almost all the women had missed their appointments from the clinic and usually went for long periods without any form of prevention method. Simphiwe informed that she got her injections from a friend of hers who worked at the clinic as she found the arrangement to be more convenient. The illegal arrangement of the contraceptive being administered outside the health facility premises was obviously open to problems with regard to the proper and accurate administering, but Simphiwe showed very little concern.

Contraception was sometimes taken too casually by the women so much so that the importance of compliance was treated with surprising indifference. Sibonelo is one such woman and she nonchalantly expressed: *“When I feel like the Pill, I usually ask from my neighbour who brings lots and lots of them from Zimbabwe...Just one pack is ok, and I go back again after some time...”* When I asked her if she had ever consulted with any health care professional about the right types of contraceptives in Diepsloot, she said she had never gone to any of the two clinics as she had heard of the legendary long queues, which also led to many questions on the correctness of use. *“You see going to the clinic is boring, you have to go and queue at 4am in the morning to get a number, then when the nurse comes, they count the number of people they want and they cut off the line! You get tired after some time*

and you don't go back there, but then after some time you have to go back, a woman needs these things..."

The triviality with which some of the women treated contraception translated from their lack of understanding of the real purposes of contraceptives. Contraception was treated as something that every sexually active woman ought to be taking but yet, hugely optional.

4.7.6 Myth versus fact

Exploration of contraceptive knowledge also extended to the awareness of known risks and precautions as knowing these risks leads to informed and improved choice. Despite medical science and international health standards having endorsed the safety and suitability of modern contraceptive methods, the women highlighted the many existing and commonly held myths around the use and acceptability of contraception. According to Ankoma (2011), myths are hindrances to family planning; they should be taken seriously by health care professionals, clarified and then countered by proper factual information. Most of the women in the study, knew of at least one myth on contraceptives that they strongly believed to be fact and these proved to be detrimental to their use and trust in contraceptives. Each of these myths is discussed separately.

Knowledge of how the contraception works requires basic understanding of the male and female reproductive systems. During the individual interviews and the focus group discussions, none of the women knew of the 'possible days' of falling pregnant, everyone strongly believed that sexual contact with a male at any stage of the menstrual cycle could result in pregnancy.

Also, all the women were not aware of the possible effects of hormonal contraception on their bodies, and whatever was not clearly understood was interpreted in the many different myths. For example, the injectable contraception works by stopping ovulation as a way of preventing pregnancy, and therefore a woman on this method is likely not to menstruate for the duration that she is using it. For the majority of the women using the injectable contraception, they simply knew that it caused an interruption of their menstrual cycle but were not aware of the exact causes of the disruption. Below are some of the commonly held myths that the women had on the use of contraception.

i) Infections

For some women, the myths were more directed at specific methods. Like Samina, who despite understanding that condoms acted as a barrier and prevented sperm from entering the uterus, therefore preventing pregnancy, her hatred for condoms came from the assumption that *“they give you worms inside and you get an infection and your man will say you have been sleeping with another man”*. In this instance I assumed that she was referring to urinary tract infections that some report to suffer from when using condoms. When I asked her to describe what type of infection it was, she explained that she had neither used condoms nor suffered from anything of that nature but had been cautioned by her grandmother against condom use and that two of her previous boyfriends had echoed the same ‘worm’ sentiments. The response was however atypical and none of the women in study shared the same myths about contraceptive use, even during the focus group discussions. Also none of the men in the group discussion knew of this.

ii) Sexual performance

For most women, the myths bordered around satisfying a partner sexually which translated in the man not straying to other women. Inasmuch as they knew that contraceptives were vital for good family planning, the prevention of pregnancy came secondary to ‘good sex’. During one of the focus groups, one of the ladies exclaimed: *“Awu, never...ever since I got off the Depo, Edwin’s father tells me I’m good. That thing made me wet, fat and tired and he even thought I was sleeping with other men while he’s at work...”* Most women in the group interjected with a “yes” showing total agreement when this statement was made. Asked if she would consider switching methods, she informed that *“these things are all the same...I will see”*. She expressed with a smug look on her face probably from being able to share her plausible sexual experiences with the group and the admiration she had got from the other women, for being able to take charge of the situation and save her relationship.

Zinhle also acknowledged improved sex after stopping using the COC. The statement came after she explained how there was no suitable method for her and she always reacted with many of the methods she had tried. She first explained how the COC gave her terrible headaches and had uncontrollable weight loss. Later during one of the interviews, when asked on the number of contraceptive methods she had actually tried and reacted badly to, she revealed that she had only used the COC, had once tried the 2 month injectable contraceptive and the occasional use of a male condom. The COCs and the injection had made her lose her sex drive and she felt she was at risk of losing her long term boyfriend and father of her 4

children, as he had already started complaining of her abnormally ‘*loose vagina*’ and her lack of interest in sex.

I asked the men during the focus group on their position with regards to contraceptives interfering with the sexual lives of the women. None of the men admitted if they would ask the women to stop using contraception for sexual pleasure and appeared uncomfortable discussing the issue. Thabani, much to the relief of other group members, nonchalantly dismissed it as women’s matters, not to be discussed with men, and all men seemed to agree. *“These are women’s things you are talking about, we don’t know how they sort these things out...but a woman has to do what she has to do to make things work.”*

iii) Infertility

The use of contraception before the birth of one’s first child was also another fear. The women believed that using contraception before having a child could also result in lifelong infertility. As a result, all but one of the women had not used contraception to prevent and plan the birth of their first child. *“It’s important to see if you can have children first”* was the reason given to justify the non-use before the first child. However, secondary infertility was also another fear amongst the women. All women appeared aware that prolonged use of contraceptives caused could lead to infertility. *“Young girls should never use the injection, but they give them at the clinic, I guess things have changed nowadays”*, Sibonile said with concern during the group discussion. Although the causes of infertility associated with prolonged use of contraception is a fact supported by medical research (Committee on Women, Population and the Environment, 2002), the women were uninformed on it. For them, the most common method of contraception was the injection, which leads to the absence of monthly periods. Such an absence was then taken to mean that one could no longer have children, even if they desired to.

Zandile a 34 year old single mother of five had never used contraceptives all her life, despite having given birth in modern clinics. She only started using the contraceptive injection for birth control after the birth of her fifth child. She described how she ‘*always ran away*’ whenever she was referred to the family planning clinic by the nurse, after every birth of four of her children. *“Those things (contraceptives) just make you bleed and bleed...and before you know it, you will not be able to have any more children”* she explained. This perceived contraceptive barrier, expressed through her fear of the infertility causing contraceptives, was

not based on any previous experiences or observations, but was a result of a general belief she held that all methods offered at the clinic could result in secondary infertility.

iv) Weight gain

Uncontrollable weight gain or loss was also believed to be an inevitable circumstance when one is on any contraceptive method. Manxiweni had the liberty to explain to the women during the discussion how she had lost more than 9kgs in 6 months after coming off the Depo-Provera injection and how she was currently not on any method, therefore suggesting an inextricable link between contraceptive use and weight gain. She received a lot of admiration for her weight loss from the rest of the group. The operations manager at OR Tambo clinic had explained during her interview that some contraceptives led to an increased appetite and that none of the methods had a calorific agent like most of the women believed. A more plausible explanation could have been that Manxiweni was eating less since coming off the injection but she strongly believed that there was something in Depo-Provera injection that had made her gain all the weight. During the focus group discussions, I teasingly asked if any of them had ever considered regular exercise and watching the type of food they were eating in order to control the weight gain and the suggestion was quickly dismissed with a bout of laughter on both occasions. *“Do we look like white women now..., what will the people say if they see me running up and down the street...it’s better to stop the injection”*, a response given by one of the women during one of the focus group discussions.

v) Abortion

Candice, a 22 year old mother of three explained that she would never use the injectable contraception because she had heard from her mother that it does not prevent fertilisation from taking place, but it worked by *“killing the baby every time you get pregnant”* and for her, that was as good as permitting abortion, which she believes is a big sin. To justify her claim, she further explained how she had heard that women on the contraceptive injection suffer from excessive bleeding, which was a result of the terminated pregnancy that her mother had told her about.

4.8 Traditional contraceptive medicines and prevalence of use

The use of traditional contraceptives acquired through traditional practitioners was very low. Only two women in the study reported having used traditional healers and both reported that the prescribed methods had failed. Sibonile explained how she and her husband had consulted with a traditional healer for contraception after she kept reacting to the Depo-Provera and the COC, which made her lose her hairline and affected her moods. She, in her opinion, was however *“fooled by these Diepsloot crooks that are not honest enough to tell you that they do not have what you are looking for.”* She further explained: *“after burning incense and praying to the ancestors to hear my requests, he (the traditional healer) gave me a red string that had been dipped in a mixture of herbs. He instructed that I tie it around my waist and that it would prevent pregnancy as long as I did not remove it. It was meant to work for as long as I kept it on...but as you see (she points to her two youngest children), my R250 went for nothing.”* Princess also shared a similar experience and informed how she had been given herbs to drink and some to bath with for a week before she was deemed safe from falling pregnant. The method had failed and resulted in the birth of her second child.

Dube, the first traditional healer interviewed explained how *“these young women that come here are not ready to listen...you tell them one thing and they go do the other. The medicines we give will not work if they don’t follow the instructions. We tell them not to sleep with a man for a certain period of time, but do they listen...? No! They come back to complain. You have to respect the guidance of the ancestors...these are sensitive things.”* For him it was the failure of the women to respect the ‘powers’ by following the prescriptions that led to method failure. On the effectiveness of modern medicines, Dube informed that he would not advise against the use but felt that man is closely linked to nature and the ancestors, in which all cures and solutions are found, traditional medicines were the most effective, if properly followed and respected.

Nyatongo, the other traditional practitioner concurred and emphasised that failed expectations were a result of failure to adhere to the prescriptions. According to him, *“the traditional contraceptive herbs have not lost their power, it’s the people that have lost faith..., the women lack commitment and discipline, we have rules that have to be respected...or else the herbs will not work.”* He emphasized that traditional medicines were only a part of the larger African traditional religion and that traditional healers were not to be used as shops for herbs but rather as mediums of divine communication with the ancestors and healing. Literature

reviewed also showed that the prevalence of traditional contraceptive medicines was low amongst South African women, as reflected in this study.

4.9 Contraceptive dialogue as a contributing factor of contraceptive use and choice

According to Idingo and Naidoo (2008), effective and consistent contraceptive use and uptake is usually a result of women encountering encouragement through peer networks, the mass media and adults. Day to day dialogues on contraceptives proved to be a medium of communication and knowledge for most of the women. Although most of the women admitted to having their first exposure to contraceptives at the family planning clinic after the birth of their first child, most of the subsequent information was acquired through dialogue, more than through the clinic. The information passed through these conversations also proved to be a strong determinant of contraceptive use and choice.

4.9.1 Adult child communication

There appears to have been a relatively strong influence in terms of adult-child communication where most of the women admitted to having been informed to a certain level of contraception by their parents or adult figure in their lives and then the later information was mostly from peer groups. However, the information relayed was not properly on reproductive health and detailed contraceptive choices and benefits. Rather, the women reported that most of the information they received discouraged pre-marital contraceptive use as this was believed to cause infertility, and were told to avoid pregnancy by abstaining from sex. Balosi explained, *“When I started having my periods my grandmother told me I was going to get pregnant if I let a man touch me...can you imagine being pregnant at thirteen...I became afraid of men”* Indigo and Naidoo (2008) suggest that parents or authority figures are often unwilling to discuss comprehensive and accurate reproductive health information due to their discomfort in providing such and the fear of promoting sexual activity. As such, almost all the women in the study entered into sexual relationships with inadequate reproductive health information - resulting in unintended first pregnancies, also clarifying the issue discussed earlier on in this chapter, where most women reported to have first started using contraception after the birth of their first child. Samina felt this was a disadvantage of *“if I had known about contraception back then I would not have fallen pregnant at such a young age (nineteen), the nurses were going to demand my mother’s name and then run and tell her that I was at the clinic looking for contraceptives...it was only married women and young girls with children that went to the clinic.”* Even in their adult life, some of the women

explained that they still had not discussed contraception with their mothers as they felt that such was too personal to discuss with an authority figure in your life.

4.9.2 Peer discussions

Topics on contraception were favourably discussed amongst women. Not only did the women actively participate in the focus group discussions but they also informed that they still discuss and share a lot of information on contraceptive use in their social circles. Peer discussion played a very important role in contraceptive use and choice. Samina shared during the individual interview, *“I spoke to this other girl who lives a few shacks away from me and she also told me how she had reliably used soda and warm water to prevent pregnancy for many years...many women know different methods...better than the clinic ones, you just have to ask.”* Most women in this study were eager to share information and contraceptive choices and side effects, based on their experiences. They were all of the opinion that their own experiences with contraceptives were better truth compared to what they were told at the clinic. As a result, the women placed more value in their shared experiences with contraception, which were sometimes clearly seen as a common burden more than a convenience. Believing that they knew better than the health care professionals at the clinic, was obviously detrimental to the effective use of contraception.

4.10 Opinions on prevention of pregnancy

The prevention of pregnancy occurs only when an individual has the desire to prevent pregnancy by making an informed decision to use contraception. In the study, not all the women had clearly set out to prevent pregnancy and they were engaging in unprotected intercourse. Eleven of the women in the study reported not using contraception at the time of the study, despite having no desire to fall pregnant. Of the eleven, two were using unconventional methods that they believed could prevent pregnancy. Only one informed not using contraception because she needed to have her last child. Eight of the women were using modern contraceptive methods to prevent pregnancy. Reasons for non-use as, discussed earlier in this chapter, varied from sheer reluctance to go to the clinic, belief that the contraceptives remained in one's system beyond the specified time, breastfeeding and dissatisfaction with side effects associated with some of the modern methods.

4.10.1 Relationship stability as a determining factor

For the women who were currently using contraception, the prevention of pregnancy was not based entirely on the desire not to fall pregnant, but sometimes on the type of relationship the women perceived themselves to be in. For example, if a woman felt that the man she was currently involved with was responsible enough and likely to financially support his child in that eventuality, then they had reason to fall pregnant.

“He bought me a cow, I think he’s a good man...” was the statement used by 36 year old Samina, justifying her decision to have a 5th child with a married man she’s been seeing for the past 6 months. She was not on any contraceptive method at the time of the interview and intentionally wanted have another child. Samina had been given money by her partner to buy the cow as a personal gift for her rural home and it was much appreciated by her family as well. None of her previous boyfriends had ever given her a present of such value, and he was thus categorised as a responsible man, worthy of being given a child. Interestingly, none of the women other than Samina boldly admitted having a child in exchange for gifts perceived to be of a huge value although most did insinuate during the conversations that they would have a child with a ‘responsible’ man. *“Diepsloot women do not prevent pregnancy for the money...they want to please new boyfriends and they end up with many children from different men”*, declared 42 year old Hemina during one of the focus groups. There was agreement from other women in the group, giving me the impression that this was an observed trend in this community and that the judgement was being passed on Diepsloot women in general and not necessarily those in this group.

4.10.2 The responsibility of preventing pregnancy

Almost all the women in the group agreed that being in a stable new relationship usually results in a child, if a woman is *“not strong enough”* to refuse having a child with a new partner. On the question of whose responsibility it was to prevent pregnancy, there was a strong consensus among the women during the focus group discussion that it was the duty of the woman to say ‘no’ and refuse having a child with a boyfriend or partner, as *“all men always want to have children regardless of their age.”* This assertion was slightly different to what most of the women had expressed during the individual interviews. Throughout the interviews, the women gave an impression of being relatively powerless in reproductive health decision making.

Most women gave the impression of being indirectly coerced into having some of the children that they had in their lives. Sometimes marriage is an oppressive institution that

emasculates the only power that women have over their bodies. One such example is Sibonile who explained that she never intended to have more than three children. However when she met her current husband, she already had 2 children and her husband had always wanted to have 7 children. After their customary marriage she felt it was her duty as a new wife to have children and honour her husband's wishes as expected by custom. She then went on to have 5 more children, not because she wanted to, but she was forced by circumstances.

“By then he wasn't happy because some of his nieces had children already and he did not. He was 28 already...very late for a man to have his first child. My last baby was still very young but he didn't want to wait...I had to give him babies, what was I to do? What were my mother in-law and his sisters going to think of me? He wanted his own children and now he is happy they are 5 and he says I should stop a little...”

4.10.3 Economic circumstances a determining factor

According to some of the literature reviewed, less empowered women living in low socio economic circumstances are most likely to conform to traditional values and men's opinions regarding the use of contraception and child bearing (Clement and Modise; 2004).

The suggestion of women having children as a result of pressure from new relationships also explains why the unmarried women had more children than their counterparts. Although they were perceived as weak by the others for failing to refuse another child, they are usually forced by the unfavourable circumstances in which they find themselves. Having an employed boyfriend or partner was something that almost every woman in the study desired or was proud of, mainly for financial reasons. It thus became apparent that sometimes children were used as tokens of maintaining relationships. Although none of the women admitted to having had children to keep the relationship afloat, most women in the focus group sessions agreed that having a child to safeguard a relationship was something that most women did. *“Women try to keep their men by having children with them...”* was the statement raised on many occasions by the women, during the interviews and the focus group discussion. Undeniably, some of the women agreed to have a child just because the man or partner wanted a child.

The Operations Manager at the Extension 7 clinic also raised the concern when she highlighted that most women in Diepsloot still did not have control over their bodies or reproductive health, where most decisions regarding when to have a child are still made by

their male partners. *“I don’t know if it’s a cultural thing or what, but most women that I meet here on a daily basis do not feel like they own their bodies...they must be educated and empowered to say ‘no’...Black women feel like they do not have a choice!”* She expressed that they did not realise the autonomy they had over their bodies and health, regardless of the socio economic pressures and that of the men in their lives.

4.11 Spacing vs limiting the number of births

Women that had been in long term relationships had fewer children, mostly three or less. However, marriage or long term unions were not the exception for large family, as Silindile, a 30 year old married woman had given birth to four boys in a space of seven years. Spacing was an issue for her and she had finally decided to go on a permanent contraceptive method, although she was yet to make such an appointment. Asked why she was considering something as permanent as sterilisation, she explained that she had followed the doctor’s advice as she had an extremely difficult birth and had *“almost died”* in labour. Even with a bit of probing, she never any stage of our interviews mentioned her ideal number of children. It was the near death experience that she had had that she considered *“a sign from the gods that they (the children) are now enough”*. It was the women who were in more unstable relationships that had more children.

An undisclosed ideal number of children was also characteristic of the more rural and the functionally illiterate women in the study. Balosi felt that she could always have one more if she met a man willing to have a child, with the hope of securing a long term relationship and not necessarily marriage. It was her desire to have one more child added to her six children, already born with three different men. Her other justification for having more children was that she came from a very small family and never enjoyed support of her siblings and she wanted her children to be there for each other. She explained: *“my children will not suffer; they will be there for each other...if one has a problem she will go to her brother or sister who will help her. They will not be like me, every time something needs fixing back home my mother calls me, all the burden is on me alone...my brother is married and never helps.”* She also added that her many children would make a collective effort to look after her in old age.

4.11.1 Spacing amongst married women

Most of the married women in the study and those in long term relationships had a greater number of children, with the exception of two women who had seven children each. Six of

the married women had three children each. Sibonile and Sibonelo, the married women with the seven children were uneducated, both not having completed the primary school level of education. In overview, married women appeared more in control of their reproductive health and were mindful of the ideal number of children. The pressure to limit the family size appeared an economic decision that also came as a result of long term plans that they made with their spouses or partners, an issue that was not characteristic of their single counterparts. Samkelo commented that, *"times are hard, paying rent, sending children to school and buying them food is not easy, you just cannot have a child, unless your husband agrees...my last child almost destroyed my marriage."* For Mary, spacing children cautiously and limiting family size was an economic issue that she jointly reached with her husband and considered it vital to keep her marriage intact, to the extent that she had secretly terminated an unplanned pregnancy over a year ago when she discovered she was pregnant. *"I couldn't help it, how was I going to explain falling pregnant to my husband when we had said that we were not having any more children, it was difficult to have another child at that time."*

4.11.2 Social environment that supports high fertility as a hindrance to contraceptive use

Although Diepsloot is largely believed to have a high birth rate, especially by welfare organisations working in the community, it would be faulty to assume that Diepsloot as a community supports high fertility as it is made up of many diverse people with various backgrounds. Also, efforts to get the exact fertility rate of this community from the City of Johannesburg records were futile. Most of the women interviewed in the study still held firmly to their personal beliefs with regard to child bearing and the use of contraceptives. The personal beliefs were strongly influenced by background and other factors discussed here such as such as male domination, marital status, level of education, and socio economic circumstances. According to the social cognitive theory, people not only learn from their behaviour but also from observing other people's actions and the results of those actions too. However, a lot of factors also came into consideration as discussed.

4.13 Conclusion

In this chapter is the presentation and analysis of findings. I have discussed themes that emerged during the study, based on the aim and objectives. Themes discussed include empowerment and reproductive health decision making; knowledge of contraception; contraceptive dialogue and choice; perceptions on the prevention of pregnancy and the

accessibility and availability of contraceptives. The next chapter concludes the study through a summary of the research, the main findings and conceivable recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This is the final chapter of the study. It begins with a summary of the study, followed by a discussion of the main findings of the research, then the recommendations drawn from the major conclusions.

5.2 Summary of the study

This study was on women and contraceptive use and was a case study of the Diepsloot community, an urban informal settlement, north of Johannesburg. It was guided by the feminist and critical theory, and made use of the qualitative research design mainly due to its exploratory nature. The history of the provision of reproductive health services in South Africa has been discussed as a process that has both marginalised the participation of communities and limited the scope for contraception use in the post-apartheid era (Maharaj and Rogan, 2007). The effects of Apartheid are still visible in present day South Africa, previously disadvantaged groups are still poor, with most Black women remaining disadvantaged at the bottom of the social and economic ladder (Sewpaul, 2005; Sewpaul, in press). Hence, the aim of the study was to explore the subject of contraception amongst women living in Diepsloot, an impoverished community. Objectives were mainly based on efforts to understand knowledge of modern contraception from the point of view of women living in Diepsloot, an urban informal settlement.

Critical theory asserts that our knowledge of reality is shaped by social, cultural, political and gender based forces that have been refined over time and preserved into social structures (Guba and Lincoln, 1994). It also contends that social realities are historically generated and that social issues are not ‘naturally’ occurring, but socially created and influenced by power inequalities (Osthus, in press). As a result, one of the main aims of critical theory is to challenge the existing power structures (Shermain and Reid 1994) and this is similar to the feminist research aims, which focus at empowering women and other marginalised groups, as well as encouraging social justice and social change for women (Hesse-Biber and Brooks, 2006). Feminist theory, is critical in nature and is concerned with social inequality, but most importantly, begins from the standpoints of women, as it seeks to bring women’s voices to the fore (Brayton, 1997). Through documenting the lives of women, their experiences and highlighting gender based stereotypes (Hesse-Biber and Brooks, 2006), feminist research challenges social structures and aims at exposing socially and politically gendered contexts (Brayton, 1997).

The use of contraception is a multifaceted phenomenon, explained by multiple realities and making it of importance that the study be conducted in a natural setting or context, and hence a case study was chosen as a more appropriate research method. Case studies have the advantage of uncovering the contextual conditions related to contraceptive use, thereby providing a thick detailed description of the experiences of the respondents (Baxter and Jack, 2008). Marshall (2006) explains how the qualitative research design is essential in studies

that seek to understand a phenomenon as experienced by a specific group of people as it goes beyond simply understanding the surface meanings attached to particular actions but further exposes the researcher to an understanding of the meanings that everyday activities hold for people, thereby gaining a richer detailed understanding of the subject. Gender is a social category created by culture and it was one of the aims of this study that its definitions and other categories linked to it be defined and investigated through first hand experiences of the women in the study. As such, qualitative methods such as in-depth interviews allow for exploration of meanings from the point of view of those being investigated (Kraus 2005:759). Qualitative methods used in the study included interviews, focus group discussions and naturalistic observations, as they recognise the social context, and also enable a thick and rich description of a phenomenon under investigation (Tuli, 2010).

I used the non-probability purposive and theoretical sampling methods. The sample size was theory driven and largely determined by the type of data acquired after a series of interviews with twenty women over a five month period. Data collection ceased when data saturation had been reached. For triangulation purposes, primary health care service providers from the two local clinics were interviewed; also one focus group discussion was done with a group of eight men; two traditional healers and the manager at the local Marie Stopps clinic were also interviewed for the same purpose. I used thematic analysis as the method of analysing data. Thematic analysis moves beyond merely describing the data but identifies both the unspoken and obvious ideas within data (Guest, McQueen and Namey, 2011). It was the intersectionality of contraceptive use and the unique lived experiences of disadvantaged women that had inspired the study and all methods employed were aimed at a deeper understanding of the effects of the cultural, social and economic environment on the reproductive health choices of the women that exist within it.

5.3 Major conclusions

The data from the study was analysed according to the seven themes that emerged from the study and these were:

- i. Empowerment and reproductive health decision making
- ii. Level of education as a determining factor in contraceptive use
- iii. Contraceptive knowledge

- iv. Contraceptive dialogue as a contributing factor to contraceptive use and choice
- v. Opinions on the prevention of pregnancy
- vi. Spacing versus limiting the number of births
- vii. The availability and accessibility of modern contraceptive methods

Several studies on contraceptive use have examined the level of women's empowerment as a determinant in the use of contraception. The definition of women empowerment used in this study was one provided by Malhotra, Schuler and Boender (2002:27), which defines women empowerment as referring to "decisions that influence a person's life trajectory and subsequent ability to exercise autonomy and make choices". Focus was on whether and how contributing to the household income influenced the balance of household power and reproductive decision making. Three types of relationships in this regard emerged. Firstly, there was a group of women that had an income and had a contribution to the household decisions, and a certain level of reproductive health decision making. Also noted was that the amount contributed by this group of women to the household was not directly relating to the amount of power. The mere ability to contribute to the running of the house gave the women in this group a voice in reproductive health decision making. Secondly was the group of women contributing in the household income and yet having no contribution to the household decision making, and ultimately with no reproductive health decision making power. The third group of women had no contribution to the income, no voice in the household decision making power and also gave the impression that they had no autonomy over their reproductive health. From the three types of relationships, it became evident that making a financial contribution to the household income had an effect on the sexual relations of a couple and also an impact on the reproductive health decisions. However, as highlighted in a study by Do and Kyrimoto (2012), the relationship between household balance of power and women's reproductive health behaviour was not always consistent. Other factors that affected household balance of power were level of education, marital status and age.

The level of education as a determining factor in contraceptive use was also one of the emerging themes in the data. Focus was on the differences in contraceptive uptake between the less educated women in the study and those who had completed a secondary and post-secondary level of schooling. Contraceptive use was very low amongst the women with less education, whilst with the more educated use was relatively higher, other factors like marital

status and household income all had an effect on the use of contraception. Amongst the women with less education, especially those with more children, concern over their own reproductive health and physical well-being was treated with a certain level of indifference. The more educated women were more concerned with the strain of childbirth and made efforts to prevent unwanted pregnancies. The perception of gender roles and how these perceptions affected reproductive health decisions were mainly determined by the level of education and marital status. It was the married women with less education that viewed themselves as occupying a subservient role to their partners.

Contraception knowledge was analysed on the knowledge of the different types, consistency and accuracy of use, including some of the commonly held myths by the women. Only two women in the study were able to accurately name and describe the modern contraceptives. The contraceptive injection was the most commonly known method, followed by the Pill and the condom; other forms of contraception, even those available at the local clinic were unknown to women. All women knew of contraceptive injection and all of them had used it at some stage in their lives. The local clinic still promoted the injection above all methods and cited low levels of education, nomadic lifestyles and poor adherence as reasons for encouraging this method. Despite popular use of the contraceptive injection, women were still not properly informed on the side effects that came with the method and most fears, though factual, were not based on informed medical advice, but were held as myths.

Contraceptive dialogue as a contributing factor to contraceptive use and choice also emerged as one of the dominant themes in the study. Adult- child communication and peer discussions were used to pass contraceptive information. Women acknowledged that they placed more value in sharing their experiences, which they considered 'real' when compared to the 'inadequate information' that they received from the local clinics. On child-adult communication, almost all the women felt that they had received inadequate information and support on reproductive health when they reached puberty.

Opinions of the women on the prevention of pregnancy were also explored as an emerging theme. Cultural and economic circumstances were found to have an influence on the desire to prevent pregnancy. Women from backgrounds that supported a high number of children were less concerned with using contraception to prevent pregnancy. Relationship stability was used to determine the importance or the triviality with which prevention of pregnancy could be treated. Because of the unfavourable financial circumstances of many women in the study,

children were used to secure long term relationships with partners that were considered responsible and capable of financially maintaining their children. Strangely, both men and women felt that the prevention of pregnancy was the responsibility of the woman.

The availability and accessibility of contraceptive methods in Diepsloot was also explored as an emerging theme. Although contraceptive services were physically accessible, the unfavourable circumstances of the women made them unreachable. Also, a range of modern contraceptive methods was available from the two local clinics but the uses of the other methods were limited due to the promotion of the injection. Some of the services that were not available at the clinics, such as termination of pregnancy, were available at local Marie Stopps centre, at a cost, or through referral to the nearest government hospitals. Although modern contraceptives were certainly available in this community, they were not accessible to all.

5.4 Recommendations

The study brought out the inextricable link between education, poverty and gender inequality. One of the most important catalysts in women's empowerment and achieving gender equality is education for women and girls. Lack of education, unemployment, poverty and inequality are all interrelated and intersect at different levels to render women invisible and inaudible social actors. As highlighted in the study, there is still a great need to prioritise the education of women as a means to achieve autonomy in making decisions that affect their well-being and their reproductive health rights. Women in poor marginalised settings are still too bound by their circumstances and are subordinate to men so much so that they are excluded from participation in decision making, even on matters that are central to their development and well-being. The need for the recognition of gender equality and women's education as a human right should not be underemphasised. Lack of education prevents women from gainful employment and economic freedom; affects their sense of self-worth and is detrimental to their existence and well-being.

Poor communities, especially in the context of rising unemployment, are seen as cheap labour reserves and provide labour exploitation opportunities for employers bent on paying paltry salaries. Basing on the low salaries paid to the women and the men in marginalised communities such as Diepsloot, - whether formally or informally employed - there is a need for increased government intervention in the form of labour administration and inspection. Decent work according to the International Labour Organisation amounts to work

opportunities that are productive and deliver a fair income. Labour exploitation is endemic and the effect is the continuation of poverty. Labour policy makers need to protect those marginalised. “Largely because they are earning such low wages, the working poor face numerous obstacles that make it difficult for many of them to find and keep a job, save up money, and maintain a sense of self-worth” (Ehrenreich, 2001)

South Africa’s concern with growth economics has alienated the poor. The uneducated and unskilled in the country have remained trapped in their situations with very little hope for improvement. As such poverty alleviation efforts should focus on the structural causes of poverty and on structural means of poverty reduction. The introduction of the Basic Income Grant (BIG) as a social safety net has been identified as an addition to the existing policies aimed at addressing poverty (Meth, 2008; Sewpaul 2005). Based on the unequal distribution of resources in the country, where a large section of the society has little access to the wealth while a small minority enjoys it disproportionately (Harber, 2011), proponents of the BIG argue that this low cost social policy can easily be sustained by the country’s middle class. Meth (2008:7) acknowledges that although “the security of many in the least secure groups has improved”, so much more can be done “if the security of all members of poor households had been taken into account.” In the case of Diepsloot, the BIG will provide the disadvantaged, mostly women, with a source of income, making them less dependent on the men for survival, thereby giving them a certain level of decision making power on issues that affect their well-being.

The media has a big role to play in facilitating the inclusion of the underprivileged and marginalised groups through consciousness raising. There is a need for the media to pay closer and more insightful attention to these areas of appalling poverty, not as areas housing criminals and other social undesirables waiting to cause commotion through service delivery protests, but as valuable elements of analysis of the country as a whole. Harber (2011:222) comments that “...partly because, in the ‘rainbow nation’ spirit of reconciliation, and in the determination to make a young democracy work, most of us do not want to face up to the most threatening and difficult issue of our society: the vast haps in wealth and access to jobs, services and opportunities.” As a result, areas like Diepsloot and its people are ignored by the media. Harber (2011:216) advises that it is good journalism, through the media and other similar community outlets that will bring attention proper development issues, and “hold the authorities and politicians accountable for their promises.”

As discussed in this section, lower level of education, views on gender roles and unfavourable economic circumstances impact women's empowerment and autonomy to make favourable reproductive health decisions. The study highlighted the need to empower Diepsloot women on their reproductive health rights, to enable them to make more informed and favourable decisions, both in the home and when dealing with the primary health care service providers. As such reproductive health education needs to be sensitive to the women's cultural backgrounds, as they proved to be influential in determining contraceptive use and family size. The Operations Managers at the two clinics both cited understaffing as reasons for failure to educate the women individually on contraceptive choices. There is definitely a need to increase the mediums of communication on reproductive health issues, in order to reach out to the large Diepsloot female population, currently deprived of contraceptive information. A possible solution could be for the clinics to partner with other local NGOs in the area dealing with gender issues, in educating the women on the available types of contraceptives methods, their side effects and on where and how to access other related reproductive health services. ABET is also another channel through which the reproductive health issues can be discussed, by including topics focusing on reproductive health empowerment. Also meeting and chatting with the women in their own spaces rather than formal clinic settings will increase the likelihood of them opening up and addressing their concerns and challenges with contraception.

To facilitate awareness on current reproductive health issues affecting women in Diepsloot, workshops on the findings of the study can be conducted with clinic staff, organisations that train health care workers and with men. Literature reviewed highlighted service provider attitude as one of the barriers to effective contraceptive use and this also came out in the findings of the study and it will therefore be necessary that it is reflected during the workshops for better service provision. These workshops should also focus on the specific reproductive health needs of this community, brought out in the study, necessary for promoting a family planning programme designed to address the needs of Diepsloot women. The study also highlighted a disparity between reproductive health intentions and outcomes, not only for the women but for the men as well. Although the men felt that prevention of pregnancy was the responsibility of the women, most of the women expressed general male disapproval of contraceptives. There is still a need to create male awareness on reproductive health matters and to further engage them as active participants in the reproductive health decisions of their partners.

The circumstances of the women in this study and those of the Diepsloot community speak to the broader economic issues of the country. As discussed, the biggest area of need is that of empowerment, and empowerment in all its related forms. To facilitate inclusion and participation of the marginalised and “in seeking to secure and improve the rights of the poor and the disadvantaged, policy makers and practitioners must make provision for people to know their rights, to define and assert their rights and to realise and exercise their rights” (Sewpaul, 2005:312).

5.5 Conclusion

The chapter gave a brief summary of the study, and background of the study, outlining the main aim and objectives. Also discussed were the major conclusions made, based on the study’s seven emerging themes. Some of the main themes from which the conclusions were drawn included empowerment and reproductive health decision making, effects of level of education on contraceptive knowledge and the availability and accessibility of modern contraceptive methods. The chapter ends by suggesting recommendations, based on the research findings and conclusions made. The objectives of the study, as highlighted in Chapter 1, have been met.

REFERENCE LIST

- Adebajo, A, Adedeji Y.Tand Landsberg, B (2007): *South Africa in Africa: The Post-Apartheid decade*. University of KwaZulu Natal Press, Durban, South Africa
- Adebisi, I.M. and Bello, S.O (2011) An ethno botanical survey of herbal male contraceptives used in South West Nigeria. *African Journal of Pharmacy and Pharmacolgy* 5(2), 289-291 Academic Journals
- Agadjanian V (1998) Women’s choice between indigenous and Western contraception in urban Mozambique. *Women and Health* 2(28), 1-17. Research Gate

Agadjanian,V (2005) Fraught in ambivalence: Reproductive intentions and contraceptive choices in a Sub Saharan Fertility Transition. *Population Research and Policy Review* 24 (6)56-76. Accessed online on 29 September 2011 on <http://www.jstor.org.ezproxy.ukzn.ac.za:2048/stable/40230928?seq=48Search=yes&searchText=traditional&researchText=Africa&SearchText>

Anderson, E (2010): intersectionality, critical race theory and American sparring oppression: Examining black and gay male athletes. Anderson, E and McCormack, M: *Journal of Homosexuality*, 57:949-967, 2010. Routledge, Taylor and Francis Group, Ltd.

Awolalu, JO (1972) The African traditional view of man. *Orita, Ibadan journal of religious studies*. Vol 1, No 2 pg 101-118. Springer

Babbie, E and Mouton, J(2010) *The Practice of Social Work Research*. Oxford University Press Southern Africa (Pty)

Bafana, T (2011) *Factors influencing contraceptive use and unplanned pregnancy in a South African population*. Accessed online on 30 March 2011 on <http://wiredspace.wits.ac.za/handle/10539/9284>

Basu, A.M and Koolwal, G.B (2005). Two concepts of female empowerment: Some leads from DHS data on women's status and reproductive health, in S Kishor (ed). *A focus on gender: collected papers on gender using DHS data*. Pg 15-53. Calverton, MD: ORC Macro

Bearack ,B (29 June 2009) *Constant fear and mob rule in a South African slum*. The New York Times. Accessed online 10 October 2011 on <http://www.nytimes.com/2009/06/30/world/Africa/30safrica.html>

Best, S. (1999) Nigeria. *The Islamist Challenge: the Nigerian Shiite movement. Searching for peace in Africa*. Ibadan press. Lagos, Nigeria

Biddlecom ,A.E and Fapohunda, B.M (1998) Covert contraceptive use: Prevalence, motivations and consequences. *Studies in Family Planning* 29 (4), 64-72. Accessed online on 28 June 2011 on <http://www.jstor.org/stable/172249>

Biddlecom, A.E (2008) *Adolescent fertility and reproductive health programmes in developing countries*. Guttmacher Institute. Accessed online on 14 April 2011 on <http://www.un.org/esa/population>

Biddlecom, AE and Fapshunda MB (1998) *Covert contraceptive use: prevalence, motivations and consequences*. Population council, New York. Accessed online on 23 August 2012 on <http://www.popcouncil.org.pdfs/wp/108.pdf>

Blancard K., Harrison. T, and Sello M (2005) Pharmacist's knowledge and perceptions of emergency contraceptive pills in Soweto and the Johannesburg Central Business District, South Africa. *International Family Planning Perspective* 31 (4), 172-178

Bogale, B, Wondafrash, M, Tilahum, T, Girma, E (2011). Married women's decision making power on modern contraceptive use in urban and rural Southern Ethiopia. *BMC Public Health*, 11(2)342-357. BioMed Central Ltd.

Boonstra, H (2001) Islam, women and family planning, a primer. *The Guttmacher report on public policy* 4 (6) 45-49 Guttmacher Institute

Brayton, J (1997) *What makes feminist research feminist? The structure of feminism within the social sciences*. SAGE publications. London, United Kingdom

Brooks, A and Hesse-Biber (2006) *An invitation to feminist research*. Retrieved online on 1 November 2011 on www.sagepub.com/upn-data/12935_Chapter1.pdf

Brooks, A and Hesse-Biber S.N (2007): *An invitation to feminist approach research*. In Hesse-Biber S.N and Leavy P.L (Eds). *Feminist research practice* (pp 1-24) CA: Sage Publications

Brown, B. B (1986) Facing the Black peril: The politics of population control in South Africa. *Journal of Southern African Studies* 13 (3), 19-22. Springer

Bryton, J (1997) *What makes feminist research feminist. The structure of the feminist research within social sciences*. Retrieved online on 12 April 2012 on www.unb.ca/PAR-L/win/feminimethod.htm

Burghard, S (2004) Factors associated with contraceptive use in late and post apartheid in South Africa. *Studies in Family Planning* 35 (2) 45-49. Population Council

Campbell, M.M., Sahin-Hodoglugil, N.N and Potts, M (2006). Barriers to fertility regulation. A review of the literature. *Studies in family planning*. (37):87-98. Berkeley, United States

Caplin, P (1987) *The cultural construction of sexuality*. Routledge, New York United States of America

Cates, W Jr and Burris H, (2010) The Global Roadmap to the Universal Access to Family Planning: From Cape to Kampala. *African Journal of Reproductive Health*, 14 (4), 13-15. Population council.

Chae MH, 2001. Gender and ethnicity in identity formation. *The New Jersey Journal of professional counselling* 13 (56), 17-23. Springer

Cherrera, D in Hill-Collins, P (2006) *Intersecting Oppressions*. Retrieved online on 3 June 2012 on http://www.uk.sagepub.com/upmdata/13299_Chapter_16_Web_Bye_Patricia_Hill_Collins.pdf

Chesney, M (Ed) *Women, work and health: stress and opportunities*. Plenum, New York, United States of America

Chimere –Dan, O (1993) Population Policy in South Africa. *Studies in Family Planning* 24 (1), 49-52. Population Council

Chopra, M, Lawn, J E, Sanders D, Barron, P, Karim S S, Bradshaw, D, Jewkes, R, Karim , A Q, Flisher, A J, Moyasi, B M, Tallman, S M, Churchyard, G J, Covadia H: (2009) Achieving the health Millenium Development Goals South Africa and priorities. *The Lancet*, 374 (9694), 1023-1031. Elsevier Ltd, South Africa.

Christopher, AJ (1987) Apartheid planning in South Africa: The case of Port Elizabeth. *The Geography Journal*, 153(2), 195-204. Population Council

Cochrain, SH. (1979) *Fertility and Education*. The John Hopkins University Press. Baltimore, United States of America.

Cooper, D., Meyer, L., Bracken, H and Zweigenthal, P (2007) *On forced sterilisation of HIV positive women*. Accessed online on 5 October 2011 on <http://www.biomedcentral.com/1471-2458/7/282>

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L and Hoffman, M (2004) Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status. *Reproductive Health Matters* 12(24): 70-85.

Creanga, A. A(2010) Low use of contraception among poor women in Africa, an equity issue. *Bulletin of the World Health Organisation* 1(89), 258-266

Davidson, E. (2011) *Explaining the feminist approach to the understanding of social reality*. Accessed online on 30 April 2011 on <http://onlineeducation.blog.net/explain-the-feminist-approach-to-the-understanding-of-social-reality>

Deaux, K (2001): Social identity. *Encyclopaedia of women and gender* 2, (1) , 1-9. Academics Press, New York

Department of Health Demographic and Health Survey 2003, Preliminary Report. Pretoria: Department of Health 2004. Accessed on 15 March 2011 on <http://www.doh.gov.org.za>

Department of Health (2012), *77 000 Abortions in South Africa in 2011*.Iol news, SAPA. Accessed online on 9 March 2013 on <http://www.iol.co.za/news/south-africa/77000-abortion-in-sa-in-2011-report-11366672>

DeRose L.F., Doodoo F.N., Ezech A.C, and Owuor T.O. (2004), “Does discussion of family planning improve knowledge of partner’s attitude toward contraceptives?” *International Family Planning Perspectives*, 30(2), 87-93.

Devos, A; Serfdom, H; Fouche L and Delport, M (2002) *Research at grass roots for the social sciences and human service professions*. van Schaik. Pretoria, South Africa

Dixon-Mueller, R. 1998. *Female empowerment and demographic processes: Moving beyond Cairo*. Policy and Research Papers No. 13. Paris: IUSSP.

Dlamini, N (2005) *Diepsloot gets a facelift*. Johannesburg News Agency . Accessed online on 7 July 2011 on http://www.info.gov.za/2005/jul/jul28_diepsloot.stm

Do, M and Kurimoto, N (2012) Women's Empowerment and Choice of Contraceptive Methods in Selected African Countries. *International perspectives on sexual and reproductive health* 38 (1),107-114

Duze, M. and Mohamed, Z.I (2006). Male knowledge, attitudes and family planning practices in northern Nigeria. *African Journal of Reproductive Health*, 10(3): 53-65.

Ehlers, VJ (1998) *Adolescent mothers and non-utilisation of contraceptive in Zimbabwe*. Unisa Department of Health Studies. Accessed online on 1 July 2011 on http://uir.unisa.ac.za/bitstream/handle/110500/4296/ajnm_v12-n2-a3pdf?sequence=1

Ellingson, S. and Green, M (2002) *Religion and sexuality, a cross cultural perspective*. Routledge Taylor and Francis Group Press, London, United Kingdom.

Eysenck, M, (2004) *Psychology: An international perspective*. Oxford University Press. United Kingdom

Ezeh A, (1996) Reproductive preferences and behaviour. Teller, C and Hailermen A (eds) *The demographic transition and development in Africa. The unique case of Ethiopia*. Springer, London, UK.

Farell, D. (2011) *What is the intersection between religion and family planning?* Think Africa Press. 14 September. Accessed online on 10 March 2012 on www.thinkafricapress.com

Garenne M (2005) Age at marriage and modernisation in Sub Saharan Africa. *Southern African Journal of Demography* 9(2), 59-79

Gauteng Department of Education 14 June 2011. *MEC Creesy to get tough with latecomers*. Accessed online on 29 August 2011 on <http://www.info.gov.za/speech/DynamicAction?pageid=46185id=19375&tid=35750>

Gready, M., Klugman, B., Xaba, M., Boikanyo, E and Rees, H (2008) *South African women's experiences of contraception and contraceptive services*. Accessed online on 8 October 2011 on http://www.rhmjourn.org.uk/publications/beyond-acceptability/023_Gready.pdf

Gribble, J and Haffey, J (2008) Reproductive Health in Sub Saharan Africa. *Population Reference Bureau*. Retrieved online on 5 November 2011 on www.prc.org/pdf08/reproductivehealth_subsaharanafrica.pdf

Group Areas Act 41 of 1950. Union of South African Government Printers, Pretoria. South Africa

Guba, E.G and Lincoln, Y.S (1994) *Competing paradigms in qualitative research. Handbook of Qualitative Research*. Thousand Oaks. C.A. SAGE, New York, United States of America

Hagenfeldt, K (1991) *Reproductive technologies, women's health and careers choices*. Oxford University Press. United Kingdom

Hall, K.S (2011): The health belief model can guide modern contraceptive behaviour, researched practice. *Journal of midwifery and women's health* 57. Issue (1), 74-81. American College of Nurse-Midwifery

Halpern V, Lopez LM, GrimesDA, GalloMF. Strategies to improve adherence and acceptability of hormonal methods of contraception. *Cochrane Database of Systematic Reviews* 4 (3) Retrieved online on 10 July 2012 on <http://apps.who.int/wholereviews/CD004317.pdfCD004317.pub3>.

Halpern, D.T., Stover, J and Reynolds H.(2009) Benefits and costs of expanding access to family planning programmes to women living with HIV.AIDS. *South African Medical Journal* 100 (9), 207-220.

Hancock, A (2007) When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on politics* 5 (1), 45-47, American Political Science Association

Harber, A, (2011) *Diepsloot*. Jonathan Ball Publishers. Johannesburg and Cape Town, South Africa

Harding, S (1988) *Feminism and methodology: Social science issues*, World Publishers. New York, United States of America.

Harper (2008) Challenges in translating evidence to practice. The provision of intrauterine contraception. *Obstetrics and Gynecology* 111 (6) 114-116 American College of Obstetricians and gynaecologists.

Harvey, L (1990) *Critical social research*, Unwin Hyman. London, United Kingdom

Haynes, J (1995) Popular religions and politics in Sub Saharan Africa. *Third World Quarterly*, Vol 16 (1) , 89-108, Taylor and Francis Ltd.

Health 24. (7 February 2011) Contraception. Accessed online on 5 July 2011 on www.health24.com

Hill- Collins, P (2000) Gender, black feminism and black political economy. *Annals of the American Academy of political science*, 568, 41-53.

Hill-Collins, P (2000): Gender, black feminism and black political economy. *Annals of the American Academy of politics and social science*, 568: 41-53. Routledge, New York

Hill-Collins, P (2002) *Black feminist thought: knowledge, consciousness, and the politics of empowerment*. (2nd Edition) Routledge, New York, United States of America.

Hogan, D.P., Berhanu, B and Hailemariam, A, (2008) *African Women's' Autonomy and Contraceptive Behaviours*. Accessed on 12 March 2011 on <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.1999.t01-2-x/abstract>

Holt, P.M. Lambton K.S and Lewis, B (2004) *Central Islamic Lands Since 1918. The Cambridge history of Islam. Vol 1B*. Cambridge University Press, London, United Kingdom

Hunter, M (2006) *Informal settlements as spaces of health inequality: the changing economic and spatial roots of the AIDS Pandemic, from apartheid to neoliberalism*. Centre for Civil Society Research report No 44, Accessed online on 7 July 2011 on http://ccs.ukzn.ac.za/files/RREPORT_Vol1_06HUNTER.pdf

Hurchzermeyer, M and Karam, A (2006) *Informal Settlements: A perpetual challenge*. UCT Press, Cape Town, South Africa

IRN – Humanitarian Needs and Analysis 30-08-2011. Southern Africa: *More Sterilizations of HIV positive women uncovered*. Accessed online on 3-07-2011 on www.irinnews.org/report.aspx?reportid=90337

IRN- Humanitarian news and analysis (30 August 2010) *More sterilisations of HIV positive women uncovered*. Accessed online on 22 October 2012 on <http://irinnews.org/Report/90337/SOUTHERN-AFRICA-More-sterilisations-of-hiv-positive-women-uncovered>

Jacard, J (2009): *Unlocking the contraception conundrum. Reducing unplanned pregnancies in emerging adulthood*. The national campaign to prevent teen and unplanned pregnancy. Washington, D.C, USA

Jalubana, B (2009) On forced contraception in South Africa. Health systems in Africa: Learning from South Africa. *The Lancet* 374: 875-882. HRSC Press. Available online at <http://www.thelancet.com>. Accessed on 19 October 2012

Jain, C.S (1989) Fertility reduction and the quality of family planning services. *Studies in family planning* 20 (1) 1-6

Jinadu, M.K., Olusiso, O., and Ajuwon, B (1997) Traditional fertility regulation among the Yoruba of South Western Nigeria. A study of prevalence, attitude, practise and methods. *African Journal of Reproductive Health* 1 (1), 56-64

Johannesburg News Agency: *Diepsloot gets a facelift*. Retrieved online on 5 May 2011 on www.joburg.org.za

Johnson, J (2002) The modernity of traditional contraception: Time and the social context of fertility. *Population and Development Review*, 28 (2), 229-249. Population Council

Jonhnsn, L, Budlender, D (2002), HIV risk factors: *A review of the demographic socio economic, biomedical and behaviour determinants of HIV prevalence in South Africa*. CARE Monograph No 8 Jan 2002

- Joseph, R. and Eyal, A, 6 November 2012 Daily Maverick. Census 2011: *Data, data everywhere, but no real information in sight*. Retrieved online on 10 November 2012 on www.dailymaverick.com/data-dat-everywhere-but-no-real-information-on-sight
- Kaida, A., Jansen, P.A., Strathdee, S.A., Money, D., Jansen, P.A (2010) *Contraceptive use and method preference among women in Soweto, South Africa*. Accessed online on 5 March 2013 on <http://www.plosone.org/article/info%3Adoi%2Fjournal.pone.0013868>
- Kambarami, M (2006) *Femininity, Sexuality and Culture: Patriarchy and female subordination in Zimbabwe*. *African Regional Sexuality Resource Centre* accessed online on 16 October 2011 on <http://www.arsrc.org/downloads/uhss/kmabarami.pdf>
- Kardas-Nelson, M (28 -09-2010) *Dire lack of birth control education*. Mail and Guardian. Accessed online on 30 June 2011 on <http://mg.co.za/article/2010-09-28-dire-lack-of-birth-control-education>
- Kath, M (2008) Dealing with chaos and complexity: The reality of interviewing children and families in their own homes. *Journal of clinical nursing* 17 (23) 3123-3130.
- Kaufman, EC, (2000) reproductive control in Apartheid South Africa. *Population Studies* 32 (54),105-114
- Kawulich, BB (2005) Participant observation as a data collection method. *Qualitative Social Research* 6 (2), 43-47 *Sozialforschung*
- Keele, J.J. Forste, R and Flake, D.F (2005) Hearing native voices: Contraceptive use in Mateme Village, East Africa. *African Journal of reproductive Health* 2005, 9(1), 32-34
- Khopotso, B. (2006) *A battle for health in Diepsloot*. Johannesburg News Agency, 2 March 2006. Accessed online on 3-10-2011 on http://www.health_e.org.za/new/article.php?uid=20031374
- Khopotso, B and Njamela, Y (2006) *Diepsloot – Long queues to health*. Johannesburg News Agency. 28 February. Accessed online on 26-08-2011 on <http://www.health-e.org.za/news/article.php?uid=20031369>
- Khumalo-Sakutukwa, G. and Garbus, L. (2002) *HIV/AIDS in Zimbabwe*. San Francisco: University of California.
- Kincheloe, J. L., & McLaren, P. L. (1994). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). Thousand Oaks, CA: Sage
- Klugman, B (1990): The politics of contraception in South Africa. *Women studies international forum*,13 (3) 169-228. Elsevier Ltd
- Knudsen, S V (2006) *Reproductive Rights in a global context*, Vandebilt University Press

Knudsen, S.V (2006) *Intersectionality- A theoretical inspiration in the analysis of minority cultures and identities in textbooks*. McGraw-Hills, Boston, United States of America

Krefting, L (1991) Rigor in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy*. 5(3), 214-222

Laher, F., Todd, C.C., Stichbich M.A, Phofa, R., Behane, X (2009) A qualitative assessment of decisions affecting contraceptive utilisation and fertility intentions among HIV positive women in Soweto. *Southern African AIDS behaviour* (13), 147-154

Lelliot, J (12-01-2011). *Diepsloot low-cost schools prove popular*. Times Live. Accessed online on 2-10-2011 on <http://www.timeslive.co.za/local/article847941.ec/Diepsloot-lowcost-schools-prove-popular>

Lewis, G and Salo, K (2009): Sub-Saharan contraception policies in light of the Millennium Development Goals. *Third world quarterly* 36 (1) 87-106. Taylor and Francis Ltd

LincolnYS and Denzin NK (2000), *Handbook of qualitative research*. London: Sage Publications.

Lynos- Amos, M.J., Durrant G.B., Padmadas,S,S, (2011) Is traditional contraceptive use in Moldova associated with poverty and isolation. *Journal of Bio Social Science May 2011, Vol 43* (3), 305-327. Research Institute, University of Southampton, UK

Magure, T.M (2010) *Trends in unmet need and demand for family planning in Zimbabwe*. Zimbabwe working papers, Calverton, Maryland USA

Maharaj, P and Rogan, M (2007) *Reproductive health and emergency contraception in South Africa: Policy context and emerging challenges*. Working Paper No 48, July 2007. Emergency Contraception in South Africa.

Malhotra, A., Schuler, S.S., and Boender, C (2002). *Measuring women's empowerment as a variable in international development*. Commissioned paper of the Gender and Development Group of the World Bank, Washington, D.C.: The World Bank .Retrieved online on 20 May 2012 on <http://siteresources.worldbank.org/INTGENDER/Resources/MalhotraSchulerBoender.pdf>

Mallet, J and Kalambi, V (2008) *Coerced sterilisation on HIV positive women in Namibia. HIV/AIDS Policy Review*. Accessed online on 13 July 2011 on www.ncbi.nlm.nih.gov/pubmed19297769

Mamdani, M, Garner, P, Harpman, T, Cambell, O (1993), Fertility and contraceptive use in poor urban areas of developing countries, *Health Policy Plan* 8 (1),34-39, Oxford Journals

Mamdani, M., Garner, P., Harpman,T., and Campell, O; (1993):Cotracement in Africa Health Policy Planning *Oxford Journals* (12),97-103.

Mapuranga, S. (2011) *Maternal deaths and child spacing in the apostolic church*. The Zimbabwean Newspaper, 22 November 2011.

Masquuilier, A (2009) *Women and Islamic revival in a West African town*. Indiana University press, Bloomington, USA

May, T (1993) *Social Research Issues, Methods and Processes*. Open University Press

Mc Devitt, T.M, Adlakha, A, Fowler BT, Harris-Bourne, V (2007) *Trends in fertility and contraceptive use in the developing world*. U.S Bureau of the census. Washington DC

McGinn,T, Bamba, A, Balma M (1989) Male knowledge, use and attitudes regarding family planning in Burkina Faso. *International family planning perspectives*, Vol 15 No 3 pg 84-87. Guttmacher Institute

Mensch B, Arends-Kuenning, M and Jain A; The impact of family planning services on contraceptive use in rural Peru, *Studies in Family Planning* 19 (27), 59-75, The population Council, retrieved online on 07 December 2012 on <http://www.jstor.org/stable/2138134>

Meyers, M (2000) Qualitative research and the generalizability question: Standing firm with Proteus. *The qualitative report*, 4 (3), 78-84. Accessed online on 3 April 2012 on <http://www.nova.edu/ssss/QR/QR4-3/meyers.html>

Michie, S., Johnston M., Abraham C., Lawton ,R., Parker, D., Walker A (2005) Making psychological theory useful for implementing evidence based practice: A consensus approach. *Quality and Safety in Health Care* 01 (14), 26-33.

Minnaar, A. (2006) People who care. *Nursing Update*. Vol 30 (1), 46-48.

Mitchell, K. and Rimmer, D, (1982) *Social Science Research Methods*. An African Handbook. Hodder and Stoughton. Toronto.

Mlambo, G.T (2005). *Perceptions of rural teenagers on teenage pregnancy*. Health SA.

Mostad, S.B, (1998) Prevalence and correlates of HIV type 1 Shedding in the female genital. *AIDS Res Hum Retroviruses* 19 (14) 11-15. Springer

Mostert, W P, Hofmeyr, B E, Oosthuizen, J S and van Zyl, J A (1998): *Demography. Textbook for the South African student*. HRSC Press, Cape town, South Africa.

Mostert, W.P, (1978) “Gesinsbeplanning in 1977 [Family planning in 1977]”, *Journal of Racial Affairs* 29 Vol 3 pg 86-88.

Moultrie, T.A., and Timaeus M.I (2003) The South African fertility decline: Evidence from two censuses and a demographic and health survey. *Population Studies*, 57 (3), 265-283

Moultrie, TA (2001) *Racism and Reproduction. The institutional effects of Apartheid on the South African fertility decline*. Paper presented at XXIV IUSSP General Population Conference, Salvador, Brazil. 18-24 August 2001, Session S19, Fertility transition.

Mpezo, M (2006) *Fertility levels and differentials in informal settlements in South Africa: Analysis of South Africa 2001 census*. Accessed online on 13/03/2011 on http://wirerdspace.wits.ac.za/bitstream/handle/10539/1651/Muanzu_Chapter1.pdf?sequence=3

Murdock, O.P., Lutchmia, J and Mkhize, M (2003) Peer led HIV/AIDS prevention for women in informal settlements. *Health Care and Women International* 24, (6), 502-512.

National Centre for Chronic Disease Prevention and Health Promotion 2010. Division of reproductive health. Accessed online on 7-07-2011 on <http://www.cdc.gov/reproductivehealth/productsPubs/Africa/AfricaFP.htm>

Ndwamato N.M (1993) The beliefs and practises of Tshivenda speaking multiparous women on contraception: a qualitative study. *South African family planning practitioners* 51 (4), 340-342

Odum, T.C (2004) *Examining intersectionality: race, gender and reproductive health*. Paper presented at the annual meeting of the American Sociological Association, on 14 August, Hilton, San Francisco

Ojo, M.A (2005) *Religion and sexuality: Individuality, choice and sexual rights in Nigerian Christianity*. ARSRC, Nigeria

Onwuzurike, B.K; and Uzochukwu, K (2001) Knowledge, attitude and practise of family planning amongst women in a high density low income urban area of Enugu, Nigeria. *African Journal of Reproductive Health* 2 (6)83-89.

Osthus, I (2011, in press) *Sexuality, parenthood, and identity: Relationships among female and male youth living on the streets of Durban CBD*. Unpublished master's thesis. University of KwaZulu Natal, Durban, South Africa.

Patton, QM (2002) *Qualitative research and evaluation methods*. 3rd Edition. SAGE.

Peterson L.S., Oakley D., Potter L.S, Darroch J.E,(1998) Women's efforts to prevent pregnancy: consistency of oral contraceptive use. *Family Plannning Perspective* 8 (30),19-23.

Plavet R, and Molednjick T (1999) *Feminist theories: The social construction of gender in families and society*. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 591-623). Plenum, New York

Polansky, NA (1975) *Social work research methods for the helping professions*. University of Chicago Press.

Population Bulletin of the United Nations (2007) *Prospects of fertility decline in high fertility countries*. Special issues No 46/47 2002. United Nations

Population Registration Act 30 of 1950. Union of South African Government Printers, Pretoria. <http://www.disa.ukzn.ac.za/webpages/DC/leg19500707.028.020.030/pdf>

Population Services International (2011). Retrieved on 29 August 2012 on www.psi.org/world-contraception-day.

Purdie-Vaughns, V and Eibach, R P (2008): Intersectional invisibility: the distinctive advantages and disadvantages of multiple subordinate group identities. *Sex roles, a journal of research*, 2008, 59: 377-391. Springer Science publications, USA

Quinn-Patton, M (2002) *Qualitative research and evaluation methods*, 3rd Edition, SAGE publications

Ramesh, A (2010), Pregnancy Childbirth, *BMC Journal* 10 (2),109 – 115.

Ray, S (2005): *Understanding patriarchy, human rights, gender and environment*. University of New Dehli, India. <http://www.du.ac.in/fileadmin/DU/Academics/course-material/hrge-06.pdf>

Reid, JW & Smith, AD (1981) *Research in Social Work*. Colombia University Press. New York.

Reinharz, S (1992), *Feminist methods in social research*. Oxford University Press. New York.

Richards, R (2007). *Social Indicators Research: Measuring the quality of life in informal settlements in South Africa*. Oxford University Press. New York.

Ritzer, G. (2007) *Contemporary sociological theory and its classical roots: the basics*. McGraw-Hills, Boston.

Roberts, D (1997), *Killing the Black body: Race, Reproduction and meaning*. New York, Vintage Books

Roberts, P., Priest H., Traynor, M (2006) Reliability and validity in research. *Nursing Standard* 20 (44), 41-45

Robinson, A (1999): *Folk medicines and their effectiveness in modern day*. Thousand Oaks, Sage Publications

Roger, S (1998) *Exploring religion*. Wadsworth Pub.Co, Carlifonia, U.S.A

Ross, J., Hardee, K., Mumford, E., Eid S (2006) Contraceptive method choice in developing countries. *International Family Planning Perspectives* (28), 20-29. Accessed online on 27 August 2011 on <http://www.jstor.org.ezproxy.ukzn.ac.za:2048/stable/3088273>

Schuler, R.S and Hashemi, M.S (1994) Credit programs, Women's empowerment and contraceptive use in rural Bangladesh. *Studies in Family Planning* 25 (2), 65-76

Setswe, G (1999) *The role of traditional healers in primary health care in South Africa. Health SA Gesondheid* 4 (2), 56-60. Population Studies

Sewankambo, N. K and Katamba, A (2009): Health systems in Africa: Learning from South Africa. *The Lancet* (374): 957-959. HRSC Press. Available online at <http://www.thelancet.com>. Accessed on 19 October 2012

Sewpaul V (2005) Feminism and Globalisation: The promise of Beijing and neoliberal capitalism in Africa. *Agenda* 64:104-113

Sewpaul, V (2012 – in press) Inscribed in our blood. *The Journal of Women and Social Work*.

Sewpaul, V and Holscher, D (2004) *Social work in times of Neo Liberalism*. A post-modern discourse. Van Schaick Publishers, Pretoria

Sewpaul, V, (2005a) A structural social justice approach to family policy: A critique of the draft South African family policy, *Social Work/Maatskaplike Werk* 41 (4), 310-122

Shermain, E and Reid, W (1994): *Qualitative research in social work*. New York, Columbia University Press

Smit J, McFadyen T, Beksinska M, de Phino H, Morroni C, Mqhayi M, Parech A, Zuma K (2001) *Emergency contraception in South Africa: knowledge, attitudes and use among public sector primary health care clients*. Women's Health Issues: School of Public Health and Health Care Services, Jacobs Institute of Women's Health.

Smith, S.M, Baslain G.B, Marx, P.A (2000) Estrogen protects against virginal transmission of simian immunodeficiency virus. *Infect Dis* 182 (3),708-715

South African Department of Health Contraception Policy Guidelines 2002, Accessed online on 10 March 2012, on <http://www.doh.gov.za/doc/factsheets/guidelines/contraception/contraception01.pdf>

South African National Demographic Health Survey (2003). Preliminary report. Department of Health, Pretoria, South Africa. www.doh.gov.za/docs/reports/2003/sadhs_2003/part1.pdf

Southern African Regional Poverty Network report (2008). Human Sciences Research Council, Pretoria.

Squires, A (2009) Methodological Challenges in Cross-Language Qualitative Research: A Research Review *International Journal of Social research* 46 (2), 277–287

Stacy, D (3 July 2009) Contraception. About.Com. Retrieved online on 5 July 2011 on <http://www.contraception.about.od/contraceptionoverview/g/glossary.html>

Stephenson, R et al (2007) Contextual influences on modern contraceptive use in Sub Saharan Africa. *American Journal of Public Health* 97 (7), 1233-1240

Stevens, M (2012), Conspiracy of silence over abortion. Mail and Guardian. Accessed online on 9 March 2013 on <http://mg.co.za/article/2012-03-09-conspiracy-of-silence-over-abortion>

Stokols, D (1996) Translating Social Ecological Theory into guidelines for community health problems; *American Journal of Health Promotion Inc.* 10 (4) 105-116

Swartz, L (2000) *Fertility Transition in South Africa and its implications on the four major population groups*. Accessed online on 13 March 2011 on www.un.org/esa/population/publications/completingfertility/Revisedswartzpaper.PDF

Symington A, (2004) *Intersectionality: A Tool for Gender and Economic Justice*. Women's Rights and Economic Change No. 9, August 2004

The Group Areas Act No 41 of 1950. Retrieved online on 2010/10/17 on www.disa.ukzn.ac.za/index.php?option=com_displayedc&recordID=leg19500707.028.020.041

The Population Registration Act No 30 of 1950. Retrieved online on 2012/10/17 on www.disa.ukzn.ac.za/index.php?option=com_displayedc&recordID=leg19500707.028.020.030

Timeslive (13 September 2011), *Preteens given birth control injections at school*. Accessed online on 15-09-2011 on <http://timeslive.co.za/local/2011-09-13/prteens-given-birth-control-injections-at-school>

Timeslive (30 October 2012); *Zuma calls Census results "the tale of our national pride"* Retrieved online on 2011/11/7 on www.timeslive.co.za/politics/2012/10/30/zuma-call-census-results-tale-of-our-pride

Traditional Health Healers Practitioners Act. Act 35 of 2004. Republic of South Africa. Government printers, Pretoria

Traditional Health Practitioners Act, 2007 No. 22 of 2007. Government Gazette, RSA Vol. 511 Cape Town 10 January 2008 No. 30660

Tuli, F (2010) The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethopian Journal of Education and Science.* 6 (1), 97-108

UNFPA (2012) *Preventing HIV and unintended pregnancies strategic framework 2011-2015: In support of the global plan towards the elimination of new HIV infections amongst children by 2015 and keeping their mothers alive*. Retrieved online on 2012/10/13 on <http://www.unfpa.org/public/home/publications/pid/10575>

United Nations report on trends in sustainable development, Africa report Mozambique 2008-2009

United Nations. The availability, accessibility and affordability of reproductive health services in Sub Saharan Africa 2000. Report for Sustainable Development Department, Food

and Agricultural Organisation of the UN. Accessed online on 7-10-2011 on <http://www.fao.org/sd/wpdirect/WPan0044.htm>

Upadhyay, D.U and Karasek, D (2010) *Women's empowerment and achievement of desired fertility in Sub-Saharan Africa*. Demographic Health Survey Working Papers No 80. Calverton, Maryland, USA: ICF Macro

USAID South Africa Report, (June 2009). *Maternal and Child Health Family planning*. Accessed online on 16/04/2011 on http://sa.usaid.gov/south_africa/node/77

Villanueva, MIM (1997) *The social construction of sexuality: personal meanings, perceptions of sexual experience, and female sexuality in Puerto Rico*. (Unpublished PhD thesis) Virginia Polytechnic Institute and State University, Virginia, U.S.A

Warriner I, (2012), *Theory-based interventions for contraception* : RHL commentary. The WHO Reproductive Health Library; Geneva: World Health Organization.

Whitehouse, A.S, (August 2011) *Why I stopped taking the pill*. Shape Magazine. Shapema.co.za

Williams CM, Larsen U and McCloskey LA, (2008) Intimate partner violence and women's contraceptive use. *Violence against women*, PubMed 14(12):1382-1396 Retrieved online on 24 May 2012 on <http://dx.doi.org/10.1177/1077801208325187>

Williamson, L.M (2009) *Reliance on traditional contraceptive methods. Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research*. Biomed Central Ltd.

Wolf, S (2005) *State provided family planning in the Limpopo Province 1974 – 1984*. Accessed online on 10-09-2011 on http://pages.unibas.ch/africa/limpopo/papers/limpopo_html/limpopo_wolf_html

Wolfinger, N.H (2002) *On writing field notes: Collection strategies and background expectancies*. Qualitative research. Sage Publications. London

Wood, K and Jewkes ,R (2006) Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters* 14 (27),109-118. Accessed online on 23 August 2011 on <http://www.sciencedirect.com/science/article/pii/S09068808006272318>

World Health Organisation (2010). *Hormonal Contraception and HIV: Sexual reproductive health issues*. World Health Organisation.

World Health Organisation. Making Pregnancy Safer: Annual Report 2007. Geneva. WHO, 2008

World Health Organization (2011): Contraception definition. Accessed online on 27 October 2012 on <http://www.who.int/topics/family-planning/en/>

World Health Organisation (2009) Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report. Geneva. WHO

Yeatman, S.E and Trinitapoli, J (2008) Beyond denomination: The relationship between religion and family planning in rural Malawi. *Demographic Research* 19 (55), 209-218

Yin, K (1994), *Case Study Research. Design and Methods*, Second edition. Thousand Oaks: Sage Publications

Yin, KR (2003) *Case study research design and methods*. 2nd Edition. Thousand Oaks. SAGE.