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Factors Contributing to Poor Utilization of Contraceptive Services by Youth in the Rural Communities of Mutale Municipality in Limpopo Province

by

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A thesis submitted in fulfilment of the requirements for degree:

Magister Curationis

Department of Advanced Nursing Science

School of Health Sciences

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Supervisor: Professor V.O. Netshandama

Co-Supervisor: Professor R.T Lebese

APRIL 2010

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DECLARATION

I, **Azwindini Valentia Mulaudzi**, declare that "**Factors Contributing to Poor Utilization of Contraceptive Services by Youth in the Rural Communities of Mutale Municipality in Limpopo Province**" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted for another degree at this university or any other institution.

Azwindini Valentia Mulaudzi : .....VMulaudzi.....
Student Number: 11629996
Date Signed : .....April 2016.....

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DEDICATION

This study is dedicated to all female youth in our society. It is also dedicated to elders, teachers and health workers who are supporting and educating the young people to be self-confident and responsible for their sexual behaviour.

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ABSTRACT

South Africa, like many other countries, is experiencing a high rate of youth pregnancy and its associated social ills, regardless of free contraceptive services. In rural areas, the rate is significantly higher as evidenced by the number of youth that fall pregnant at any given point; hence, there is poor utilization of contraceptive services in rural communities. The aim of this study was to determine the factors that contribute to poor utilization of contraceptives and contraceptive services in the rural communities of Mutale municipality Limpopo Province. A qualitative, explorative, descriptive and contextual design was used for this study. The target population was female youth between the ages of 16 - 20 years and community elders at Mutale municipality in the Limpopo Province. Non-probability sampling, using a purposive sampling technique was used to select 15 participants. In-depth, face-to-face interviews were conducted with youth aged 16-20 years and elders between 50 and 65years using an unstructured question and data was guided by data saturation. Data were analyzed using an open-coding method. Permission to carry out the study was obtained from the University of Venda Research Ethics Committee and Limpopo Provincial Department of Health. Trustworthiness of the data was ensured by meeting the criteria for transferability, confirmability, dependability and credibility. The study found that some youth were troubled by perceived barriers that hindered them from using contraceptive services. Recommendations to the Departments of Health and Education as well as community leaders and further research were made based on conclusions drawn from the results. This may assist stakeholders to plan intervention programmes to ensure that the contraceptive services are better suited for marginalized youth in the rural areas.

Keywords: youth, rural community, contraception, contraceptive services

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CTOP	Choice on Termination of Pregnancy
DHIS	District Health Information Software
DoE	Department of Education
DoH	Department of Health
EC	Emergency Contraception
HBM	Health Belief Model
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IUD	Intrauterine Device
MDGs	Millennium Developmental Goals
NGOs	Non-Governmental Organizations
PEP	Post-Exposure Prophylaxis or Post-Exposure Prevention
PHC	Primary Health Care
RHS	Reproductive Health Services
RHRU	Reproductive Health Research Unit
SA	South Africa
SADHS	South African Demographic Health Survey
STIs	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
USA	United States of America
WHO	World Health Organization
YFHS	Youth Friendly Health Services
YRHS	Youth Reproductive Health Services

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

South Africa has a relatively progressive legislative response to youth pregnancy and motherhood, with some even suggesting it has a 'feminist influence' (Bhana and Clowes, 2008). The South African Constitution (1996) 'protects the right of all citizens including children to make decisions regarding reproduction and the right to access health care services, including contraceptive services (Hoffman-Wanderrer, 2013). Since 1996 a number of laws have been passed to actualise these rights, and some are discussed below, of particular relevance is: the Choice on Termination of Pregnancy Act, the South African Children's Act and the Sexual Offences Act (Hoffman-Wanderrer, 2013).

- **The Choice on Termination of Pregnancy (CToP) Act (No. 92 of 1996)** uses a rights-based framework to introduce the legalisation of termination of pregnancy. It allows that any pregnant women or girl can have a pregnancy terminated on request up to 12 weeks of gestation4, provided by a certified midwife or doctor. And terminations can also be performed from 13-20 weeks in cases where the pregnancy poses a risk to the women's social, economic or psychological well-being. After 20 weeks terminations will only be performed to save the mother's life (Cooper et al., 2004 and Jewkes et al., 2005). Importantly this applies to 'any person of any age'5 and can be performed without parental consent, so long as the child is deemed able to provide informed consent. Children under 18 years are advised to seek counselling before doing so, but they are not obligated to do so (Hoffman-Wanderrer, 2013). The Act allowed for surgical terminations to be performed by a doctor or trained midwife in designated facilities, whereas medical terminations can be performed anywhere.

- **The South African Children's Act (2005)** (as amended by the Children's Amendment Act, No. 41 of 2007) came into effect, with regulations, on 1 April 2010. It allows those over 12 years to 'access health care services, including HIV testing, contraceptives and termination of pregnancy (TOP) services, without parental consent'. The Act stipulates that: 'contraceptives other than condoms and also including condoms may be provided to a child on request by

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the child and without parental consent of the parent or care-giver of the child if the child is at least 12 years of age (Hoffman-Wanderrer, 2013).

- **The Criminal Law (Sexual Offences and Related Matters) Amendment Act (Sexual Offences Act) (2007)** protects children and adults from non-consensual sex, it states that children can only consent to sex once they are 16 years old. This means that even consensual sex between a child under 16 years and those over 16 would be considered non-consensual and statutory rape (Hoffman-Wanderer, 2013). It had also criminalised consensual sex between two children where both parties are between 12 – 15 years of age, this has been taken to court and on 14 January 2013 'Judge Pierre Rabie found that sections of the Sexual Offences Act, which made consensual sex between teenagers a crime, were unconstitutional' (Parker, 16 January 2013).

- **Sterilization Act, 1998 (Act No. 44 of 1998)** it provides for the right to sterilization of any person over the age of 18 years if s/he is capable of consenting.-Prohibits sterilization on any person capable of consenting without his/her consent and on any person under the age of 18 years, except on medical grounds.

- **The National Contraception Policy Guidelines, (2012)** noted four key challenges facing adolescents in preventing unplanned pregnancies :
    - peer pressure to be sexually active or to conceive and demostrate their fertility; inaccurate ideas about conception, reproduction and contraception ;
    - clinics which are not open after school, or are not youth friendly (e.g. embarrassment to be seen at the clinic by their community);
    - negative and judgemental health care provider attitudes towards teenagers who are sexually active
    - unanticipated sex, sexual coercion.

1.2 Background

Despite the government's intentions to provide free contraceptive services in South Africa, there are still a high proportion of adolescents who are exposed to the risk of

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pregnancy. South Africa, like many other countries is experiencing a high rate of youth pregnancy and its associated social ills, regardless of free contraceptive services.

Studies conducted in South Africa indicated that rural youth tend to start childbearing earlier than urban youth (National Department of Health, 2002). Ngabaza (2011) found that while there is a general decline of youth pregnancies across South Africa, rates are still higher in certain provinces such as: Mpumalanga, Northern Cape, Limpopo and the Eastern Cape, which is reflective of historic apartheid divides, and poorer black communities. Rural areas also see a different trend Ardington found that despite a general trend of declining births among youth, 'the proportion of youth who gave birth has remained higher in rural areas over time. While rural youth births increased slightly between 1984 and 2008, the increase was driven by births to older teen mothers and the proportion of younger teen births almost halved' (Ardington, 2012). Flanagan et al (2013) supported this noting that youth pregnancy was higher in rural areas than urban areas. 'The DBE suggest that the difference between urban and rural fertility rates is due to increased access to education, economic development and more access to contraceptive services in urban areas' (Flanagan et al, 2013). The increase in sexual activity among adolescents and the failure to use effective contraception result in a large number of pregnancies among young females (Zimmerman: 2003), however, there was poor utilization of contraceptive cervices among youth of rural communities of Mutale municipality Limpopo Province.

For some of these young women, pregnancy and childbirth are planned and wanted, but for many others they are not. Several factors may contribute to unplanned and unwanted pregnancies in adolescence. Adolescents may be under pressure to marry and to bear children early, they may have limited educational and employment prospects (WHO, 2011). Some do not know how to avoid a pregnancy, while others are unable to obtain condoms and contraceptives to do so. Unwanted pregnancies may end in abortions, which are often unsafe in this age group. There were an estimated 3 million unsafe abortions among 15–19 year olds in 2008 (WHO, 2011).

These unintended pregnancies could be turned away by effective and consistent use of contraceptives as reported in the United States of America (USA). Although not necessarily the same, the terms 'adolescent' and 'youth' are often used interchangeably to define a person between the age of 15 and 24 years (World Health Organization, 2010). The youth period is important because it is the stage of life where transitional

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changes in biological and psychological aspects mostly occur. As a result, these changes lead to deleterious problems and issues, especially concerning reproductive health, such as unwanted pregnancy, which is often considered a serious social public health problem (Gomes, Speizer, Oliviera, Moura, & Gomes, 2006; Mestad, Secura, Allworth, Madden, Zhao, & Pelpert, 2011). So, if this age group is the one which is encountering unplanned pregnancies in large numbers, it means the government of South Africa (SA) is going to be forced to spend a lot of money to overcome this problem so as to preserve the future leaders.

Contraceptive usage among youth has been perceived to be influenced by various factors, including, socio-economic status, knowledge about contraceptives, attitudes about issues related to contraceptives, residential area, educational status, counselling received about contraceptives, attitudes of the contraceptive providers, cultural values, beliefs and norms according to the DoH (DoH, 2001; Kanku & Mash, 2010).

In South Africa, teenage pregnancy rose from a low of 2% among 15-year olds and peaked at 30.2% among 19-year olds in 2002 (DoH, 2002). Data from the 2003 Reproductive Health Research Unit (RHRU) survey showed that teenagers aged 17-19 years account for 93% of teenage pregnancy (Harrison, 2008). Teenage pregnancy increase is supported by the findings of a study on contraceptive use and pregnancy among 15 - 24 year old South African women, which reported that 65% of pregnancies in this age group were premarital, and unplanned (MacPhail, Pettifor, Pascoe, & Rees, 2007). Comparable results were found among South African HIV-positive women, who alone were reported to account for an estimated annual 220 000 unintended pregnancies (WHO, 2011).

There is a strong association between pregnancy and HIV infection in South Africa. Antenatal data show that 12.9% of 15 – 19-year old pregnant women are HIV-positive (DoH, 2008). From age 17 years onwards, every second women who has been pregnant is infected with HIV (Harrison, 2008). Even though teenage fertility has been the subject of substantial debate in social science research and policy circles, concern has not emanated from the increased risk that pregnancy confers to HIV infections. While current political and media depictions imply that South Africa is confronted with an escalating epidemic of teenage pregnancies, available data suggest that it is an area in which substantial progress has been made since democracy. Yet teenage pregnancy has grown in significance as a social construct and come to represent one of several

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indicators of burgeoning adolescent delinquency, sexual permissiveness and moral decay.

Stephen, Beke & Tshibangu (2008) studied contextual influences on contraceptive use in the Eastern Cape in South Africa and found that several pathways of influence between the community and individual contraceptive adoption are centering primarily on the community climate of female autonomy. Their work made a valuable contribution in identifying the residual variation in contraceptive use that highlighted the deficits that exist in current datasets for capturing community influences on contraceptive behavior. Furthermore, evidence as to how community contextual factors influence contraceptive use is limited (Stephenson & Tsui, 2002, 2003). At the community level, studies of contraceptive use have focused on the influence of health service characteristics, primarily the influence of quality of care on contraceptive adoption in the absence of other community-level characteristics (Tuoane, Diamond & Madise, 2003).

Wood & Jewkes (2006) reported a widespread knowledge by participants of local traditional and religious methods of contraception, such as tying a rope containing traditional medicines around the waist which are being used by youth. This traditional knowledge and practice can result in poor utilization of contraceptive and contraceptive services. The girls who were interviewed said they did not use these methods themselves, but believed they were effective, explaining that pregnancy would only occur if the traditional medicine had lost its strength. They further reported that they found such methods quite commonly used by adolescents and the widespread belief that conception is most likely to occur during menstruation (Wood & Jewkes 2006).

Various studies have reported that adolescents in South Africa had some knowledge of one or other method to prevent pregnancies, but never as much as tried to use these methods. Most pregnant teenage girls interviewed knew some, but not all contraceptive methods available at their facilities (Setiloane, 1990; Ehlers Maja, Sellers & Gololo, 2000; Ehlers & Khoza, 2001). Furthermore, Ehlers (2003) reported in a study done in Tshwane, South Africa, that 60% of adolescent mothers knew about contraceptives, but only 43% used injections, condoms and the pill. This provides evidence that youth have limited knowledge about methods of contraceptives. In most studies, youth gave many reasons for non-use of contraceptives, such as fear of parents and of infertility. It is also a concern of the researcher that many studies have shown a lack of dialogue between parents, teachers and church leaders about sexuality and teenagers because it is

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regarded as embarrassing and probably immoral.

The results of this study may enable the provision of contextual recommendations for enhancing the utilization of contraceptive services to all youth who stay in rural areas.These results may also be used by programme managers to shape the development of family planning provision and promotion programmes.

1.3 Problem Statement

A problem statement conveys a specific problem or issue that needs to be adressed and the reasons why the problem is important to study (Cresswell Plano Clark & V.L: 2011). Burns & Grove describe a research problem as an area of concern, in which there is a gap or a situation in need of solution, improvement or alteration, or in which there is a discrepancy between the way things are and the way they ought to be (Burns & Grove, 2011).

Despite the availability of free hormonal contraceptives to female youth in Masisi and Manenzhe clinics, female youth are still becoming victims of unplanned pregnancies at an alarming rate, causing population dynamics. It was revealed through the ascalating number of women less than 18 years admitted at Masisi and Manenzhe clinic for delivery and counselling for termination of unwanted and unplanned pregnancies.

These problems are evidenced by the escalating number of women less than 18 years old who visited selected clinics for counselling before termination of pregnancy and for deliveries, as reflected in Table 1.1.

Table 1.1: CTOP counselled and deliveries under 18 years

Year	Total counselled in facility	Total counselled under 18 years old	Percentage	Total deliveries in facility	Total deliveries by under 18 year olds	Percentage
2010	67	48	72%	170	26	15%
2011	89	69	78%	154	29	19%
2012	56	49	88%	162	31	19%

Source: District Health Information Software (DHIS) an open source software platform

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for reporting, analysis and dissemination of data for all health programs, developed by the Health Information Systems Programme (HISP; https://en.wikipedia.org/wiki/DHIS).

The question that emanate is to what extent is the youth in the rural areas in the Mutale district utilizing contraceptives and contraceptive services? To make sense of the situation, this study sought to determine the extent to which the youth are utilizing various forms of contraceptives and contraceptive services in the selected rural areas.

1.4 Purpose of the Study

The purpose of this study was to determine the factors that contribute to poor utilization of contraceptive services by youth in selected rural communities of Mutale municipality in Limpopo Province.

1.5 Objectives of the Study

According to Burns and Grove (2011), objectives are clear, declarative statements expressed in the present tense and for clarity, focusing on only one or two variables.

The research objectives were to:

- Identify the factors contributing to poor utilization of contraceptive services by youth at rural communities of Mutale municipality in the Limpopo Province.
- Identify various forms of contraceptive and services available to youth in rural areas
- Explore and describe the views of elders regarding use of contraceptives and contraceptive services by youth in the rural areas and their perceptions of available contraceptive services for youth.

1.6 Research Questions

1.6.1 Central Question

What are the factors that contribute to poor utilization of contraceptive services by youth at rural communities of Mutale municipality?

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1.6.2 Related Sub-Questions

To address the objectives, the following questions were formulated:

- What are the factors that contribute to poor utilization of contraceptive services by youth at rural communities of Mutale municipality?
- What are the various forms of contraceptives and contraceptive services available in rural communities?
- What are the views of elders regarding the use of contraceptive services among youth in the rural areas?

1.7 Significance of the Study

The significance of the study is the state that research is conducted in order to solve problems, make sense of human experiences understanding regularities and predict future circumstances Polit & Beck (2004).

The findings and recommendations of the study might help to:

- Provide policy makers with suggestions and useful information regarding the extent to which youth in rural communities utilize various forms of contraceptive services and how intervention programmes could take their plight into consideration.
- Influence collaboration between government and non-governmental organizations (NGOs) and promoting reproductive health and contraceptive use.
- Change youth's views and use of contraceptive services.
- Ameliorate the problems arising from not utilizing contraceptive services.
- Reinforce the existing body of knowledge about youth reproductive health.
- Espouse the development by the Department of Education (DoE) of health education programmes in high schools to promote access to youth friendly services.

1.8 Theoretical Framework

1.8.1 The Health Belief Model

This study was based on the Health Belief Model (HBM). The model suggests that

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health seeking behaviour is influenced by a person's perceptions of threat posed by a problem and the value associated with the action aimed at reducing the threat (Polit & Beck, 2008). The main component of the HBM is based upon the psychological expectancy value theory. Within such theory it is assumed that human behaviour depends mainly upon the value placed by an individual on a particular goal, and upon his/her estimate of the likelihood that a given action will achieve that goal. The two main factors of the HBM are: the desire to avoid illness or to get well, and the belief that a specific behaviour will prevent or reduce illness. According to the HBM, the likelihood that an individual engages in a given health enhancing behaviour is seen as function of following factors:

1.8.1.1 Perceived Susceptibility

It assesses the individual's perception about how likely the behaviours that they are involved in will lead to bad health outcome. In this study, this was one of the best risk views which forces one to change his/her perception of being at risk of poor health. When risk is perceived to be high there is need for perception change and need for taking action. In this study, the increased rate of teenage pregnancy is explored. This study assumed that the youth believed that by engaging in sexual activity without the use of condom a person can be infected with STIs, including HIV, and can become pregnant. This can help the youth to take care of their reproductive health by taking necessary precautions. Contraceptive services will be sought to prevent pregnancy and STIs by using condoms.

1.8.1.2 Perceived Severity

Feelings concerning the seriousness of the consequences of getting the diseases, that is becoming pregnant, contracting STIs, HIV and abortion. Most people probably belief that being infected with HIV would mean reducing life expectancy substantially. In this study, this refers to an individual's perception about the seriousness or severity of the disease—it is more on medical information. It is also depended on the individual beliefs about the severity that the diseases will cause to his/her general health. Most people will act or change their perceptions when they realize or feel that their life is threatened. The youth know that they are at risk of becoming pregnant if they do not use contraceptive services, yet they are sexually active and are at risk hence the perceived severity seriousness will lead to proper utilization of such services.

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1.8.1.3 Perceived Benefits

This is the extent to which the individual believes the various available actions are effective in reducing the threat. If the use of condoms is regarded to be effective in reducing the risk of contracting HIV, the likelihood of taking such is higher than if this is believed not to be the case. In this study, the benefits of using contraceptives implied the possibility to have children if and when the youth is ready to do so. The use of contraceptives saves women's lives and improves their health by allowing them to prevent unplanned pregnancies. Lives are saved from high-risk pregnancies or unsafe abortions. Effective use of condoms can prevent maternal deaths, cancers and STIs, including HIV/AIDS. Contraceptive use saves children's lives by allowing individuals and couples to delay and space births thereby providing greater opportunities for emotional support from the parents for each child. In addition, the parents are able to provide for each child's physical needs and so help each child to attain his/her maximum potential in life.

Contraceptive use also helps to provide better lives for families with less emotional and financial strain than with having to provide for a large family. The use of contraceptives saves women's lives and improves their health by allowing them to prevent unplanned pregnancies. Lives are saved from high-risk pregnancies or unsafe abortions.

1.8.1.4 Perceived Barriers

These are one's opinion of the tangible and psychological costs of the advised action. It is about complexities, duration and accessibility of the treatment. Youth might not be using these services due to nurses' behaviour towards them, unavailability of the services and culture. Motivation is the best way for them to comply with the treatment. Perceived barrier is the individuals' assessment of the influences that facilitate or discourage their adoption of promoted behaviour. The positive and negative aspects of a particular health action may function as impediments to undertaking the recommended behaviour. The perceived barriers could indicate reasons why youth failed to use free contraceptive services at Masisi village. If such barriers could be identified and addressed, then a greater number of youth could make use of the range of contraceptive services offered free of charge. If a person believes using a condom is going to reduce pleasure during sexual intercourse, this is expected to reduce the

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likelihood that this person actually will use a condom. Or if using oral pill or injectable can cause a person not to have children in future, this can cause a person not to use contraceptive services.

Access to health care services for adolescents also affects the utilization of contraceptives. Distances from the nearest clinics and payment for transport sometimes prevent adolescents from travelling to health care services for contraceptives and information. Most adolescent girls are financially dependent on their parents who might be unable to pay for transport to clinics. The service should be within a reasonable geographic distance and be functional in terms of the needs of adolescents. Accessibility could also be improved by rendering services on Saturdays. Reproductive health care services at government institutions are free of charge, but to improve access to adolescents, the services should be accessed by everyone, irrespective of sex, age, creed, colour, marital status, disability or any characteristic that puts individuals at a disadvantage.

1.9 Definitions of Terms

A conceptual definition conveys the general meaning of the variable or concept while the operational definition provides specificity and direction for the concept to guide the development of the research plan (Akinsola, 2004). Operational definitions are descriptions of how variables or concepts will be measured and manipulated in the study (Burns & Grove, 2011). The following definitions of key terms are pertinent to this study:

1.9.1 Youth

According to the South African National Youth Policy (2009-2014) crafted by the National Youth Development Agency (NYDA); youth is defined as individuals between the ages of 14-35. In this study, a youth is a young person who has not reached full maturity, and is aged between 16 and 20 years.

1.9.2 Contraception

Contraception is people's conscious efforts and capabilities to control their fertility. It does not capture all actions taken to control fertility, since induced abortion is common

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in many countries. (www.un.org.) Those include pill forms, abstinence, male and female condoms, spermicides, patches and injections. In this study, contraceptives include cultural, indigenous and religious forms of contraceptives.

1.9.3 Contraceptive Service

A safety-net health centre that provides contraceptive services is a site that offers contraceptive services to the general public and uses public funds (Guttmacher Institute & IPPF, 2010). In this study, contraceptive services are services provided to render impregnation virtually impossible and, include professional and non-professional cultural, indigenous and religious forms of contraceptive services.

1.9.4 Rural Communities

A rural community is a geographic area that is located outside cities and towns (Wikipedia Free Encyclopaedia). In this study, a rural community refers to communities residing in the areas under the traditional authorities.

1.9.5 Elders

Elders are persons of greater age or seniority (The Concise Oxford Dictionary, 2011). In this study, elders are senior members of the community, or knowledge holders, such as traditional healers, traditional leaders and pastors.

1.9.6 Factors

Factors is a circumstance, fact, or influence that contributes to a result (www.vocabulary.com/dictionary). In this study, the factors are the things that contribute to non-utilization of contraceptive services by youth.

1.10 Summary

This chapter provided a broad overview of the study, background, problem statement and the purpose and objectives. The research questions and significance of the study were presented in terms of the theoretical framework of the HBM in terms of perceived susceptibilty, severity, benefis, barriers and cues to action. Definitions of key terms used

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in this study were also delineated here such as youth, elders and factors. The next chapter deals with the literature review.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review is a process that involves findings, reading, understanding and forming conclusions about the published research and theory on a particular topic (Burns & Grove, 2003). A literature review is aimed at contributing to a clearer understanding of the nature and meaning of the problem that has been identified. It serves to put the researcher's effort into perspective, situating the topic in a larger knowledge pool (De Vos, 2012). In this chapter the researcher reviewed other researchers work with related or similar topics.

The following issues about contraceptive utilization are discussed in the literature review:

Individual Factors

- Demographic factors
- Socio-cultural factors
- The high rate of teenage pregnancy and STIs, including HIV/AIDS

Reproductive Health Servive Factors

- The alternative options to forms of contraceptives and availability
- The long distances to health clinics, impassable road infrastructures and cultural influences
- Attitudes of health professionals around uptake of contraceptives and contraceptive services
- Stigmas associated with the use of contraceptives
- Privacy and confidentiality
- Information and counselling

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2.2 Individual Factors

2.2.1 Demographic Factors

Demographic characteristics such as age, gender, educational status, number of living children and desire for additional children play an important role in determining the use of contraception. In addition, ethnicity, marital status, age, and gender all shape clients' experiences with family planning and reproductive health services (RHS). In some cultures, women may be unwilling to receive care from male providers, or husbands may object to having their wives see male providers, so a shortage of female providers may limit women's access to service.

According to Velasco (2001), women in Bolivia, who were often too shy to discuss contraceptive use with their husbands, expressed even greater fear about talking to a male provider. Further still, education also influences contraceptive uptake. A study in Kenya by Lasee & Becker (1997) revealed that if the husband lacked schooling, but the wife had some higher education, they were 4.3 times likely to use contraceptives compared to uneducated couples. According to the researcher, one interpretation of this result was that in case the wife was better educated than her husband, she might have considerably more household decisions-making influence (Lasee 2001). On contrary, a study in Mexico by Nazar-Beustelspacher indicated that non-use of contraception was higher among the illiterate women than those who completed secondary schooling—49 per cent vs 31 per cent (Nazar, Beutelspacher, Molina, Salvatierra, Zapata & Halperin, 1999).

Related to the above is knowledge about contraception. According to Jejeebhoy et al. (2005), inadequate knowledge about contraception and how to obtain health services is one of the reasons why many adolescent women in developing countries are especially vulnerable. Inadequate knowledge about contraception brings fears, rumours, and myths about family planning methods and can prevent young people from seeking contraception.

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In one survey in Uganda, some participants gave reasons why they would fail to use contraceptives even if they did not intend to get pregnant. Many participants, both male and female, distrusted male condoms, the contraceptive used most frequently by young people. They believed that it was potentially dangerous to use condoms because it could get stuck in the vagina where it would get rotten and cause damage. Likewise there were rumours that the pill could cause deformed babies, inability to get pregnant in the future as well as cancer of the cervix and the breasts (Eva & Robert, 2010). Rumours and myths about family planning may raise potential clients' concerns about the side effects, safety, and effectiveness of different methods. Another study in Uganda found that young people believed that contraceptives interfered with their fertility, and they were frightened to use something that could harm their ability to reproduce. In the same study by Nalwadda et al. (2011) most married and unmarried women believed that pills burned the woman's eggs.

2.2.2 Socio-Cultural Factors

In many parts of the world, women do not have the decision making power, physical mobility, or access to material resources to seek family planning services. Women's use of contraceptives is often strongly influenced by spousal or familial support of, or opposition, to family planning. Research in northern Ghana found that women who chose to practice contraception risked social ostracism or familial conflict (Phillip, 1997). In some areas, women need their husband's permission to visit a health facility or to travel unaccompanied, which may result in either clandestine or limited use of contraceptives (Biddlecom & Fapohunda, 1998). Additionally, stigma around young people's sexuality may similarly deter young people from seeking such services or may result in denials of RHS, even where parental consent is not required. Many sexually active young women report fear, embarrassment, or shyness about seeking family planning services (Biddlecom et al., 2007).

Furthermore, family planning methods sometimes challenge bio-cultural beliefs. For example, women in some societies believe it is healthy to menstruate monthly, and therefore refuse to use injectable contraceptives that often result in irregular bleeding, spotting, or amenorrhoea (no monthly bleeding). A Tanzanian woman lamented providers' discussions of the advantages of Depo-Provera: "They talk of it as the best family planning method despite the fact that we miss our monthly periods when we use it. A woman is not perfect if she doesn't get her monthly periods" (Flora, 2001).

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Providers sometimes ignore such concerns because they do not consider them clinically significant. Understanding clients' beliefs can help providers align their services with these ideas or, when necessary, address local misconceptions. Providers can also bridge such gaps by expressing respect for the clients' beliefs and drawing connections between these beliefs and medical models of health (Obermeyer & Potter, 1991).

On the other hand, socio-economic factors have been shown to be of greater importance than demographic factors in influencing the use health services (Obermeyer & Potter, 1999). In fact, fees for transportation, services, and supplies, can be a major barrier to contraceptives for many young people. Cost is a significant obstacle for adolescents, as young people frequently lack their own source of income or control over their finances to be able to afford contraceptives (Centre for Reproductive Rights, 2009). Even free or low-cost reproductive and other health care involves costs, including the opportunity cost of time away from income-generating activities (Abouzahr, Vlassoh & Kumar, 1996) In addition, competing demands on women's time can also make it difficult for women to use services, particularly when facilities are far away. Child care, food preparation, household sanitation, maintaining fuel and water supplies, and income-generating work outside the home can make seeking health care seem like a luxury.

Adolescents from different cultural backgrounds or traditions might be influenced by different factors, or by the same factors but to different extents, not to use contraceptives. According to Kaufman, De Wet & Stadler (2001), educated girls tend to fetch greater bridal wealth (known as 'lobola' in many South African traditional cultures), which may encourage parents to support their daughters' schooling, and perhaps their return to school following childbirth. However, encouraging their daughters to use contraceptives in order to complete their schooling prior to childbearing could be problematic for many parents, especially those living in traditional communities. Cultural/traditional factors could pose a hindrance to youth utilization of contraceptives, leading to unplanned pregnancies. According to Williams & Mavundla (1999), parents are in a dilemma to respect the traditional and cultural values at the expense of their daughters' rights to access and utilize contraceptives and contraceptive services. Youth might share the same dilemma in many traditional societies regarding cultural factors, requiring them to have as many children as possible. This practice may infringe the right of youth to use contraceptives in order to postpone childbearing until they have completed their schooling, hence, to be financially independent to care for their children

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Cultural taboos are a major obstacle to informed discussions about sexual and reproductive health issues, particularly with regard to young people (Cobb, 2010). The findings of a study conducted by Lebese et al. (2013) revealed that culture can have a negative impact on contraceptive use and practices. For many adolescents it was a taboo to discuss sexuality with parents and partners, and the majority of the participants could not initiate conversation about contraceptives with their parents (Lebese et al., 2013). In many parts of the world, women do not have the decision making power, physical mobility, or access to material resources to seek contraceptive services. Women's use of contraceptives is often strongly influenced by spousal or familial support of, or opposition to, family planning.

The gradual decline of the taboo against pregnancy before marriage, and the breakdown of social mechanisms to ensure that unmarried young men take responsibility for procreation have influenced adolescent decision-making regarding the timing of full sexual debut and contraceptive use. Cultural beliefs regarding reproduction can cause unfounded concerns about the effects of certain contraceptives, and lead to the unnecessary rejection of effective methods. In SA, the increasing preference for dry sex may result in the rejection of some highly effective contraceptives that are associated also with greater vaginal wetness.

Contraceptive services might pose challenges of bio-cultural beliefs, for example, women in some societies believe it is healthy to menstruate monthly, and therefore refuse to use injectable contraceptives that often result in irregular bleeding, spotting, or absence of menstruation. Cultural beliefs and practices such as the preference for sons, pregnancy, childbirth taboos, traditional contraceptive methods and patriarchy have been identified as problems which hold back the improvement of women's health, especially their reproductive health (Arrow of Change, 1999). The need for women to improve their fertility continues to influence the sexual and reproductive choices of many people (DoH, 2001).

Youth from different cultural backgrounds or traditions might be influenced by different factors, or by the same factors but to different extents, not to use contraceptives. According to Kaufman, De Wet & Stadler (2001), educated girls tend to fetch greater bridal wealth (known as 'lobola' in many South African traditional cultures), which may encourage parents to support their daughters' schooling, and perhaps their return to school following childbirth. However, encouraging their daughters to use contraceptives

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Youth might share the same dilemma in many traditional societies regarding cultural factors, requiring them to have as many children as possible. This practice may infringe the right of youth to use contraceptives in order to postpone childbearing until they have completed their schooling, hence, to be financially independent to care for their children. Cultural taboos are a major obstacle to informed discussions about sexual and reproductive health issues, particularly with regard to young people (Cobb, 2010). The findings of a study conducted by Lebese et al. (2013) revealed that culture can have a negative impact on contraceptive use and practices. For many adolescents it was a taboo to discuss sexuality with parents and partners, and the majority of the participants could not initiate conversation about contraceptives with their parents (Lebese et al., 2013.

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pregnancy, childbirth taboos, traditional contraceptive methods and patriarchy have been identified as problems which hold back the improvement of women's health, especially their reproductive health (Arrow of Change, 1999). The need for women to improve their fertility continues to influence the sexual and reproductive choices of many people (DoH, 2001).

2.2.3 High Rate of Teenage Pregnancy and STI, Including HIV/AIDS

The World Health Organisation (WHO, 1998:6) estimates that close to 17 million girls under the age of 20 years give birth annually and a further 4.4 million abortions are sought by adolescents each year worldwide as a results of inadequate and non-utilization of contraceptives. Unwanted pregnancies and sexually transmitted diseases is as much a problem for the male adolescent as it is for the female. However, girls stand a greater risk of unwanted pregnancies and sexually transmitted diseases. Due to the development of secondary sexual characteristics following adolescence, young people feel a great push to explore and experiment with their bodies.

Youth often equate intimacy with sex. Most sexually active youth are not fully informed about contraceptives and contraceptive services, pregnancy, and sexually transmitted diseases, including HIV infection. Developed countries experienced a long period of industrialization which was accompanied by declining overall fertility levels and a rise in the age at first marriage since the 1970s (Singh & Darroch, 2000). The United States (US), however, has experience a large number of teenage pregnancies which is a worldwide problem among youth (Singh & Darroch, 2000:16). Because of the policy strategies that have been used in the US, there was a dramatic decline in teenage pregnancies. Teenage pregnancy decreased in the US by 35% between 1991 and 2005 (Ventura, Abma, Mosher & Henshaw, 2008), and rates in the UK declined by 10.6% between 1994 and 1998 and 1999 and 2003 (Wilkinson French, Kane, Lachowycz, Stephenson & Grundy, 2006). Global declines in overall fertility have been attributed to the increased availability of contraceptives, but there is, as yet, a substantial unmet gap for contraception use among youth (United Nations, 2008).

Bisika et al. (2007) indicated that in Africa most young girls are dying because pregnancy-related conditions and unsafe abortions account for a great deal of youth morbidity. This study further says that over 60% of all unsafe abortions occur amongst youth. Furthermore, half of all new HIV infections occur in people of 15 – 24 years of

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age, most of them sexually active young girls—who are thus in even greater need of contraception and the dual protection it offers.

Approximately 30% of teenagers in South Africa reported of having been pregnant and that their pregnancy was not planned. While this number has decreased over the past few decades, it is still unacceptably high (Jewkes, Morrell & Christofides, 2009; Lince, 2011; Flanagan Lince, Durao de Menezes & Mdlopane, 2013; Pettifor Rees, Steffenson, Hlongwa-Madikizela, MacPhail & Vermaak, 2005; Reddy, Panday, Swart, Jinabhai, Amosun, & James, 2008). Many authors have attributed teenage pregnancy in South Africa to be driven by many factors, including: gender inequalities; gendered expectations of how teenage boys and girls should act; sexual taboos (for girls) and sexual permissiveness (for boys); poverty; poor access to contraceptives and termination of pregnancies; inaccurate and inconsistent contraceptive use; judgmental attitudes of many health care workers (HCWs); high levels of gender-based violence; and poor sex education (Jewkes, Morrell & Christofides, 2009; Panday et al., 2009; Chigona & Chetty, 2007; Bearinger, 2007; Pettifor et al., 2005). When exploring knowledge, access to, and use of contraceptives, it was found that many youth have basic knowledge about contraceptives and protection from unplanned pregnancies, STIs and HIV. Furthermore, many report insufficient contraceptive knowledge and not using contraceptives correctly and consistently, as well as limited reproductive knowledge about fertility and conception (Samantha William, 2013).

Unwanted pregnancies have negative consequences as youth do not come for antenatal booking leading to anaemia, low birth weights, home deliveries, and STIs to both mother and babies and so on. Untreated STIs may also expose youth to HIV/AIDS. Most teenage mothers reported limited contraceptive use prior to falling pregnant and following pregnancy almost all girls began using the hormonal injection. While this is positive in terms of preventing future unplanned pregnancies, it does not assist in preventing STIs or HIV, and there was very little consideration given to this, by either teenagers or HCWs.

Furthermore, (Dallimore, 2002) reveals that some boys actually engage in premature sexual activity to prove their manhood by fathering a child out of wedlock. Teenage pregnancies are on the increase despite preventive measures and problems associated with illegitimate pregnancies and the scare of the HIV/AIDS pandemic. The young women or youth who are coming for antenatal clinic at Mutale municipality are

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increasing each year despite the free contraceptive services that are available to the facilities.

2.3 Reproductive Health Services Factors

2.3.1 Lack of Alternative Options to Forms of Contraception

Clients want a variety of services. Providing a wide range of contraceptive methods can help clients find those that match their health circumstances, lifestyle, and preferences (John, 2002). In an assessment of nine countries, the percentage of women who said that they would rather be using a different method ranged from 11 percent (Mauritius) to 48 percent (Costa Rica). Respondents cited several reasons, including the cost of their preferred methods, difficulty in obtaining their current methods, medical ineligibility for other methods, and family disapproval of certain methods (John Snow, 2000). Supply shortages can lead to dissatisfaction; as a result, some clients may discontinue using family planning altogether. Substantial evidence is found in the literature for how broadening the choice of contraceptive methods results in increased overall contraceptive prevalence (Magandi & Curtis, 2003). The provision of a wide range of contraceptive methods increases the opportunity for individuals to obtain a method that best suits their needs (John, 2002).

Flanagan et al. (2013) also noted that even when girls do go to clinics, and are fortunate enough to find friendly HCWs they often still face limited contraceptive options (the injection being most common). The most basic needs of adolescents are for accurate and complete information about their body functions, sex, safer sex, reproduction, and sexual negotiation and refusal skills. Without information, adolescents are forced to make poorly informed decisions (Bearinger, 2007). Staff knowledge on modern contraceptives, especially emergency contraception (EC) and post-exposure prophylaxis or post-exposure prevention (PEP) and the necessity for dual protection, was also found to be very limited in a number of studies. A recent study found that: 'all HCWs in three public clinics in Soweto needed additional training on modern forms of contraceptives in order to provide comprehensive family planning counselling' (Holt et al., 2012; Flanagan et al, 2013).

Youth Friendly Health Services (YFHS) should have a wide range of services and contraceptive methods available. In addition, educational materials, condoms and STI

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drugs should be available on-site (Oxfam, 2007; 2003). The Sexual and Reproductive Health (SRH) materials should include accurate and complete information about body functions, sex, reproduction, sexual negotiation and refusal skills (Bearinger, Sieving, Ferguson & Sharma 2007). Ideally, YFHS should provide "one-stop shopping" to avoid sending adolescents elsewhere for care because they may not follow through with the referral (Oxfam 2007). However, where necessary, partnerships should be formed for providing referrals. The male condom is the most commonly used modern contraceptive among young people in many countries. A four-country study conducted in sub-Saharan Africa found that at least half of sexually active males aged 15 – 19 who reported having sex with more than one partner in the past three months said they had used a condom. According to Bankole, Ahmed, Neema, Ouedraogo & Konyani (2007:199) condom use was highest among male adolescents in Ghana (68%), and lowest in Malawi (50%).

On the contrary, data from Demographic and Health Surveys show that oral contraceptives or injectables are the most popular hormonal method among 15 - 24 year-olds in the developing world, with rates of use exceeding 20% in some countries. Far fewer young women use implants, with rates of use below 1% nearly everywhere. Data from the District Health Barometer (2010/2011) show that despite the high awareness of hormonal methods among youth by NGOs, such as Love Life, there is much lower rates of use among youth ages 15 - 19 years.

The findings of a study conducted by Lebese, Maputle, Ramathuba, & Khosa (2013) about the factors influencing the uptake of contraceptive services by Vatsonga adolescents in rural communities of Vhembe District in Limpopo Province, South Africa, revealed that adolescents are aware of the availability of contraceptive services. However they found that there is lack of comprehensive knowledge about contraception and contraceptives, which led to negative attitudes towards using the services. Cultural health beliefs and attitudes were also identified as a barrier to the uptake and use of contraceptives. Recommendations were made on interventions to increase the uptake of contraception services amongst adolescents.

This was confirmed by Biddlecom, Munthali, Singh & Woog (2007) who indicated that the barrier preventing adolescents from accessing SRH services is lack of knowledge about where to access these services and lack of knowledge about what services are available. Young people may be unaware of their risk of pregnancy, unfamiliar with STI

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symptoms, and unsure of what types of services are offered. To have complete information on contraceptive methods, one must have knowledge of how to use the method, how to obtain the supplies and also know the common side effects and how to deal with warning signs of complication and where to obtain help in case of emergencies (DoH, 2001). Wood, Maepa & Jewkes (1997) indicated that in Limpopo Province girls use contraceptive pills when partners visited them, and stop taking the pills when they experience side effects. Ehlers & Khoza (2001) investigated adolescents' knowledge and attitude towards contraception and uptake of contraceptive and identified lower levels of knowledge and negative attitudes towards contraception.

Some youth might perceive contraceptives to be irrelevant or even harmful and these perceptions could result in unplanned pregnancies. Unplanned pregnancies could have serious implications for the physical, psychological and social well-being of young people and even for their nuclear as well as extended families. Youth should therefore be knowledgeable about contraception and different contraceptives, to enable them to make informed decisions about their own as well as their children's future. Adequate information about contraceptives could help youth to realize that effective utilization of contraceptives can successfully postpone pregnancies until they have completed their schooling and/or are financially capable of caring for their children. Numerous factors could contribute to the many adolescent pregnancies in the Mutale sub-district area. However, youth require knowledge to be able to make informed decisions and to evaluate their attitudes towards and beliefs about contraceptives.

Wood & Jewkes' (2006) study about barriers to adolescent contraceptive use in SA reported a widespread knowledge of participants about local traditional and religious methods of contraception, such as tying a rope containing traditional medicines around the waist, mixing a cloth covered in the woman's menstrual blood with medicines from a traditional healer and burying it, and drinking tea or concoctions prayed over by religious leaders. Khoza (2004) reported that female adolescent participants did not have knowledge of emergency contraceptives, what they were and when to use them and further cited Ehlers (2003) who indicated that 40 out of 60 adolescent mothers in Tshwane, SA, did not know about the availability of emergency contraceptives to be taken 72 hours after unprotected sex. Netshikweta (1999) also reported in a survey conducted in Limpopo that 73% of 93 student nurses had no knowledge of emergency contraceptives despite being health care providers. In a nation-wide survey among young adults aged 15 - 29 years, knowledge about contraception was found to be as

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high as 90% and 87% for condoms and pills, respectively. But when it comes to practice, only 15% of the males used condoms and 39% of the females used pills. A study conducted in high schools in Addis Ababa, Ethiopia, indicated that 54% of sexually active youth have experienced sex with more than one partner, but only 18% said they had ever used a condom. Another study conducted in south Ethiopia reported condom use rate during the first sexual intercourse as 13.5%, while it was 27.6% during their recent one. Studies conducted in rural towns in Ethiopia revealed that 65.7% of sexually active group reported to have used some form of modern contraceptive in the past. Young people may be unaware of pregnancy, unfamiliar with STI symptoms and unsure where to obtain services and what type of services is offered. Young people often seek information about reproductive health from their peers and the media, rather than from teachers, health professionals or parents.

Many adolescents do not have adequate information on SRH, especially with regard to contraceptives and STIs. For example, a significant proportion of sexually active adolescents do not know where or how to obtain contraceptives or get STI treatment (Biddlecom et al., 2007). Unfortunately, many adolescents get information on SRH from each other, and this information is often incorrect (Baloyi, 2006). According to Oxfam (2007), poor knowledge and lack of awareness are the main underlying factors for adolescents not using SRH services. In one survey in Uganda, some participants gave reasons why they would fail to use contraceptives even if they did not intend to get pregnant. Many participants, both male and female distrusted male condoms, the contraceptive used most frequently by young people. They believed that it was potentially dangerous to use condoms because it could get stuck in the vagina where it would get rotten and cause damage. Likewise there were rumours that the pill could cause deformed babies, inability to get pregnant in the future as well as cancer of the cervix and the breasts. Rumours and myths about family planning may raise potential clients' concerns about the side effects, safety, and effectiveness of different methods.

Another study in Uganda found that young people believed that contraceptives interfered with their fertility, and they were frightened to use something that could harm their ability to reproduce. The same study by Nalwadda Mirembe, Tumwesigye, Byamugisha (2011) claimed that most of the married and unmarried women believed that pills burned the woman's eggs. All of the policies and procedures at the clinic should support the rights of adolescents (Baloyi, 2006). Recommended policies include:

- Drop-in clients are welcome and appointments arranged quickly (Oxfam, 2007)

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- A written policy on management of adolescents under 16 who are sexually active, based on their care needs and their right to confidentiality (Rogstad, Ahmed-Jushuf & Robinson, 2002)
- A written policy informing consent to and refusal of treatment, based on national legislation (Rogstad et al., 2002).

Despite international consensus regarding youth's right to RHS and information, young people are often excluded from national health policies. Some countries have restrictive legal health policies, while others have more positive ones that may not be well known to providers or educators. Policies concerning youth reproductive need to be clarified and more widely disseminated to providers, managers, policymakers, and young people, and further research is needed to determine the legal policies make a difference (Barnett & Katz, 2000). Politicians and government restrictive laws and policies often limited access to reproductive health. Such regulations usually require a minimum age, parenteral consent, or that a person is married to receive the services. In the US, for example, most states require women under the age of 18 years to obtain consent of or notify one or both parents prior to abortion. In many countries in the Middle East and North Africa laws restrict access to sexual and RHS for young people and government programmes. In India, for example, censors block television advertisement for a society marked condom.

Similarly, government officials in Zambia initially rejected advertisements for condoms as too explicit for a youthful audience (www.pathfind.org/pf/pubs/focus/IN FOCUS/nov.2000htm). It has, however, been observed by some researchers like Cobb (2001) that most adolescents are surprisingly misinformed about their own reproductive capabilities. Some surveys have shown that as many as two-thirds of adolescent girls believe it is not necessary for them to take precautions because they are too young to get pregnant or because they have not had sexual intercourse enough times to become pregnant. Again, it has also been observed that the use of contraceptive is not popular with teenagers because of ignorance, insufficient sex education and other reasons (Cobb, 2001).

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2.3.2 Stigma Associated with the Use of Contraceptives

Stigma around young people's sexuality may similarly deter young people from seeking contraceptive services or may result in denials of RHS, even where parental consent is not required. Many sexually active young women report fear, embarrassment, or shyness about seeking contraceptive services. A study conducted in Malawi, Ghana, Burkina Faso and Uganda in 2007, found that along with financial cost, social-psychological/stigma issues (e.g., embarrassment or fear) are the most common barriers to adolescents accessing health services (Biddlecom et al., 2007). Flanagan et al. (2013) also noted that even when girls do go to clinics, and are fortunate enough to find friendly HCWs they often still face limited contraceptive options (the injection being most common). Because of this stigma toward adolescent sexuality, adolescents often report they do not access SRH services due to fear of being chastised, stigmatised or punished for sexual involvements (Bearinger, 2007, cited in MIET, 2012).

In another study conducted in Burkina Faso, results showed that adults were supportive of young people accessing contraceptive information, but they were less supportive of young people accessing actual services (Ouedraogo Woog, & Ouedraogo, 2007). Surveys reveal that young people do not want to run into family members and neighbours when entering, utilizing, or leaving reproductive health facilities. But still, many youth have difficulty traveling very far away, unless public transportation is available.

This further illustrates the fact that stigma still exists related to young people accessing contraceptive services. In particular, there is often a negative attitude toward young unmarried women who are utilizing contraceptive services (Erulkar, Onoka & Phiri, 2005). Health care providers' attempts to stigmatize teenage sexuality, their scolding and harsh treatment of adolescent girls, and their unwillingness to acknowledge adolescents' experiences as contraceptive users, undermined the effective use of contraception by girls (Wood & Jewkes, 2006).

Youth need better information on reproductive physiology and sexual health, and detailed information on contraception. Because of this stigma toward youth who are utilizing contraceptive services, youth often report that they do not access contraceptive services due to fear of being chastised, stigmatised or punished for sexual involvement (Bearinger, et al., 2007,WHO 2009). Because of this stigma young people often have

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fear of being recognised in the waiting room by adults from their community. This results in young people being reluctant to go and seek contraceptive services (WHO, 2009, UNFPA 2011).

2.3.3 Long Distances to Health Clinics and Inconvenient Hours

Long distances to health clinics and impassable road infrastructure are amongst the reasons why there seem to be a low uptake of contraceptive services among youth in rural areas (Hamid & Stephenson, 2006; Katende, Gupta & Bessinger, 2003; RamaRao Lacuesta, Costello, Pangolibay & Jones, 2003; Seiber & Bertrand, 2002; Magnani Hotchkiss, Florence & Shafer, 1999; Steele, Curtis & Choe, 1999). Richter (2000) stressed that according to the principles of primary health care (PHC), a health service should be accessible to its users. Access to health care services for youth also affects the utilization of contraceptives. Distances from the nearest clinics and payment for transport sometimes prevent youth from travelling to health care services for contraceptives and information. Most young girls are financially dependent on their parents who might be unable to pay for transport to clinics.

Clinics are often designed for adult clients, and service providers are not trained in adolescent sexuality and youth-friendly concepts. As a result, young people are neither well received nor comfortable in mainstream family planning clinics (MIET Literature Review, 2012). Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need. In both Malawi and Senegal, clients identified long waiting times as a concern. One client said, "The wait is a big problem. I'll sometimes skip my appointment if I think about the hours I'll have to spend at the centre" (John Snow, 2000).

Some clinics do not post their hours of service, or do not serve clients during certain hours when they are supposed to be open. A study in Kenya found that although clinics were officially open from 8 a.m. to 5 p.m., providers discouraged clients from coming in the afternoons and often did not provide services to women who were only able to attend in the afternoon (Population Council, 2002). Competing demands on women's time can also make it difficult for them to use services, particularly when facilities are far away. Villages that are far from the health care facilities lead to non-compliance to contraceptive methods by the young people.

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The health services should be within a reasonable geographic distance and be functional in terms of the needs of youth. Accessibility could also be improved by rendering services on Saturdays. Contraceptive services could be located at schools, clinics or community centres accessible to youth so that the distance can be easily accessed (Richter, 2000). Health services should be offered at a time that is convenient for young people, such as late afternoons, evenings and weekends because most youth are out of school during those hours of the day (WHO, 1999; Oxfam, 2007). Special opening hours could also be offered to adolescents, separate from the normal opening hours of the clinic (IPPF, 2007; Oxfam, 2007). Also, with regard to time, it is essential that there are short waiting times for youth and that adequate time is spent on client and provider interactions (Oxfam, 2007; WHO, 1999), but these are ideal conditions for any health care environment and not just for adolescents.

2.3.4 Attitude of Health Care Professionals

Youth-friendly staff was recognized as the single most important condition for establishing youth-friendly health services (Oxfam, 2007). Attitudes of health care providers at PHC facilities can lead to negative attitudes towards contraceptive use among youth and this can result in unwanted or unplanned pregnancies. Youth saw nurses as 'rude, short-tempered and arrogant' and complained that nurses were asking 'funny questions' about whether they had boyfriends or why they wore mini-skirts. For young people contemplating or engaged in sexual activity, HCWs play a vital role in the provision of contraceptives and counselling, and have a significant impact on sexual decision-making and behaviour (Bearinger et al., 2007).

In a study on youth and contraceptive utilization, Woods, Maforah & Jewkes (1998) stated that adolescents reported that nurses would not give them contraceptives before asking about their sexual relations and lecturing to them on being too young to have sex. These questions asked by nurses resulted in underutilization of contraceptive services because youth feel intimidated by too many questions. Effective staff attitudes are crucial for improving the quality of care rendered to adolescents. Knowledge about contraceptives and youth reproductive rights constitutes the basis on which contraceptive service providers should function effectively.

Another study by Ndyanabangi and Kip (2002) reported that one contraceptive provider considered oral contraceptives to be dangerous and refused to give it to one of their

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mystery clients and it was reported in Kabarole health district in Uganda that providers discouraged women from using contraceptive. Service providers are often judgemental toward sexually active youth and have negative attitudes toward them (Oxfam, 2007; WHO, 2009). Furthermore, service providers sometimes deny access to a contraceptive service as a result of their own prejudices about the method or its delivery system. Provider bias, which occurs when service providers believe that they are in a better position to choose the most appropriate method for the client, or are biased toward certain methods, may preclude women from using a method appropriate to their circumstances and needs (Irwanto, 2013).

In Senegal, clients posing as unmarried youth were denied contraceptives after requesting them (Annova.com/news/story/sm19567 htmm). Another attitude differentiated between boys and girls. Many field staff acted on underlying biases that limited girl's access to care. In Jamaica, for example, HCWs were more likely to serve boys than girls. One study found that less than one fifth of Jamaica providers would give condoms to girls compared to more than two thirds who said they would give condoms to boys (www.pathfind.org/pf/pubs/focus/INFOCUS/nov.2000.htm).

Many youth who visited clinics for contraceptive services reported that service providers in normal clinics treated them rudely and denied them services (WHO, 2009; UNFPA, 2011). This reveals that staff may not have the counselling skills and training necessary for dealing with young people (Oxfam, 2007). As a result, young people are neither well-received nor comfortable in mainstream family planning clinics (Erulkar, Onoka & Phiri, 2005).

Provider attitudes, opinions, and biases about contraceptives represent what providers truly believe, including their support or opposition to provision, and opinions potentially affecting distribution practices. Research shows that some family planning providers still restrict access to contraceptives based on age or marital status. In many societies and cultures, adults have difficulty accepting youth's sexual development as a natural and positive part of growth and maturation. Access to contraception was reported as a significant barrier, with many teenagers reporting that the attitudes of HCWs and clinic access often stopped them from accessing contraceptives (Irwanto, 2013).

Young people are not encouraged to seek care if they encounter providers whose attitudes convey that youth should not be seeking sexual health services. Young people may be embarrassed and refuse to return for services if staff asks personal questions

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loudly enough to be overheard by others (Irwanto, 2013). In addition to the above, studies have shown that women are more likely to seek out and continue using contraceptive services if they receive respectful and friendly treatment. In many societies, courtesy is a sign that the client is regarded as the provider's equal. Research showed that the provider's tone, manner, and modes of speech are important to clients. This was a study that was carried out in Kenya and Zambia to investigate the attitudes of nurse-midwives towards adolescent sexuality and related reproductive health problems.

The study reported that nurse-midwives regarded adolescent sexuality as a moral issue and disapproved of adolescent pre-marital sex, safe abortion, and safer sex practices, including contraceptive use and masturbation.(Godia,2012) In spite of this, the majority of the nurse-midwives were supportive of sexually active girls using contraception and counselling for boys on condom use (Warenius et al. 2006). Although over half of the providers did not agree with girls being allowed to undergo abortions, they were willing to treat girls who presented to their facilities with complications resulting from induced abortions (Godia,2012). Moreover, providers who had received continuing medical education on ASRH showed more tolerance towards adolescent sexuality (Warenius et al. 2006).

2.3.5 Privacy and Confidentiality

Clients feel more comfortable if providers respect their privacy during counselling sessions, examinations, and procedures. Particularly those who obtain services in secret report higher satisfaction with providers who keep their needs and personal information confidential (Andrea, 1996). Lack of privacy can violate women's sense of modesty and make it more difficult for them to participate actively in selecting a contraceptive method. In a few places, obtaining and using contraceptives can be a difficult and risky decision that can lead to abandonment, violence, ostracism, or divorce. In such situations, women need assurance of absolute confidentiality. Linked to this is the fear that confidentiality cannot be guaranteed: 'Whether teenagers are knowledgeable or ignorant about contraceptives, this [lack of confidentiality by HCWs] is a definite barrier for some patients who want to keep their sexual activities private' (Hoffman-Wanderer et al., 2012). All of our respondents expressed concern about their information being shared by the health care nurses, and everyone 'knowing that they are having sex'.

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2.3.6 Information and Counselling

Clients want to receive information that is relevant to their needs, desires, and lifestyles. Because clients differ in their reproductive intentions, attitudes about family planning, ability to make decisions, and other factors that affect contraceptive choice, they need information that is tailored to their individual needs. Clients who are well-informed and have made their choice about a contraceptive method may not want detailed information on a range of other methods. Others may want information about procedures, treatment, risks, and side effects. In a study in Kenya, women were not satisfied with the information provided; they wanted to hear about a larger number of methods so that they could make an informed choice (Lewis, 1997). Over 40 percent of the women in one Indonesian study wanted more information on side effects, and over 26 percent wanted to know more about how contraceptives work (Irwanto, 1997).

A study of 1,570 Norplant users in Indonesia found that women who had received counselling and information about Norplant were more satisfied than those who had received less information (TAN, 1995). Similarly, the Davao Project in the Philippines demonstrated that lack clients counselling, lack of privacy for counselling and high clinic caseloads were major weaknesses in the province's family planning programme (Costello, 2000).

In addition to comprehensive knowledge about contraceptives, concern has been raised that many teenagers do not understand how conception occurs, when they are fertile, and the impact of incorrectly or inconsistently using the pill (The National Contraception Policy Guidelines, 2012). This can lead to misunderstanding about how one falls pregnant, when one is most likely to conceive, and notions that 'if I just have sex once I won't fall pregnant'. Such essential information should be the basis of sex education.
However, Hoffman-Wanderer et al. (2013) reviewed a number of teenage pregnancy studies and found that: 'pregnant teenagers have relatively low levels of knowledge about modes of contraceptives' (Hoffman-Wanderer et al., 2013). A literature review on the topic by MIET (2012) found similarly that many adolescents do not have adequate knowledge on contraceptives. A further study of 250 adolescent mothers by Ehlers (2003) also found that 34% did not know about contraceptives whilst 55.6% knew about contraceptive injections.

Some studies of HCWs also reflected low levels of knowledge among teenagers. Holt et

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al. (2012), in their work with HCWs, highlighted that some of the HCWs they spoke to felt the level of knowledge was insufficient: 'young women don't have sufficient information about consequences of sex and the importance of prevention.' They went on to highlight poor communication, often between teenage girls and their mothers: 'for example when mothers take their daughters for family planning but do not discuss sex or why the daughter might need family planning' (Holt et al., 2012). Hoffman-Wanderer et al. (2013) also interviewed HCWs and again they stressed their belief that teenage girls do not have enough information to protect themselves adequately.

Ehlers (2003) also enquired about other means of protection such as the emergency contraceptive: '189 out of the 250 respondents (75.6%), did not know about the availability of emergency contraceptives to be taken within 48 - 72 hours after unprotected sex' (Ehlers, 2003). And the National Contraception Policy Guidelines (2012) noted that: 'The 2003 SADHS indicates that knowledge of emergency contraception remains low (19.6% women and 3.6% of men knew about emergency contraception).'

Young people lack information on sexuality and contraception as most of the education that is presented on this is partial. Youth are not prepared to deal accurately with their sexual feelings and this has been reflected in various studies, like the study undertaken in Kwazulu-Natal in secondary school. This study revealed that 30% of teenagers became sexually active during their school years. Of these, 2% did not know what a condom was and 8% had never seen a condom. Half of them had used a condom once and none of them had used the condom consistently. Forty per cent of students did not know that birth control pills could be obtained without parental permission.

2.4 Summary

In this chapter, the literature review covered demographic and socio-cultural factors that play an important role in determining the use of contraception and contraception services by youth. It also underscored how RHS factors such as lack of alternative options to forms of contraception, stigma associated with the use of contraceptives, long distances to health clinics and inconvenient hours, attitude of health care professionals, privacy and confidentiality, information and counselling impact youth's decisions to use contraception and contraception services. Chapter 3 covers the research design and methods used in this study.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides an overview of the research methodology that was used in the study. Research methodology is a way to systematically solve the research problem, that is, how the research is carried out scientifically (Creswell et al., 2011). The following were the main areas of focus in the chapter: research design, research setting, study population, sample and sampling procedure, data collection instruments, methods of data analysis, measures to ensure trustworthiness and ethical considerations.

3.2 Research Designs

A research design is a blueprint for conducting a study that maximizes control over factors that could interfere with the study's desired outcome. The type of the design directs the selection of a population, sampling procedure, methods of measurement and a plan for data collection and analysis (Burns & Grove, 2005). Maree (2007) and Kruger & Mitchel (2005) also defined research design as a plan that helps to obtain research participants and collect data from them and in it we describe what we are going to do with the participants in order to reach conclusions with our research problem. The purpose of the research design is to provide the scheme for achieving the objectives of the study either in the form of research questions, hypotheses or study objectives. In this study, the researcher will use the qualitative design.

3.2.1 Qualitative Study

A qualitative study is descriptive and subjective approach and is used for selected strategies of inquiry where clinical ethnography and qualitative interviews are intended (Creswell, 2009). A qualitative study is an investigation of phenomena, typically in an in-depth and holistic fashion.This is achieved through the collection of rich narrative materials, using a flexible research design. It is a way of finding out what people think and feel through observing and interviewing and reading documents (Brink, 2011).

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A qualitative design is used when little is known about a phenomenon or when the nature, context and boundaries of a phenomenon are poorly understood and defined (Botman, Greeff, Mulaudzi & Wright, 2010; Morse, 1992). Therefore, it is concerned with understanding processes and social and cultural contexts which underlie various behaviour patterns by interacting with and observing participants in their natural environment with a main focus on quality and depth of information, hence it does not attempt to control the context of the research (Brink, 2012).

That is why human actions are looked at in a more holistic way in an attempt to locate an individual's action in their cultural context to gain an understanding on why people say this, do this, or act in that way, linking them to other people's events. However, the stories, experiences and voices of participants are mechanisms through which we explore and understand reality, hence it emphasizes people's interpretation of events and circumstances rather than the researcher's interpretations. Furthermore, qualitative research can be described as an approach generally covering an array of interpretive techniques which attempt to describe, decode, translate and come to terms with the meaning of naturally occurring phenomena in the social world (Welman, Kruger & Mitchell, 2009).

According to Creswell (2007), qualitative research is a form of study where the researchers make interpretations of what they see, hear, and understand while keeping focus on learning the meaning that participants hold about an issue under study. The proposed study will employ qualitative interviews with the relevant participants in order to make sense about the extent to which youth are using contraceptives and contraceptive services in rural communities given all the challenges of teenage pregnancy in Masisi and Manenzhe villages.

3.2.2 Explorative Approach

Brink (2007) indicated that an explorative study is aimed at exploring the dimensions of a phenomenon and the manner in which they are related. This is conducted to gain insight into the situation, phenomenon, community or individuals (Blaikie, 2000). The exploratory study help to uncover unknown research areas and to gain new insights into phenomena under study (de Vos, 2005). In this study, in-depth information will be gathered by means of interviews in order to explore the dimensions of the youth's utilization of contraceptives and contraceptive services in rural communities of the

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Mutale district.

3.2.3 Descriptive Approach

A descriptive design is research, in which phenomena are described, or the relationship between variables is examined; no attempt is made to determine cause-and-effect relationship (Brink, 2012). According to Rubin & Babbie (2005), description is more likely to refer to a more intensive examination of phenomena and the deeper meanings, thus leading to thicker descriptions. A descriptive design may be used to identify problems with current practices; to justify current practices, make judgements or determine what other professionals in similar situations are doing, or to develop theories (Burns & Grove, 2011). In this study, the researcher will be able to determine youth utilization of contraceptive services in rural communities of the Mutale district. The researcher will use a descriptive design because these studies are used where more information is required in a particular field through the provision of a picture of the phenomenon as it occurs naturally (Brink, 2012).

3.2.4 Contextual Approach

A contextual study focuses on studying a phenomenon because of its contextual significance with the aim being to produce an extensive description of the phenomenon, group or event within the context of a unique setting of the domain of the phenomenon. A phenomenon must be studied in its natural setting because individuals make their meaning from themselves and within their context (Lincoln & Guba, 1985). This study was contextual because it was undertaken in the rural communities of Mutale municipality of the Limpopo Province.

3.3 Study Setting

Brink (2012) referred to research setting as a specific place or places where the data will be collected and where the participant lives and has experiences. Limpopo Province is located in the far north of South Africa, and there are five districts in the province, of which Vhembe is one. Vhembe district is demarcated into four municipalities: those of Thulamela, Makhado, Musina and Mutale. This research will be conducted at the rural villages of Mutale municipality. Mutale local municipality is one of the four local municipalities in Vhembe district municipality. It is situated in the far north eastern

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corner of the district. The Kruger National Park forms the eastern boundary of Mutale local municipality, with the Limpopo River forming the northeastern boundary. Mutale municipality shares borders with Musina local municipality and Zimbabwe in the north, Mozambique in the east, Makhado local municipality in the west, and Thulamela local municipality in the south.

As a rural municipality, Mutale municipality has countless opportunities for development and has vast land available for exploitation; hence, it is an environmentally sensitive area. Opportunities are available in the areas of agriculture, mining, tourism, arts and culture. The exploitation of the above issues could give a positive contribution to the development of the municipality. The Masisi and Manenzhe communities are homogeneous in terms of culture, tradition and language. The source of income is mostly subsistence farming. Most of the community members, including the youth, are working in nearby farms for their basic living expenses. A few women engage in petty trading and a few are employed at the nearby Tshikondeni mine. There are two health facilities located in these two communities. The distance from the villages to the clinic is between 15 and 30 kilometres. The area where the study was conducted is in the villages were the participants were found at their homes and clinic setting.

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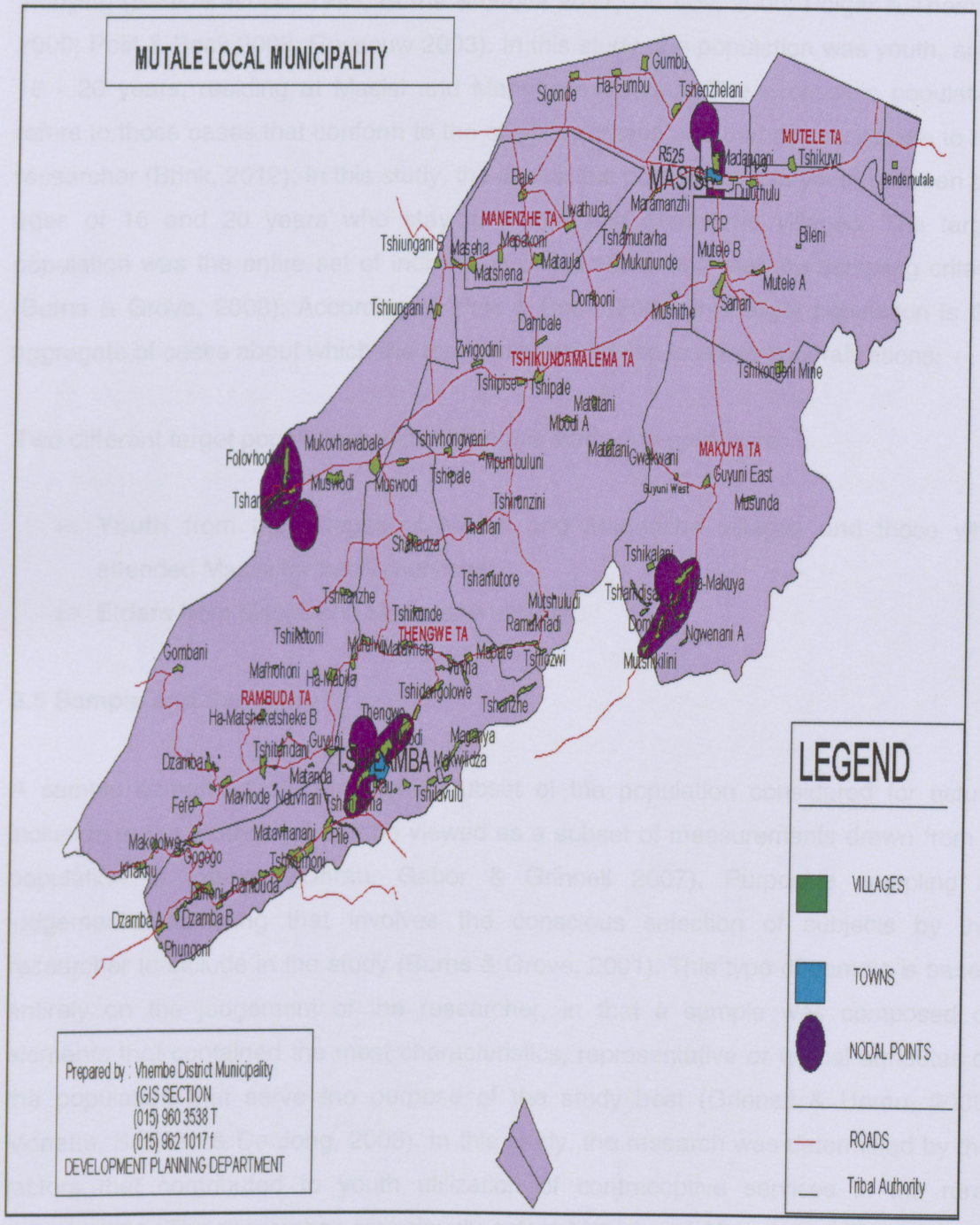

Figure 3.1: Map of Mutale municipality and study setting locality in the Limpopo Province

3.4 Study Population

A study population is the entire group of individuals or objects that are of interest to the researcher, in other words, who meet the criteria that the researcher was interested in

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studying (Brink & Wood, 1998; Burns & Grove 2011; De Vos, 2005; Polgar & Thomas, 2000; Polit & Beck 2008; Rossouw 2003). In this study, the population was youth, aged 16 - 20 years, residing at Masisi and Manenzhe villages. The accessible population refers to those cases that conform to the eligibility criteria and that are accessible to the researcher (Brink, 2012). In this study, the accessible population was youth between the ages of 16 and 20 years who stay in Masisi and Manenzhe villages. The target population was the entire set of individuals or elements who met the sampling criteria (Burns & Grove, 2008). According to Polit & Beck (2004) the target population is the aggregate of cases about which the researcher would like to make generalizations.

Two different target populations with whom this study engaged were:

- **Youth** from the villages of Masisi and Manenzhe villages and those who attended Masisi for health services.
- **Elders** from Masisi and Manenzhe villages.

3.5 Sample and Sampling

A sample comprises elements or a subset of the population considered for actual inclusion in the study, or it can be viewed as a subset of measurements drawn from a population of interest (Unrau, Gabor & Grinnell 2007). Purposive sampling is judgemental sampling that involves the conscious selection of subjects by the researcher to include in the study (Burns & Grove, 2001). This type of sample is based entirely on the judgement of the researcher, in that a sample was composed of elements that contained the most characteristics, representative or typical attributes of the population that serve the purpose of the study best (Grinnell & Unrau, 2008; Monette, Sullivan & De Jong, 2008). In this study, the research was determined by the factors that contributed to youth utilization of contraceptive services in the rural communities. The researcher consciously select Masisi and Manenzhe villages in the Mutale sub-district due to the high rate of teenage pregnancy in the area.

3.5.1 Sampling Procedure

Sampling is a process of selecting a portion of the population to represent the entire population. Non-probability sampling may or may not represent the population. It is more convenient and economical and allows the study of populations when they are not

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amenable to probability sampling, or when the researcher is unable to locate the entire population, or where access to participants is limited (Brink, 2012). Purposive sampling is often used when the researcher wants a sample of experts and is good in sites sampling (Polit & Beck, 2010). Purposive sampling was used in this study to select youth who met the set criteria.

Purposive sampling is judgemental, involving the conscious selection of certain subjects or elements by the researcher to include in the study (Burns & Grove, 2001). It was based on judgement of the researcher regarding participants or objects that were typical or representative of the study phenomenon, or who are especially knowledgeable about the question at hand (Brink 2012). Data saturation determined the sample size. The data saturation is the point at which new data no longer emerged during data collection process (Brink, 2012).

3.5.2 Sampling of Villages

In this study, the researcher purposefully selected Masisi and Manenzhe villages because of their rural nature and the underutilization of contraceptive services, as reflected by the number of teenage pregnancies in the area.

3.5.3 Sampling of Participants

Polit & Beck (2010) stated consecutive sampling as a method that involves recruiting all of the people from an accessible population who meet the eligibility criteria over a specific time interval, or for a specified sample size. In this study, the researcher use consecutive purposive sampling in which all eligible youth, and community elders were recruited to participate in a study.

3.5.4 Eligibility Criteria

Eligibility criteria include a list of characteristics essential for membership or eligibility in the target population (Burns & Grove, 2008). In this study, the inclusion criteria were females from ages 16 - 20 years, and community elders who reside at the Masisi and Manenzhe villages. The exclusion criteria include males, females below age 16 years and females above 20 years. Inclusion sampling criteria are those characteristics that subjects or elements must possess to be part of the target population. These were the

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eligibility criteria which led a researcher to exclude certain elements, individuals or objects from the population (Brink, 2012).

3.6 Data Collection

In this study, unstructured in-depth interviews were used following an interview guide. The method of in-depth interviews has been chosen because participants could provide historical information. It also allowed the researcher to take control over the line of questioning. Methods of data collection go according to target group as follows: youth individual interviews and checklist were used. With elders, individual interviews were used. During interviews, the researcher observed and made field notes in a chronological order to distinguish information.

The researcher used in-depth the interview method because it was focused and discursive and allowed the researcher and participants to explore issues. The interviews was audio-recorded with the permission of the participants, transcribed, and then translated from Tshivenda to English and then analyzed. Each interview began with one central open-ended question that focuses on the research question. The interview last for at least forty five minutes. During data collection, the researcher was more directly involved in the experience where the researcher observed verbal and non-verbal behaviour.

3.7 Data Analysis and Interpretation

Data analysis entails categorising, ordering and manipulating and summarizing the data and describing them in the meaningful terms (Brink, 2005). According to Babbie (2007), qualitative analysis is the non-numerical examination and interpretation of the observation for the purpose of discovering underlying meanings and patterns of relationships. Data analysis is the systematic way of organizing and synthesising research data (Neuman, 2011). Data collection and analysis in a qualitative study take place simultaneously and involves bracketing of preconceived ideas, beliefs and assumptions (Neuman, 2011). In this study, analysis of qualitative data was a creative process of making sense of the findings and meaning of the collected data.

The data collected were transcribed verbatim from the audiotape recordings into written notes. The transcriptions were analyzed individually in order to identify similarities, differences and relationship. Data were closely examined and themes were developed.

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The following steps were followed when analyzing data as shown by Tesch, cited in (Creswell, 2003). This enabled the researcher to voice-record all the interviews with the respondents. Following immediate voice recording, the researcher closely examined and identified themes that were generated. In doing so, the researcher followed Tech's steps (Creswell, 2003) as indicated in Table 3.1.

3.8 Measures to Ensure Trustworthiness

Trustworthiness refers to the employment of procedures to ensure accuracy of the study and also refers to consistency across studies and researchers. Trustworthiness is a way of ensuring data quality or rigour in qualitative research based on the model of Lincoln & Guba (1985). These authors proposed four criteria for developing trustworthiness, namely: credibility, transferability, dependability and confirmability. These criteria are described in the subsections that follow.

3.8.1 Credibility

Credibility refers to the assurance in the truth of data and the interpretation thereof. The aim was to show that the enquiry was conducted in a way that the subject is accurately identified and described (Brink et al., 2012).

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Table 3.1: Tesch's eight steps of qualitative data analysis

Step	Description
1.	**Getting a sense of the data** The researcher tried to make sense of the whole by reading the entire transcript carefully and wrote ideas as they came to mind. The researcher carefully read through all the transcriptions, some ideas were jotted down as they came to mind. At this stage, the researcher organized the data, and transcribed/translated the data verbatim.
2.	**Pick up one interview document** The researcher picked one short interesting document from the interviewed documents, read it and checked the meaning and wrote thoughts that arose in the margins.
3.	**Make a list of all topics and cluster similar topics** After all the data were analysed, the researcher made a list of topics that were similar and clustered them together as major, minor or unique topics.
4.	**Abbreviate the topic as codes** The researcher abbreviated the formulated topics as codes and wrote them next to each other appropriate segment and reviewed them to see if new codes emerged.
5.	**Find the most descriptive wording** The researcher found the most descriptive wording for the identified topics and turned them into categories while grouping the related topics and indicating their interrelationships.
6.	**Make a final decision on the abbreviation** The researcher did this for each category and alphabetized the codes.
7.	**Assemble similar categories of data** The researcher assembled data materials belonging to one category and placed them in one location and ran preliminary analysis.
8.	**Recoding data** The researcher recorded the existing data, where possible, as indicated by (Creswell, 2003). The researcher in qualitative research transcribed the audiotaped interview and field notes and researcher ensured that the transcriptions were accurate, that they reflected the totality of the interview experience, and that they facilitated analysis. After transcription of the data the researcher then converted the data to smaller and more manageable units that

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can be retrievable and reviewed. The researcher developed a category scheme and then coded data according to categories. Once a category scheme has been developed, the data were read in their entirety and coded for correspondence to the categories.

Sources: Tesch R (1990) Qualitative Research: Analysis Types and Software tools, New York, Falmer; Creswell. J.W., (2009) Research Design, Qualitative, Quantitative and Mixed Method Approaches, 3rd Edition, Sage Publications Inc. In this dissertation, see also Creswell (2003:156).

In this study, the interviewer prolonged the stay with the participants, whereby in depth-interviews with follow-up and probing questions to ensure longer contact. A rapport was established and use of participants' first language was ensured. Triangulation was used whereby the researcher asked questions to ensure understanding to the participants and using different sources and methods such as taking field notes, observation notes and audiotapes which were used to ensure credibility. Field notes were taken through interview sessions. Reflexivity and peer review were also done.

3.8.2 Transferability

Transferability refers to the ability to apply the findings in other contexts or to other participants and still maintain the meaning of the study. This was ensured by using purposive sampling working contextually and using dense description (Brink, 2012) which includes the collection and provision of enough detailed descriptions of data within a different context. Data were collected until data saturation was reached; this occurred when new participants were not providing additional information and whereby the participants repeated what had already been said.

3.8.3 Dependability

Dependability refers to the provision of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar. It refers to the stability of data over time (Brink, 2012). When dependability is absent, credibility will also be absent (Guba & Lincoln, 1995). Dependability was ensured by thick description of methodology and peer debriefing who were independent and were checked by the independent audit trail who is an experienced qualitative researcher.

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3.8.4 Confirmability

Confirmability is the point to which the result is the product of focus of the enquiry and not of the biases of the researcher (Mouton & Babbie, 2001). It ensures that the data represents the information provided by the participants and that the researcher's imagination does not influence the interpretation of the data. The researcher audited the whole research process through reflective analysis and triangulation. Finally, the researcher also used the strategy of confirmability to ensure neutrality and trustworthiness.

3.9 Ethical Considerations

Ethical considerations refer to a set of widely accepted morals and principles that offer guidance and behavioural expectation through the research process. Ethics provides rules and guidelines to the researcher on how to behave and expected conduct towards participants, research assistants, field workers, the institution, sponsors and the employers in the study (De Vos et al., 2005).

3.9.1 Permission to Conduct the Study

In this study, the researcher obtained permission to conduct the study from the following authorities; Department of Advanced Nursing Science Committee, School of Health Sciences Committee, Higher Degree Committee of the University of Venda, Ethics Committee of the University of Venda, the Chiefs of the villages in Mutale municipality where this study was conducted and from the participants through informed consent (Annexures 1-12).

3.9.2 Avoidance of Harm to Participants

The researcher has an ethical obligation to protect participants within all possible and reasonable limits from any form of physical, emotional, psychological harm or discomfort that may emerge from the research project (De Vos et al., 2011). The researcher should not injure the people being studied, whether or not they volunteered for the study (Mouton & Babbie, 2001). In this study, avoidance of harm to participants was ensured by maintaining privacy, confidentiality and anonymity. No sensitive information was discussed and whenever the participants were not comfortable with

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discussion the participants was excused. Participants were not forced to talk when she was not comfortable. Since the interviews and they were recorded only after they had agreed that they were comfortable with it.

3.9.3 Voluntary Participation

Participation should at all times be voluntarily and no one should be forced to participate in research (Mouton & Babbie, 2001). In this study, participants who volunteered to form part of the study were informed that they had the right to participate in the study without being forced, and they signed consent forms which also reminded them that they were free to leave the study at any time. Participants were also informed that they were voluntarily participating in the study.

3.9.4 Informed Consent

For participants to be respected, they need to be given the opportunity to choose what will or will not happen to them (De Vos et al., 2011). Brink (2012) stated that the ethical principles of voluntary participation and protecting the participants form harm are formalized in the concept of informed consent and it has three major elements, namely:

1. The type of information needed from the research participant.
2. The degree of understanding that the participant must have in order to give consent
3. The fact that the participants have the choice of whether or not to give consent.

In this study, the consent form was translated into the participants' fist language, which is Tshivenda. This was done to assist the participants to understand the intentions of the study and their role in the study. The participants were also assured that the information given by them would not be shared with anyone else and the recorded information would be deleted once the study was completed. For young participants, aged 16-18 years, the consent was obtained from their parents. (Annexures 11 and 12).

3.9.5 Privacy and Confidentiality

Privacy means keeping to oneself that which is normally not intended for others to observe or to analyse (De Vos et al., 2011). Privacy is also defined as the right that one has to determine the time, extended and general circumstances under which personal information will be shared or withheld from others (Burns & Grove, 2001). Confidentiality

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is defined as the continuation of privacy which refers to agreement between two people that limit others access to private information (De Vos et al., 2011). Burns & Grove (2001) defined confidentiality as the researcher's management of private information shared by a participant that must not be shared with others without the permission of the participant.

The privacy and confidentiality of the participants were protected throughout the study though informed consent from participants. All information collected from participants were kept private and confidential and only used for research purposes. No data were collected without the participants' knowledge or their willingly forming part of the research. No unauthorized person would be allowed to gain access to the raw data of the study and no true identity of any participant would be used or published.

Participants may be considered anonymous when the researcher cannot identify a given response with a given participants (Mouton & Babbie, 2011). Burns & Grove (2001) agreed with Mouton & Babbie (2011) that anonymity exists when the participants' identity cannot be linked, even by the researcher with his/her individual response. In this study, codes were generated, which were used instead of participants' names. Participants were asked not to use their real names and instead they were code-named, for example, participant 1, 2, 3, etc.

3.10 Summary

This chapter described in detail the research methodology. The study design used was qualitative, descriptive, exploratory and contextual. The setting of the study, population, sampling methods, methods of data collection and analysis and how trustworthiness was be ensured in the study were discussed in this chapter. Elements of the time schedule (work plan), budget, and dissemination of results are contained in the original research proposal to the University of Venda Higher Degrees Committee and confirmation of language editing are contained in Annexure 17. The next chapter encompasses the analysis and discussion of the research findings.

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CHAPTER 4

RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

The previous chapter discussed the research methodology used in this study at length. The main objective of this chapter is to analyze the raw data and reduce it into a main theme, themes and sub-themes. The participants of this study were chosen from two villages, Masisi and Manenzhe of Mutale municipality. The reason for selecting these two villages was because of high prevalence of teenage pregnancy reported during clinic sessions conducted with young people on Counselling of Termination of Pregnancy (CTOP) and deliveries among teenagers less than 18 years of age, in 2010, 2011 and 2012 from District Health Information Software (DHIS) Vhembe District (2012). A relevant literature control and a conceptual framework based on the Health Belief Model (HBM) were used to support the findings of the study. The main question that directed the discussions was:

> *What are the factors that contributed to poor utilization of contraceptive services at communities of Mutale Municipality?*

This question was translated into Tshivenda for participants who did not understand English; this ensured full participation and deepened the discussions. More questions emanated from the discussions with follow-up questions, probing and paraphrasing.

4.2 Biographical Background

Data were collected from two villages (Masisi and Manenzhe) in the perimeter of Mutale municipality. Interviews were conducted with a total of 15 participants (youth from the age of 16 - 20 and elders from 57 – 65 years) from both villages. The educational status of the youth who participated in the study was from grade 9-12 and the elders were from grades 2-5. The total number of youth who were having children during the time of study was six. From Manenzhe village data were collected from six (6) participants. The four (4) participants were youth from the age of 16 - 20 years and the two (2) participants were elders from the age 60 - 65 years. Data saturation was reached with the 5th participant as it was apparent that no new information was forthcoming with the 6th

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participant. All participants were individually interviewed, and each interview session lasted for about 40 - 45 minutes. In Masisi village, data were collected from a total of nine (9) participants—five (5) youth aged 16 - 20 and four (4) elders aged 57 - 65. Data saturation was reached with the 7th participant as no new information emerged after the 8th participant. Tables 4.1 and 4.2 show the demographic characteristics of participants in Manenzhe and Masisi villages, respectively.

Table 4.1: Demographics of participants in Manenzhe village

Manenzhe village				
Participant Number	**Age (Years)**	**Grade**	**Parity**	**Data collection method**
1	17	10	0	Individual interview
2	16	9	0	Individual interview
3	18	11	1	Individual interview
4	17	10	1	Individual interview
5	60	2	5	Individual interview
6	65	4	6	Individual interview

Table 4.2: Demographics of participants in Masisi village

Masisi village				
Participant Number	**Age (Years)**	**Grade**	**Parity**	**Data collection method**
7	17	11	1	Individual interview
8	17	9	1	Individual interview
9	19	11	0	Individual interview
10	18	10	1	Individual interview
11	20	12	2	Individual interview
12	57	9	3	Individual interview
13	66	1	4	Individual interview
14	60	3	6	Individual interview
15	63	5	8	Individual interview

4.3 Data Management and Analysis

Data collection from the sample was determined by data saturation as suggested by Brink (2002).

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A voice recorder was used to capture narrations during interview sessions and written field notes were taken in order to supplement interview data. During the taking of field notes, the researcher took appropriate measures to reduce bias by avoiding leading questions. Then the researcher listed and transcribed verbatim data from audiotape to the written word. Data were then translated from Tshivenda to English with the assistance of a language specialist and compared with field notes. No information was changed. No attempt was made to summarize, paraphrase or correct bad grammar. Table 4.3 displays the main theme, themes and sub-themes that emerged from data collected from the two villages which are presented as one because the findings from the two villages were almost the same.

4.3.1 Main Theme 1: Factors Contributing to Poor Utilization of Contraceptive Services

In this study, it was found that in both villages there was poor utilization of contraceptive services by youth which was due to different factors towards the use of contraceptive services. The parents were found to be a hindrance to the using of contraceptive services in many ways. The parents were found not to be communicating contraceptive services with their children resulting in fear of using contraceptive services as there was no approval from their parents. The participants expressed their frustration, especially when they tried to go to the clinic for contraceptive services and most of them were not pleased with nurses as most of the nurses were impolite to them or they witnessed other youth being shouted at. These experiences made youth not to want to come to the clinic again for contraceptive services.

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Table 4.3: Main theme, themes and sub-themes that emerged from data collected and analyzed

Main Theme	Themes		Sub-Themes	
1. Factors contributing to poor utilization of contraceptive services	1.1	Youth expressed fear associated with disapproval and intimidation from parents and nurses	1.1.1	Youth expressed fear that their parents might learn of their visit to the clinic.
			1.1.2	Youth expressed fear that their parents may not approve the use of contraceptives.
			1.1.3	Youth expressed that when they go to the clinic nurses handled them in an impolite way.
			1.1.4	Youth expressed fear that health care workers will not maintain confidentiality, especially from parents.
			1.1.5	Youth expressed Christianity as the religion that they believe in does not allow young people to use contraceptive services.
	1.2	Absence of conversation about contraceptives between youth and parents	1.2.1	Youth expressed that they do not talk to their parents about contraceptive services.
			1.2.2	Elders expressed poor communication between them and youth.
	1.3	Elders expressed concerns related to sexual norms and behaviour	1.3.1	Cultural perspective
			1.3.2	Elders expressed concern that initiations school were giving rules to young people so that they cannot engage in sexual activity at an early

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			age.
		1.3.3	Elders expressed that the contraceptive services are for people who already have children.
		1.3.4	Elders believed that if youth use contraceptives at an early age they would become infertile.

Continued/…

Table 4.1: Main theme, themes and sub-themes that emerged from data collected and analyzed (continued)

Main Theme	Themes		Sub-Themes	
	1.4	Factors related to contraceptive services	1.4.1	Youth believed that there is no privacy at their local clinics.
			1.4.2	The distance from their local homes to the clinics act as a contributory factor for youth not seeking contraceptive services.
			1.4.3	Youth expressed that they cannot afford to go to the clinics for every visit because of lack of transport in their area.
			1.4.4	Youth expressed that the time for contraceptive services at the clinic is not convenient for them.
	1.5	Factors related to contraceptives	1.5.1	Youth expressed that they do not have enough information with regard to contraceptives.
			1.5.2	Youth expressed that use of contraceptives

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		results in irregular bleeding that make them reluctant to use such barrier methods against pregnancy and STIs.
	1.5.3	Traditional and religious contraceptive practices

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Because of this experience, some youth decided to use other methods like tying a rope around the waist or using spiritual waters. In this study, youth also cited factors caused by contraceptive services that hindered them from utilizing contraceptive services like lack of privacy at clinic facilities and long distances that they had to travel to health care facilities.

From this main theme and five themes emerged (Table 4.3), namely: youth expressed fear associated with disapproval and intimidation from parents and nurses; absence of conversation about contraceptives between youth and parents; elders expressed concerns related to sexual norms and behaviour; factors related to contraceptive services and factors related to contraceptives. The sub-themes that emerged from the theme youth expressed fear associated with disapproval and intimidation from parents and nurses are the following: youth feared that their parents might learn of their visit to the clinic, young people feared that their parents may not approve the use of contraceptives, young people expressed that when they visit the clinic nurses handled them in an impolite way, young people feared that health workers will not maintain confidentiality, especially from parents, young people expressed Christianity as the religion that they believe does not allow them to use contraceptives.

Under absence of conversation about contraceptives between youth and parents the following sub-themes emerged: young people expressed that they do not talk to their parents about contraceptive services and elders expressed poor communication with young people. Elders expressed concerns related to sexual norms and behaviour have the following sub-themes: cultural perspective, elders expressed the concern that the initiations school were giving rules to young people so that they cannot engage in sexual activity at an early age, elders expressed that the contraceptive services are for people who are already having children and elders believed that if young people use contraceptive at an early age they will become infertile. Under factors related to contraceptives the following sub- themes emerged: young people expressed that they do not have enough information with regard to contraceptives, youth said that there are myths related to use of contraceptives and that the use of contraceptives results in irregular bleeding that make them reluctant to use such.

One of the youth offered the following as a reason for not using contraceptive services:

It is not easy for us to use contraceptive services because we are

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oppressed both ways. I am saying that because our parents do not approve us to use contraceptive services as they do not even want to talk about that with us and at the same time the nurses are not even good at us so to use contraceptive services is not easy really. (Female, Grade 12, aged 20, participant no. 11)

A research study reported that health systems, especially in developing countries, are not well equipped to deal with certain issues related to youth sexual and reproductive health, even where there are no legal restrictions on the use of contraceptive services, youth may not always be able to use them for a variety of reasons, such as distant location, cost, inconvenient opening hours, perceived unfriendly and judgmental attitudes of service staff, and lack of confidentiality (Eke & Alabi-Isama, 2011). In this study, it was found that youth were not using contraceptive services because of various factors that contributed to poor utilization.

Another study revealed that several factors contribute to this low rate of contraceptive services utilization, including difficulties in obtaining contraceptive supplies, limited numbers of contraceptive service, and the value that many culture attach to contraceptive practices (Allen, 2001). Similar to this study, it was revealed that youth were not utilizing the contraceptive services, giving reasons such as that they were too far away, culturally not permitted, others were shy and others saying that the staff were rude to them. The study findings revealed that young people experienced resistance and opposition to contraceptive use by adults, including religious, political, and cultural leaders (Nalwadda, Mirembe, Byamugisha & Faxelid, 2011). It was also cited in another study that similar factors restricted young women's contraceptive choices across different developing countries, in particular limited knowledge, access, worries about fertility and the low status of women (Williamson 2013). Similar to another study, it was revealed that youth were delaying to use contraceptive services because of a lack of information about services available, fear of adult disapproval, unfriendly health service providers and concerns by teenagers about the side effects of contraception (Dickson-Tetteth & Foy, 2000).

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4.3.1.1 Theme 1.1:Youth Expressed Fear Associated with Disapproval and Intimidation from Parents and Nurses

Youth Expressed Fear Associated with Disapproval and Intimidation from Parents and Nurses

In this study, youth expressed different views and concerns indicating that various factors contributed to poor utilization of contraceptive services. The use of contraceptives and contraceptive services was seen by youth as an admission to their parents of being sexually active and tended to arouse fears of being punished by family and scoffed at by nurses, thus negatively affecting their ability to seek out those services. In this study, it was revealed that youth feared that their parents might notice them when they visit clinics for contraceptive services and were expressing fear that the parents will not approve their use of contraceptive services. This resulted in poor utilization of contraceptive services by youth. Some participants in the study indicated that they were reluctant to use contraceptive services because of the way nurses were handling them at the facility.

From this theme five sub-themes emerged, namely: youth expressed fear that their parents might learn of their visit to the clinic; young people feared that their parents may not approve the use of contraceptives; young people expressed that when they go to the clinic nurses handled them in impolite way; young people fear that health workers will not maintain confidentiality, especially from parents; young people expressed christianity as the religion that they believe in and claim that christianity does not allow young people to use contraceptive services.

One of the participants said:

> *When you think of going to clinic for contraceptive services you go mad because now you don't know who you are going to meet at the clinic, whether your parents that day has decided to go for other services. Thinking they do not allow us to use those services. The nurses can also frustrate you with their questions and you end up deciding what you were not supposed to do at the clinic. (Female, Grade 11, aged 17, participant no. 7)*

The major reasons cited for poor utilization of contraceptive services include fear of

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parental authority, that it is morally wrong, and fear of being ridiculed by nurses were also expressed by Lebese, Maputle, Ramathuba & Khoza (2013). Another study revealed that youth might feel intimidated by meeting their teachers, their parents and other community members at contraceptive services and this could contribute to youth underutilization of these clinics (Little, 2007; Wood et al., 2000).

4.3.1.1.1 Sub-Theme 1.1.1: Fear that Parents Might Learn of Their Visit to the Clinic

Youth Expressed Fear that Their Parents Might Learn of Their Visit to the Clinic

Many young people normally find it difficult to use the same facility that they believe their parents use because they are afraid that they could possibly meet their parents or any other family members. In this study, the young people indicated that they were not visiting clinics due to fear of meeting their parents. The youth who took part in this study believed that when they go to the clinic for contraceptive services the elders they found at the clinic when they learn that they are coming for contraceptive services they seem not happy about their visits and this was noticed by the way elders and parents look at them while seeing them at the clinics.

From these quotations, it could be deduced that participants were of the opinion that if they visited the clinic they felt that other people, especially their parents and elders, would not approve such clinic visits. This clearly shows that young people avoided collecting contraceptives from clinics due to parental fear.

This concern was expressed by one of the participants:

> *I don't want to meet my parents or any other relative or family member at the clinic, especially when they know that I am not sick. The clinic that accommodate all categories of people are not good, it would be good if young people are having their own youth centre where they are treated with dignity. (Female, Grade 11, aged 18, participant no. 13)*

Another participant said:

> *Victimization is when people are looking at you like you have done something wrong. When you go to the clinic for contraception and you*

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find elders or relative at the clinic they will look at you with big eyes as if contraception is a sin." (Female, Grade 10, aged 17, participant no. 1)

A study conducted in the US revealed that a prominent confidentiality-related concern for many adolescents is fear of parental notification through provider communications or health benefits notices issued by private insurers (Reddy, Fleming & Swain, 2002). It was also found from the study conducted by Lebese & Davhana (2010) that the high number of poor utilization of contraceptive services may be attributed to the fact that youth have little access to free confidential contraceptive services, little communication with their parents and lack of knowledge regarding contraception by parents. Nalwadda et al. (2011) cited that young women also reported experiencing this stigma at points of contraceptive delivery and they revealed fear of being reported to their parents if they were found at health facility or at shops seeking for contraceptives. In this study, the results revealed that when youth go to the clinics in both villages for contraceptive services they do not want to meet their parents or relatives because they would have been given permission to do other things not to go to the clinic.

4.3.1.1.2 Sub-Theme 1.1.2: Fear That Parents May Not Approve Use of Contraceptives

Youth Expressed Fear That Their Parents May Not Approve The Use of Contraceptives

In this study, it was discovered that youth feared that their parents might not approve their use of contraceptive services and, as a result, they do not want to talk to their parents about contraceptive services. Also, young people expressed that from the point of view of clinic nurses, the young people were supposed to seek permission from parents before accessing contraceptive services, knowing well that parents would not accept such a request. Because of this reason youth end up not using any method as they feared that parents will disapprove their request to use contraceptive services. It is clear that youth fear that their parents or elders may not approve of them making use of the contraceptive services. If parents were not approving the use of contraceptive services it would be difficult for youth to make use of the services. Thus, the study indicated that contraceptive use was not approved to be used by youth because young people were afraid that their parents will reprimand them for engaging in sexual activities prematurely.

A participant mentioned:

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Tjo! It is not easy to talk about contraceptive services. According to our culture it is a taboo to talk about this issue at home. Mostly, we are sharing this with our friends. If I can try and talk about contraceptives and contraceptive services with my mom she can cut off your head. In case where you have some doubts or questions about contraception, you better talk to your elder siblings. Myself I talk with my friends. (Female, Grade 11, aged 19, participant no. 7)

Another participant said:

I do not want to tell my mother about the use of contraceptive services because I know that they cannot allow me to use contraceptive because they believe that those services are for married couples. (Female, Grade 11, aged 17 and participant no. 9)

One of the elders said:

What I usually tell my grandchildren is that they must not use contraceptive services before they are married. They must only abstain from sexual activity. (Female, Grade 2, aged 60, participant no. 5)

Another elder said:

Eee ee! Do you know the children of today, if you know them you will understand what I am taking about? Firstly, I will never talk to them because these children they do not regard us as human beings. If you try to show them a way, this young people will show you a way instead. Those children they are very disrespectful. I will never talk to them or give them any advice in life. The last thing that makes me not to talk to young people about the use of contraceptives is that they are still young and need to have their families tomorrow. If I can tell a young person today to go and use contraceptives it's like I am saying she must go and look for man. That person will be very stubborn if she is sent by me. It is better for her to go there on her own not sent by

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me. (Female, Grade 2, aged 60, participant no. 5)

This was analogous to another study which found that women were influenced more by their perception of their social network's approval of contraceptive services than by their own approval (Jere, Hans-Peter & Susan, 2002).

4.3.1.1.3 Sub-Theme 1.1.3: Nurses Treating Youth in An Impolite Way at the Clinic

Youth Expressed That When They Go to the Clinic Nurses Handled Them in An Impolite Way

In this study, it was found that young people do not easily access contraceptive services because of the care that they receive at the clinic and the attitude of nurses. Most of youth found nurses to be rude to them. The way the nurses treat them ended up in chasing them away from the clinic facility. Another participant revealed that the nurses at the clinic were not showing respect towards youth as they use to shout and ask funny questions to those who come for contraceptive services at the clinic. This behaviour makes the young people to be reluctant to seek contraceptive services. It was also revealed in this study that youth has found out that nurses at the clinic use to talk about their visits to the clinic with their parents which youth found it as factor that prevent them from using contraceptive services.

One of the participants said:

> *Sometimes nurses at the clinic, though it was not directly done to me, it was done to others in my presence. Nurses at the clinic use to shout to young people who have come for contraceptive services. Nurses also ask funny questions like did you start moving around with boys? And they can say you must not use contraceptive services instead you must abstain. They forget that is not every one who can abstain. This thing embarrasses us as young people because when you go and seek contraceptives it means you are sexually active. (Female, Grade 10, aged 18, participant no. 10)*

Another participant exclaimed:

> *The nurses at the clinic are very good when you are sick. They can*

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> *take good care of you while examining you. The only problem is when you are seeking contraceptive services they will ask you so many questions that can make you feel that the service you are requesting is not relevant to you and I think they do that to young people. It's like they do not want us to use contraceptive services. (Female, Grade 10, aged 17, participant no. 1)*

One participant responded in this way:

> *If you are a youth, nurses ask if your parents know that you come to the clinic for contraceptive services. To us as young people is very scary because when we decide to use contraceptive we do not consult our parents it's our own decision. When we decide for contraceptive is my deal with the person who is offering me the services not my parents. (Female, Grade 11, aged 17, participant no. 7)*

In another study it was found that young people may be embarrassed and refuse to return for services if staff asked personal questions loudly enough to be overheard by others (Irwanto, 2013). In addition to the above, studies have shown that women are more likely to seek out and continue using contraceptive services if they receive respectful and friendly treatment. From another study it was revealed that many youth who visited clinics for contraceptive services reported that service providers in normal clinics treated them rudely and denied them services (WHO, 2009; UNFPA, 2011). This may be an indication that staff does not have the counselling skills and training necessary for dealing with young people (Oxfam, 2007). In a study carried out in Kwazulu-Natal on barriers to accessing contraceptive services, service providers (clinic nurses) confirmed that the interpersonal relationships between clinic nurses and young clients were influenced by many factors, especially the negative attitude of the clinic nurses.

Clinic nurses are judgemental towards young people utilizing contraceptive services; consequently, they are impatient and rude to the youth (Ali et al., 2013). It was also shown that nurses are rude to youth in a study conducted by Lesedi, Hoque & Ntuli-Ngcobo (2011) that health providers' attitudes were rated the lowest and even though the clinic was youth-friendly. This also agreed with a study that revealed that negative responses from health workers also served as obstacles to initiation as well as to

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continuation of modern contraceptive methods among young people, however, it was further noted that providers restricted access to contraceptives to the unmarried and those with no children (Nalwadda et al., 2011).

4.3.1.1.4 Sub-Theme 1.1.4: Fear that Health Care Workers Will Not Maintain Confidentiality

Youth Expressed Fear that Health Care Workers Will Not Maintain Confidentiality, Especially from Parents

In this study, youth explained that lack of confidentiality was an important underlying reason for them not using contraceptive services. Youth indicated a reluctance to visit nearby clinics. When youth go to the clinic they said they were afraid that nurses would disclose the purpose of their visit to the clinic seeking contraceptive services to other people.

In this study, many youth reported that they were afraid that a clinic nurse would share with their relatives the reasons for their visit to the clinic or some other confidential information. The participants in this study believed that the local nurses and the fact that local nurses are church members, they will not maintain their confidentiality if they go and seek contraceptive services at their clinics.

One of the participants stated:

> *I do not want to go at our clinic for contraceptives because most of the nurses who are working at our local clinic are our church members and are related to my mother, so if I seek services there they can tell my mother that I am using those services. (Female, Grade 12, aged 20, participant no. 11)*

Another participant said:

> *A service like issuing of contraceptive is embarrassing if it is done in front of the elders or your parents. I think people won't be able to stigmatise the young people if they are catered in a private place where they would be on their own. (Female, Grade 10, aged 17, participant no. 4)*

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Health services might not be acceptable to young people, even if available and accessible, fear about lack of confidentiality is a major reason for young people's reluctance to seek help (Sanci, Sawyer, Kang, Haller & Patton). Youth stated that privacy and confidentiality are extremely important to them when making decisions about whether or not to seek contraceptive services. Similar to the study, young people also feared that clinic nurses would not maintain confidentiality, especially from parents (WHO, 2000). In a study carried out by Donovan, Mellanby & Jacobson (1997), it was also reported that youth were worried that their request for contraceptive services would be disclosed to their parents.

Another study revealed that youth were concerned with privacy and confidentiality and feared that the provider would share their personal business with adult community members (Senderowitz, Hainsworth & Solter (2003). It was also cited in another study that confidentiality has been found to be a contributing factor associated with utilization of contraceptives and contraceptive services among youth (Agampodi, Agampodi & Piyaseeli, 2008). Youth expected this vital piece of information to remain confidential between them and the nurses.

4.3.1.1.5 Sub-Theme 1.1.5: Christianity Does Not Allow the Use Contraceptive Services

Youth Expressed Christianity as the Religion that They Believe in Does Not Allow Young People to Use Contraceptive Services

In this study, it has been found that many young people were not using contraceptive services because of religious reasons, however, they still fall pregnant even if their religion dictates that they must abstain and only and engage in sexual activities when they are married. It has been expressed that Christianity as the religion does not allow young people to use contraceptive services before marriage. Christianity was viewed as a factor that contributed to poor utilization of contraceptive services. Another participant believed that there are other methods of contraception like water that is obtained from the spiritual healers. Participants also cited that Christianity as a religion discourages them to use contraceptives as such practices are sinful.

One of the participants stated:

Eish! I think young people are not using contraceptive services

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because of the religion that they belong to. Example, I am a Christian and according to our religion it is not allowed to use contraceptive services before you married. If you are practicing that you are committing a sin. Contraceptive services are for those who are married. (Female, Grade 11, aged 18, participant no. 3)

Other participant responses were:

But I heard other people saying that there is another religion that is giving people water to prevent pregnancy in our area, but I don't know much about how that water prevents pregnancy. (Female, Grade 12, aged 20, participant no.1 1)

Yeah, according to my perceptions, I think family planning is for the married couple and those who have children. And according to our religion of Christianity, they stress abstinence and keeping of virginity. One more thing is that youth should not engage in sexual relations before marriage. According to the bible that is a sin. (Female, Grade 9, aged 16, participant no. 2)

Eee! I don't believe in any method because relationship is for married couples. My religion does not allow me to engage in sexual activities before marriage. As a Christian I do not engage in sexual activities. I do not support them because this contraceptive service is not allowed in our church. And when I talk about it, I feel like I am one of those who are using contraceptive services. (Female, Grade 10, aged 17, participant no. 1)

According to Amirrtha, Robert & Reid (2008), religious behaviour is a strong predictor of sexual behaviour. Religious factors have the potential to influence the acceptance and use of contraception by youth from different religious backgrounds in very distinct ways. In agreement with another study, it was revealed that young people experienced resistance and opposition to contraceptive use by adults, including religious beliefs (Nalwadda et al., 2011).

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4.3.1.2 Theme 1.2: Absence of Conversation About Contraceptives Between Youth and Parents

Youth Expressed Absence of Conversation About Contraceptives Between Youth and Parents

In this study, youth expressed that they did not talk to their parents about contraceptive services. Correspondingly, elders that were interviewed mentioned that conversation about contraceptives between youth and parents is a very uncomfortable subject matter to discuss with youth. This study revealed that there was no conversation between elders and youth concerning contraceptive services.

One participant said:

> *That is ridiculous, sexual health and a contraceptive service is something that is not easy to discuss with parents. There are things that can be discussed with parents and elders, but this issue is so sensitive that talking about them is not child play. If you can start with my mother yoooo! (Female, Grade 9, aged 16, participant no. 2)*

In support of this notion, the study conducted by Kempner (2003) showed that adults were uncomfortable about adolescent sexuality and often try to ignore the fact that the young people are sexual beings who engage in sexual behaviour. In another study it was also found that youth are not the only ones who feel uncomfortable discussing contraceptives—many providers and elders report that they often feel uncomfortable raising issues of sexuality and contraceptive use with their youth (Brindis & Davis, 1998).

4.3.1.2.1 Sub-Theme 1.2.1: Youth Do Not Talk to Parents About Contraceptive Services

Youth Expressed that They Do Not Talk to Their Parents About Contraceptive Services

In this study, youth indicated that they do not talk to their parents about contraceptive services because their culture does not allow them to talk about contraceptive services with their elders. In this study, it was also discovered, though from a cultural perspective, that parents do not talk to their youth about contraceptive issues. Other participants in this study were of the view that they do not talk to their parents or elders because they feel that it was embarrassing to talk about contraceptives with parents.

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A study conducted by Wood, Maforah & Jewkes (1998) established that youth were not given information about reproductive matters (which includes utilization of contraceptive services) by their mothers beyond the warning of saying that when they start menstruating they must stay away from boys as intergenerational transmission of sexual information was taboo.

It was revealed when a participant said:

> *Tjo! It is not easy to talk about contraceptive services. According to our culture it is a taboo to talk about this issue at home. Mostly, we are sharing this with our friends. If I can try and talk about contraceptives and contraceptive services with my mom she can cut off your head. In case where you have some doubts or questions about contraception, you better talk to your elder siblings. Myself I talk with my friends. (Female, Grade 10, aged 17, participant no. 1)*

Another elder participant said:

> *What I usually tell my grandchildren is that they must not use contraceptive services before they are married. They must only abstain from sexual activity. (Female, Grade 4, aged 65, participant no. 6)*

Another participant said:

> *Discussing sexual issues with my father is totally out. My mother sometimes likes to bring up the topic when we are alone in the kitchen, but when she asks me anything to do with boyfriends or sex, I get very angry because I am embarrassed to talk to her about my sexual experiences. (Female, Grade 10, aged 17, participant no. 4)*

Wulf (2004) indicated that most parents talk to their children by giving orders or correcting them. In this study, the parent or elder does not communicate with youth in a way of giving them information related to contraceptives, but give them orders that they must abstain. Similar to this study, children have reported that they often felt

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embarrassed when they talked to parents about issues of sexual health (Ogle, Glasier & Riley, 2008). This view is in alignment with the study which found that participants believed that when they spoke to their parents about sex, their parents would get worried and nervous, thinking that they were now engaging in sexual intercourse (Eastman et al., 2005).

Again, in another study it was observed that contraception might remain a source of embarrassment to many youth (MacPhail & Campbell, 2001). Contrary to the study conducted by Muller & Powers (1990), the communication style between parent and child if perceived as friendly, attentive and open, was seen as having a positive influence on the use of contraceptives by teenagers. Research conducted amongst Malaysian boys on sexual issues has shown that they would feel comfortable if their parents would talk to them about these issues (Wah-Yun et al., 2007). This is contrary to the research conducted by Ogle et al. (2008), who found that adolescents were not willing to discuss sexual health matters with their parents and were embarrassed about this, lending support to the findings of this study.

4.3.1.2.2 Sub-Theme 1.2.2: Elders Expressed Poor Communication with Youth

Elders Expressed Poor Communication Between Them and Youth

The elders expressed that there was no communication between them and young people, especially when they talked about contraceptive services. It has also been discovered that the information parents give to their children regarding sexual matters is too inadequate to equip teenagers to face the pressures related to sexual matters (Mavundla & Williams, 1999. For instance, Wulf (2004) indicated that most parents talk to their children by giving orders or correcting them. Parents are said not to ask children about their opinion (Wulf, 2004).

One elder participant emphasized:

> *I will never talk to youth any information related to contraception because contraceptive matters is not something that one needs to discuss with young people, youth need to go to school. (Female, Grade 5, aged 63, participant no. 15)*

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Another elder participant also said:

> *Eee ee! Do you know the children of today, if you know them you will understand what I am taking about! Firstly I will never talk to them because those children they do not regard us as human beings. If you try to show them a way, this young people will show you a way instead. Those children they are very disrespectful. I will never talk to them or give them any advice in life. The last thing that makes me not to talk to young people about the use of contraceptives is that they are still young and need to have their families tomorrow. If I can tell a young person today to go and use contraceptives it's like I am saying she must go and look for man. That person will be very stubborn if she is sent by me. It is better for her to go there on her own not sent by me. (Female, Grade 2 aged 60, participant no. 5)*

From the above stated quotations it can be deduced that there is no communication between parents and young people with regard to contraceptive services. Similarly, Mfono (1998) mentioned the difficulties that parents experience in communicating with their children about sexual matters. It was also found in another study that parents and other family members may be ill-prepared to discuss reproductive health care issues with their children, an observation previously made by Barnett (1997).

4.3.1.3 Theme 1.3: Concerns Related to Sexual Norms and Behaviour

Elders Expressed Concerns Related to Sexual Norms and Behaviour

Each society has different norms about premarital sex, the age of sexual consent and other sexual behaviours. Individuals are socialized to these norms from an early age by their family, education system, peers, media, and religion. Human sexuality is part of the social life of humans, governed by social norms, including implied rules of behaviour (www.boundless.com). The study conducted by Espey, Cosgrove & Ogburn (2007) suggested that social support programmes and cultural values may subtly condone teen pregnancy, blinding teens to the negative ramifications of unplanned pregnancies, hence resulting in poor utilization of contraceptive services.

Most of the elders who participated in this study emphasized that in order for youth to behave according to the set norms and behaviours of the community they need to

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follow the cultural instructions as spelt out by society.

One elder participant said:

> *Young people of today they are just moving around like lost chickens because they do not have manners. They are not taught and taken to "vhushani" that is why they are using contraceptive services because they do not know the law that young people must engage in sexual activities when they have their own families. They do not know that modern contraceptive will destroy their fertility. (Female, Grade 3, aged 60, participant no. 14)*

However, the sub-themes that have emerged from this theme are: i) the cultural perspective, ii) elders expressed the concern that the initiations school were giving rules to young people so that they cannot engage in sexual activity at an early age, iii) elders expressed that the contraceptive services are for people who are already having children and iv) elders believed that if young people use contraceptive at an early age they would become infertile.

4.3.1.3.1 Sub-Theme 1.3.1: Cultural Perspective

Cultural beliefs and attitudes also determine how youth relate to their parents and elders in the community and it dominate the way of life in the rural areas. Values and norms guide what can be discussed between different age groups (Mfono, 1998). Therefore, the extent to which issues of sexual health are discussed between different age groups is also determined by their cultural practices. Many youth who participated in this study mentioned that they never discussed contraception with their mothers or fathers or any other elderly persons as a result of cultural beliefs.

For the elderly participants also, culture prohibited them to speak to their youth about sexuality and contraceptive services. Therefore, it could be concluded that cultural standpoint contributes to poor utilization of contraceptive services among youth at Masisi and Manenzhe villages. Cultural taboos are a major obstacle to informed discussions about sexual and reproductive health issues, particularly with regard to young people (Cobb, 2010).

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One of the participants said:

> *What I am saying is that according to culture, to talk about sexual issues with your parents is totally unacceptable. It is like when you talk to your parents about methods of contraception you are now doing promiscuous things. You are like a child who is misbehaving. You need to respect your parents by not talking with them anything you like. (Female, Grade 10, aged 17, participant no. 4)*

Another elder commented in this way:

> *Even to talk about this contraception with young people is not good; we are not doing justice to our children if we allow them to use these contraceptives. It is better to tell them what is expected from them according to our culture. (Female, Grade 4, aged 65, participant no. 6)*

Another participant said that:

> *Hm! You know people have different customs, so according to my customs you cannot discuss sex-related issues with your parents or elders because they believe that sexual intercourse is meant for adults or married people. So when you discuss that with them, which grounds are you going to base yourself on? It is not easy to discuss such issues. And according to our custom you need to wait engaging in sexual activities until you get married. Young people do not engage in sexual activities, it is for adults. (Female, Grade 10, 17 years old, participant no. 1)*

From the quotations cited above it is evident that culture plays a major role in contributing to poor utilization of contraceptive services among youth. Alli et al. (2013) recognized cultural factors as a barrier, specifically looking at the age and gender of the clinic nurse, the young girls in particular are less likely to discuss sexual and reproductive health issues even to utilize the contraceptive services for fear of being disrespectful.

Bushaija et al. (2013) attained similar results that cultural factors, cultural beliefs and

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taboos hindered parents and elders from discussing sexual matters with youth. Some parents even found it difficult to mention sexual terms in their vernacular. Therefore, the extent to which issues of sexual health are discussed between different age groups is also determined by their cultural practices. Similarly, a research study conducted in Kenya by Mbugua (2007) described society in that area and other parts of sub-Saharan Africa as having similar cultural barriers that deter members of one group (elders) from discussing matters of sex with members of another age group (youth).

It was also revealed that at the same time societal norms/values do not support use of contraceptives and parents were said to use scare tactics about contraceptives, for example; contraceptives lead to development of fibroids and infertility to keep their children from having sex (Nalwadda et al., 2011).

4.3.1.3.2 Sub-Theme 1.3.2: Concerns About Initiations Schools and Sexual Education

Elders Expressed Concern that Initiations School Were Giving Rules to Young People So that They Cannot Engage in Sexual Activity at An Early Age

Elders that participated in this study indicated that during the olden days there were initiation schools where young people were given rules and regulations on how to behave, especially relating to sexual behaviours. They believed that if young people were sent to initiation schools this would reduce the tendency of teenage pregnancy and hanging around with boys. The elders in this study believed that initiation schools serve as medium for informing children about sexuality issues as it taught about abstinence.

One elder said:

> *The disrespectful children I mean those children who did not go to the mountain or vhushani. If a female child did not see the elders and given some words of wisdom that child is very hard to handle. (Female, Grade 2, aged 60, participant no. 5)*

Elders who participated in this study were of the view that if young people were taken to their initiation schools they would not use contraceptive services at an early age because at the initiation school they would be told what to do and what not to do. This

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finding was supported by a study conducted by Mulaudzi (2007) describing how focus on sex education in initiation schools among Vhavenda people is emphasized. The researcher explained how the girl initiates are warned against engaging in sex at an early stage as this was described as going to deflower them. Contrary to this study, initiation schools also do not give teenagers enough information about sexual health as most of the time teenagers are to recite poems and songs (Mfono, 1998). A study by Maluleke (2007) showed that initiation had both positive and negative effects: some participating teenagers thought that going through puberty rites (initiation) helped them to remain virgins whilst, on the other hand, some teenagers felt that puberty rites were performed too late as they had already been sexually active and there was nothing new to learn.

4.3.1.3.3 Sub-Theme 1.3.3: Contraceptive Services Are for People Who Already Have Children

Elders Expressed Concern that Initiations School Were Giving Rules to Young People So that They Cannot Engage in Sexual Activity at An Early Age

The elders who participated in this study expressed that the contraceptives were supposed to be used by people who were married. Elders expressed that young people were not expected to use contraceptive services as they did not have families yet. The elders in this study believed that if youth can use contraceptive services they would promote promiscuous behaviour. In in order for elders to protect the youth they must not engage in contraceptives services.

One elder said:

> *Youth are not supposed to use contraceptive because they do not have families yet. The contraceptives are for those who are married who are planning for their families. How can a young person plan for a family which is not there? (Female, Grade 1, aged 66, participant no. 13)*

Another elderly participant asserted:

> *The real fact is that young people are not supposed to use this contraception because we will be promoting promiscuous life to our*

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young people. (Female, Grade 4, aged 65, participant no. 6)

It could be deduced that elders who participated in this study did not support the idea that young people should use contraceptive services as they thought that by doing so they would become irresponsible about their future.

4.3.1.3.4 Sub-Theme 1.3.4: Use of Contraceptives at An Early Age and Infertility

Elders Believed that If Youth Use Contraceptives at An Early Age They Would Become Infertile

The elders who participated in this study believed that if young people used contraceptive services at an early age they would become infertile. It was revealed in this study that the elderly people do not want youth to utilize contraceptives because they believe that if contraceptives are used by youth they will have problems to conceive in future. Some youth in this study believed that contraceptives interfered with fertility, and they feared that using such could harm their ability to reproduce. In this study, it was also found that elders believed that contraceptive services need to be used by youth who are already having children. This was further confirmed by a study which revealed that many young women believed that injectable contraceptives were only recommended for women who already had children (Ochako, Mwende, Stephen, Kaimenyi, Thompson, Temmerman & Kays, 2015).

This view was also noted in some of the statements that the elders had made:

> *Young people without a child are not allowed to use those form of contraception because if they use today and tomorrow when they want to have a child becomes difficult it would be very bad. It is done to avoid infertility if it can occur. (Female, Grade 2, aged 60, participant no. 5)*

> *Youth do not have any families yet I do not see any reason for young people who do not have families to use contraceptive services. When are they going to study because now they doing family matters. Youth must concentrate on their studies; family issues will follow when they have completed their studies. And I think if we encourage those children to use those services they will give more of their time in*

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sexual issues. I think for now let's encourage our young people to go to school and finish their studies. It is also a pity because our religion for those who follow Christianity it is not allowed to do or to use contraceptive services because sex before marriage is a sin. (Female, Grade 1, aged 66, participant no. 13)

A youth participant said:

When I say many people I am including young people who have had one or more children. Those without a child are not included or allowed to use contraceptives because they may end up not having children. (Female, Grade 11, aged 17, participant no. 1)

From the quotations above it is clear that elders do not want young people to use contraceptive services with the reason that it will be difficult for youth to bear children when they are ready or married. Another study in Uganda corroborated the results of this study by reporting that young people believed that contraceptives interfered with their fertility, and they were frightened to use something that could harm their ability to reproduce. The same study revealed that clinic nurses believed that contraceptives would cause infertility, thereby influencing the clinic nurses not to provide contraceptive services to youth (Nalwadda et al., 2011).

In the same manner, some of the clinic nurses in the study conducted by Nalwadda et al. (2011) believed that if contraception was started too early or before childbirth it would lead to delayed fertility or to the worst, infertility. The results of this study are similar to the study conducted by Makhetha (2006) which showed that some youth and their parents believed that the pill can cause serious side-effects, such as high blood pressure and infertility. Another study revealed that the largest concern cited by participants was fear that a particular method would render them infertile; in many cases, this prevented them from using contraception (Ochako et al., 2015).

4.3.1.4 Theme 1.4: Factors Related to Contraceptive Services

Factors related to contraceptive services such as privacy at local clinics, the distance from local homes to the clinic, lack of transport in their area, inconvenient time at the clinic were found as factors that contributed to poor utilization of contraceptive services

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by youth in this study. A study on creating youth-friendly sexual health services in sub-Saharan Africa by Moya (2000) identified barriers to accessibility of contraceptives and contraceptive services as follows: characteristics of facilities, the design of services, and provider's attitude and actions. The findings in that study suggested that youth do not want to run into their family members and neighbours when entering, utilizing, or leaving sexual health facilities.

One participant said:

> *To reach for those services is not that easy in our area because we do not have proper transport in this area as you can see that clinic is very far from our area of stay. Another problem is the time that they offer the contraceptive services; the nurses prefer to do contraceptive services in the mornings or during early hours of the day. During those hours most of us we are still at school. (Female, Grade 12, aged 20, participant no. 11)*

4.3.1.4.1 Sub-Theme 1.4.1: Lack of Privacy at Local Clinics

Youth Believed that There Is No Privacy at Their Local Clinics

Lack of privacy was identified as one of the barriers why youth do not visit the clinics for contraceptive services. In most cases, clinics in SA are designed for adult clients, and service providers are not trained in adolescent sexuality and youth-friendly concepts (MIET Literature Review, 2012). As a result, young people are neither well received nor comfortable in mainstream family planning clinics (MIET Literature Review, 2012).

A participant said:

> *According to my own understanding, I think another thing of not using contraceptive is the privacy. At our clinics there is no privacy, a person who is coming for another services can easily notice that you are coming for contraceptive services because nurses will shout, those who has come for contraceptive services must come this side or queu here. By so doing, everybody now knows that you are here for contraceptive services. (Female, Grade 10, aged 18, participant no. 3)*

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The participant further remarked:

> *Another thing in our area that can prevent youth from using contraceptive services is because at our clinic there is no area where young people are catered for in private. It means that if you are going for contraceptive services, it can happen that you meet your mother in the line which is not nice. (Female, Grade 10, aged 17, participant no. 4)*

In this study, it has been deduced that young people are of the opinion that there is no privacy at clinics, hence they are not utilizing contraceptive services. Furthermore, taking into account that parents put restrictions on the use of contraceptives by youth, youth will not expose them by collecting the contraceptives in the presence of local patients in clinics (Biddlecom et al., 2007). It was also found in the study conducted by Crosby & Yarber (2004) that youth in rural areas were at greater risk of unintended pregnancies and negative birth outcomes because of limited availability of health services. It was also cited in another study that fear of stigma at the health facility propelled some women to procure contraceptives from private clinics/stores since they provided privacy and confidentiality (Nalwadda et al., 2011).

4.3.1.4.2 Sub-Theme 1.4.2: Long Distances to Clinics Discourage Use of Contraceptive Services

The Distance from Their Local Homes to the Clinics Act as a Contributory Factor for Youth Not Seeking Contraceptive Services

In this study, the youth expressed that clinics were far from their homes and it was difficult to travel to the clinics, especially when one is going only for contraception. If there is no serious medical illness, youth avoid going to the clinics only for contraceptive services, because of long distances. It has also been noted that due to long distances to the clinic, the participants will need to pay for transport to the clinic which is also contributing to poor utilization. It was revealed in another study that clinic facilities might be located a long distance from where young people live and this resulted in poor utilization of contraceptive services (WHO, 2002).

For example, one of the participants expressed:

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> *And if the services are taken or moved next to our place of stay because the clinic is very far from our home it would be better. (Female, Grade 10, aged 17, participant no. 4)*

Furthermore, another participant echoed this seniment:

> *I don't know but I just think that because our area is far from the clinic, may be some of young people are not going to the clinic because of distance. And in our area there is no taxi we use our animal drawn vehicles as means of transport and sometimes those who operate with their private cars use to carry people to the clinic. If you do not have money for transport it will be difficult to reach health facility. (Female, Grade 11, aged 18, participant no. 3)*

Another participant said:

> *Here in our area the clinic is far away (±10 km) from the residence and thus it needs money for one to reach the clinic. Due to the fact that the area is too far from the clinic, it makes youth not to utilize contraceptive services. (Female, Grade 10, aged 17, participant no. 1)*

Many youth that participated in the study mentioned that the long distance from their homes to the clinics was one of the reasons they were not using contraceptives. The results of this study were also supported by a study of service provision in rural Pakistan which found that women who lived within a 5 km radius of two community-based workers were significantly more likely to adopt a modern method of contraception (Sultan et al., 2002).

It was evident in another study that long distances to health clinics and impassable road infrastructure are amongst the reasons why there seem to be a low uptake of contraceptive services among youth in rural areas (Hamid & Stephenson, 2006; Katende, Gupta & Bessinger, 2003; RamaRao Lacuesta, Costello, Pangolibay& Jones, 2003; Seiber & Bertrand, 2002; Magnani Hotchkiss, Florence & Shafer, 1999; Steele, Curtis & Choe, 1999).

In support of this study it was revealed that lack of facilities in close proximity to

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communities was a major limiting factor to contraceptive use, as most women live far from the clinic facilities and cannot afford to pay for transportation (www.advanceafrica.org). Another study has found that fees for transportation can be a major barrier to contraceptives for many young people as cost is a significant obstacle for adolescents, as young people frequently lack their own source of income or control over their finances to be able to afford contraceptives (http://reproductiverights.org).

4.3.1.4.3 Sub-Theme 1.4.3: Lack of Transport Is An Impediment to Regular Visits to Clinics

Youth Expressed That They Cannot Afford to Go to the Clinics for Every Visit Because of Lack of Transport in Their Area

Masisi and Manenzhe villages have a major problem with public transport. The communities rely solely on transport that is owned by some of the community members.

On this matter, one participant said:

> *Hhmm … when we want to go to the clinic we use the cars of people who are staying around this area. They go to the clinic in the morning and afternoon. If you miss that transport you will have to use a cart if your family is having one. (Female, Grade 10, aged 17, participant no. 4)*

One of the participants also stated that:

> *At our village and nearby villages there is a bus organized by the government which carry us to and from school on a daily basis. And we do not pay anything; the government is paying on our behalf. During the weekends there is no transport even during the week that bus does not carry us to the clinic only from home to school and school to home. (Female, Grade 11, aged 18, participant no. 3)*

Another participant said:

> *Our clinic is very far from where we are staying. If you do not have money to go to the clinic you find yourself missing the date for next*

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repeat. (Female, Grade 10, aged 18, participant no. 10)

The participant expressed that:

> *People who are coming to this clinic are from different areas, and those areas are far apart. When you want to come to the clinic just for family planning services is not easy because you need to have money for transport. (Female, Grade 10, aged 17, participant no. 1)*

Another participant said:

> *The transport is the main problem in our area because even if you have money, there is no stable transport like taxis. The only means of transport that is available is the cars that moves around on defined times of the day. You cannot go to the clinic in your own time. (Female, Grade 11, aged 18, participant no. 3)*

Studies conducted by Remare & Catherine (2012) have shown that health facilities offering contraceptive services are not equitably distributed throughout the country. In this study, youth were not using contraceptives consistently because of the long distances to the clinics which required them to use transport which was not available because of lack of transport in these two villages. Furthermore, some of the youth did not even have money to go to the clinic.

4.3.1.4.4 Sub-Theme 1.4.4: Times for Contraceptive Services at Clinics Are Not Convenient

Youth Expressed that the Time for Contraceptive Services at the Clinic is Not Convenient for Them

The findings of this study revealed that youth could not go to the clinics for contraceptive services because the time the clinics offered the contraceptive service was not convenient for them. Similar to the findings of this study, another study reported that the majority of clinics were not open during convenient times for youth, such as weekends or evenings although some of the clinic facilities offered emergency or curative services 24 hours a day, contraceptive services were offered only during regular business hours on weekday s(AYA Pathfinder, 2003). Youth who participated in

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this study mentioned that most clinics did not set aside special examination rooms, waiting space or clinic hours to serve young people.

This was an observation made by a participant who said:

> *Eish! You know what? It is also difficult for us because usually family planning services are conducted during early hours of the day and to us as scholars it's not favourable because we attend school till late for, example, we finish our afternoon studies at 15:30. And when we come to the clinic at that time some nurses refuse to offer contraceptive services during late afternoon hours. (Female, Grade 10, aged 17, participant no. 1)*

During interviews, a major complaint of participants was of current users of contraceptives and this was the waiting time at the health facilities. This was in response to questions of what the youth disliked about clinics. The youth participants indicated that they spent about two to three hours waiting for services. Some participants noted that on several occasions, they leave without the service being rendered even when the contraceptives are available at the facility.

Other participants indicated:

> *The worst thing that I hate going to the clinic is that you will stay there for hours and hours, three to four hours. Remember contraceptive services are not something that you can stay there the whole day like you are waiting to be seen by a doctor. It is just a matter of issuing what you have agreed upon with your nurse and off you go. (Female, Grade 11, aged 17, participant no. 7)*

Other participant said:

> *Yes, I think that is all I can say except that sometimes when we go to the clinic, you stay there for a long period of time. And if you are staying longer it is not easy to go there tomorrow for your next follow-up. (Female, Grade 9, aged 16, participant no. 2)*

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In this study, it was inferred that waiting for a long time to be served in a clinic was a barrier to accessing of contraceptives by the youth. The youth were not willing to wait for a long time to get services at the clinics. This observation was similar to a study which revealed that youth were reluctant to seek contraceptive services because of long, inconvenient waiting times (WHO, 2000).

In Senegal, Senderowitz (2007) found that although a specially designed youth clinic was established, it was perceived to be unsuccessful as it was not accessible to youth after 16:00. Special hours should be set aside for youth services if the RHS are integrated with PHC services (Netshikweta, 1999; Senderowitz, 2007).

4.3.1.5 Theme 1.5: Factors Related to Contraceptives

Contraceptive factors such as lack of information related to contraceptives, irregular bleeding due to the use of contraceptives and traditional and religious contraceptive practices contributed to poor utilization of contraceptive services by youth at clinic level. The participants in this study were of the view that poor utilization of contraceptive services was sometimes due to the reason that they don't have enough information on how to use contraceptive services.

A participant said:

> *I think contraceptives are good, the only reason that we are not utilizing it is because the information that we have is not enough in such a way that if I come across some side effects I will not be able to deal with them, and result in quitting. And there are other forms of contraceptive services in our area like the method of using water from the spiritual healers. (Female, Grade 10, aged 17, participant no. 1)*

Another study found that there are factors that contribute to poor utilization of contraceptive services like design of services, lack of information and providers' attitude (Kayongo, 2013).

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4.3.1.5.1 Sub-Theme 1.5.1: Lack of Information on Contraceptives

Youth Expressed That They Do Not Have Enough Information with Regard to Contraceptives

Youth and elders who participated in the study knew of the three types of contraceptive methods like pill, injections and condoms and they had different perceptions on contraceptive services. Young people have inadequate knowledge about the reproductive function and consequently lack knowledge about contraception. In this study, youth expressed lack of information on who should be using contraceptive services. They said that contraceptive services were meant only for adult people who are married. The youth who participated in this study indicated that if you engage in contraceptive services at an early age it would result in many complications in future and that resulted in youth not using contraceptive services. Youth in this study lacked information with regard contraceptive services only basic information of three types of contraceptive was available. Without information, youth are forced to make poorly informed decisions.

One participant said:

> *Mmm … This contraceptive service will only help you to finish schooling with no problem. The problem will come when you feel you want a baby when the baby is not coming. They are saying, if you are injected for a year you will have to wait for five years in order to have a child. This means that if you are injected for two years, you will have to spend ten years in order to have a baby. There are people today who are childless because of using these contraceptive services. That is the worst thing that I don't like about the use contraceptive services. (Female, Grade 10, aged 17, participant no. 1)*

Another participant said:

> *There is a myth related to use of contraceptives. Sometimes, I just think that contraceptives are for married couples. Especially when I think that they may cause a person not to have children in future. Because if you become childless before you had only one child, hey it's a problem. I do not like the fact that they cause childlessness. I*

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don't want to remain childless because of the fact that I have used contraception. (Female, Grade 12, aged 20, participant no. 11)

For information and services to effectively reach young people, youth-friendly services are needed that encourage youth to be agents of their own social and health welfare (Gonzola, 2012). In their study, Ziyani, Ehlers & King (2003) reported that participants were not informed about contraceptives, no information was available in their communities and that education programmes were unavailable to their schools.

In another study conducted by Maja (2007) about the involvement of males in promoting reproductive health, a significant number of males were found to have knowledge about contraceptives including condoms, however, this knowledge did not influence the use of these methods to prevent unplanned and unwanted pregnancies. These findings corroborated the findings of this study.

Another study, focusing on contraceptive knowledge and attitudes among residents, suggests that while a large share of residents reported receiving contraceptive training, it was often inadequate and variable across primary care specialties (Schreiber, Harwood & Switzer, 2006). The studies conducted by Muhwava (1998) and Burgard (2004) have demonstrated that a large proportion of young women are exposed to the risk of conception, received poor or no sex and contraceptive education, and experienced a high incidence of youth childbirth. The most basic needs of youth are for accurate and complete information about their body functions, sex, safer sex, reproduction, and sexual negotiation and refusal skills (Bearinger, 2007).

4.3.1.5.2 Sub-Theme 1.5.2: Irregular Bleeding Associated with Contraceptives Hampers Their Use

Youth Expressed that Use of Contraceptives Results in Irregular Bleeding that Make Them Reluctant to Use Such Barrier Methods Against Pregnancy and STIs

Most of youth in this study who once used injectable contraceptives reported having experienced menstrual irregularities, which often resulted them in stopping contraceptive use. This was aggravated by lack of knowledge as the clinic nurses did not give enough information about the methods. Exaggerated side effects of different contraceptive methods were considered as one of the main reasons for discontinuation of contraceptive services. In this study, it was revealed that young people do not use

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contraceptive services because immediately after the use they started to experience irregular bleeding. Similar to the another study, the females who were participating said they would not use a contraceptive method to avoid pregnancy in the future and nearly 80 percent of them mentioned this was because they feared side effects, including irregular bleeding (Okanlawon, Reeves & Agbaje, 2010).

One participant said:

> *My cousin was using three months injection, she menstruated from the day she started the injection until she went back to the clinic. Then she was given pills that stopped that bleeding. That is why I am saying this contraceptives especially injections they cause bleeding. Hey can you imagine menstruating the whole months it no longer serves the purpose. Now you are applying divorce daylight because there is no one who can wait for a person who is always bleeding. (Female, Grade 10, aged 17, participant no. 1)*

One participant explained irregular menstruation as follows:

> *You know the menstruation and womanhood go hand in hand, if you are not menstruating and being a woman it is not good at all. A woman must be seen at the shops buying something that is supposed to be used by ladies. Buying a pad at a shop as woman is our pride it makes one feels good. (Female, Grade 11, aged 19, participant no. 9)*

Another participant said:

> *The issue of taking away your menses. Yoo! You become old while still young. Contraception is boring when you don't see your menses. I have heard that if you do not menses on a monthly basis as young person, it causes waist pains and you can become sick. (Female, Grade 11, aged 18, participant no. 3)*

Another participant said:

> *I am talking about bleeding always. People cannot like menstrual*

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blood everyday, it is boring. For that reason contraceptives can be left alone with their side effects. But I don't know the truth of this because my boyfriend never told me this. They say a contraceptive causes waist pains to partners. (Female, Grade 10, aged 17, participant no. 1)

According to the quotations, is clear that young people believe that contraceptives cause irregular menstruation and other side effects like waist pains to opposite partners, and this has resulted in poor utilization of contraceptive services. Similarly, Kenya's DHS found that nonusers who did not intend to use contraception in the future most commonly cited fear of side effects (KNBS & ICF Macro, 2009). It was also found that disruption of menstrual cycle was the most common reported reason for discontinuation of contraceptive services among women in Kenya (Burke & Ambasa-Shisanya, 2011).

Another study also found fear of side effects as the main reason for discontinuation and non-use of contraceptive services (Mosha, Ruben & Kako 2013). Again, in another study it was revealed that contraceptive services sometimes challenge bio-cultural beliefs, for example, women in some societies believe it is healthy to menstruate monthly, and therefore refuse to use injectable contraceptives that often result in irregular bleeding, spotting, or amenorrhoea, which is absence of monthly bleeding.

4.3.1.5.3 Sub-Theme 1.5.3: Traditional and Religious Contraceptive Practices

The Youth Expressed Various Views on Traditional and Religious Contraceptive Practices.

The youth in this study revealed that local traditional and religious methods of contraception such as tying a rope containing traditional medicines around the waist, mixing a cloth covered in the woman's menstrual blood with medicines from a traditional healer and burying it, and drinking tea or concoctions prayed over by religious leaders are a few of the traditional methods that are being used by some of them. This resulted in poor utilization of modern contraceptive services. The other participants revealed that there are other methods that are used as contraceptives in their community like the withdrawal method. The participant explained that this method is not easy to use especially by young people, however, the method can result in teenage pregnancy as it is unreliable.

One elder participant said:

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> *Rope and water does not have any side effects; they are very good, even for young people. The rope is used to tie around your waist but it is having some medicine in it which is mixed by the traditional healers. (Female, Grade 3, aged 60, participant no. 14)*

Another elder participant said:

> *The other methods that are used in our area are the withdrawal method. This method is very difficult because many people find it difficult to withdraw and end up releasing inside and if you are not ready for a baby you can regret. This method needs a very discipline person who can control himself during the activity. (Female, Grade 9, aged 57, participant no. 12)*

Yet another elder participant said:

> *The rope that is tied around the waist does not have side effects it is a very good method of contraceptive because when you want to have a child you just untie it and immediately you fall pregnant unlike those that are used at the clinics. I do not want my daughters-in-law to use this contraceptives of clinics. I want them to use the African way of contraceptive—it is not harmful. (Female, Grade 1, aged 66, participant no. 13)*

Wood & Jewkes (2006) reported the widespread knowledge of participants about local traditional and religious methods of contraception, such as tying a rope containing traditional medicines around the waist, mixing a cloth covered in the woman's menstrual blood with medicines from a traditional healer and burying it, and drinking tea or concoctions prayed over by religious leaders. The study conducted by Biddlecom (2007) reported analogous results in that although youth used modern contraceptive services these were lower in scale than the use of the traditional methods.

4.4 Summary

In this study, the data collected from youth of two different villages (Masisi and Mulala)

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were analyzed and discussed. The main five themes that emerged were: youth expressed fear associated with disapproval and intimidation from parents and nurses, factors related to contraceptive services, absence of descent conversation about contraceptives between youth and parents, elders expressed concerns related to sexual norms and behaviour, factors related to contraceptives. The sub-themes also emerged from the main themes which were discussed in detail. The next chapter will advance the recommendations, limitations and conclusion of the study.

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CHAPTER 5

EVALUATION, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 Introduction

Chapter 4 discussed the analysis of the data controlled with relevant literature on the factors contributing to poor utilization of contraceptive services in selected villages within rural areas of Mutale municipality, Limpopo Province. This chapter presents the recommendations limitations and conclusions, in alignment with the purpose and objectives set out for the study. Recommendations that might influence policy and service delivery with regard to improvement of treatment outcome will be described and a conclusion which is based on the findings of the study will also be outlined. This chapter includes an appraisal of whether the objectives of the study were met.

5.2 Evaluation of the Study

The study was evaluated against its purpose and objectives as set out in Chapter 1.

5.2.1 Purpose of the Study

The main purpose of this study was to explore the factors that contribute to poor utilization of contraceptive services by youth in the rural communities of Mutale municipality Limpopo Province. The study used a qualitative, explorative, descriptive and contextual design. The discussion which follows will be aligned with the objectives of the study. The factors that contributed to poor utilization of contraceptive services by youth in the rural communities of Mutale municipality in Limpopo Province of South Africa were explored and compared with the relevant literature.

5.2.2 Objectives of the Study

The objectives of the study as highlighted in Chapter 1 were to:

- Identify the factors contributing to poor utilization of contraceptive services by youth at rural communities of Mutale municipality in the Limpopo Province.
- Identify various forms of contraceptive and services available to youth in rural areas.

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- Explore and describe the views of elders regarding the use of contraceptives and contraceptive services by youth in the rural areas.

The objectives of the study were met during data collection which was conducted through individual face-to-face interviews followed by data analysis. The research design used in this study was qualitative, explorative, descriptive and contextual in nature. The qualitative method helped the researcher to discern the factors contributing to poor utilization of contraceptive services by youth at the study site and to integrate views of elders on the phenomenon. The population of this study consisted of youth aged 16 - 20 years and elders aged 57.- 60 years. The central question was directed to youth and probing questions that emanated were further explored.

The data obtained for the two villages were analyzed together as they were interrelated. The factors contributing to poor utilization of contraceptive services and views of elders on contraceptive use were attained according to Teschs' eight steps of qualitative data analysis and represented by themes and sub-themes that emerged. Dense description of the factors and views of elders was also done with the relevant literature control. From the results it was identified that there was poor utilization of contraceptive services due to negative attitude that youth have towards contraceptive services. Factors that led to poor utilization of contraceptive services were also categorized and discussed. All the objectives of the study were met and are discussed in detail under that conclusion section of this chapter.

5.3 Recommendations

The recommendations in this study stem from the findings recorded from interviews with youth and elder participants. From the study findings, recommendations were conceptualized for the DoH, DoE and community leaders. Suggestions for further research are also offered.

5.3.1 Department of Health

- The study found that youth do not utilize contraceptive services regardless of their availability due to long distances they travel to the clinic, long waiting time at the clinic, lack of privacy and confidentiality in the case of the nurses.

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- The way nurses handle youth when they seek contraceptive services was unacceptable by the youth and they viewed it as impolite, hence contributing to poor utilization of contraceptive services. From these findings, the study recommend that the DoH urge all health care facilities to implement practical guidelines and policies that are youth friendly; this can be achieved through securing a section for youth consultation separate from normal consultation areas, organizing separate waiting areas and different and conveneint waiting times so that teenagers will be with their peers and have access to nurses trained specifically for contraceptive services.

- The DoH should also organize people who can render education and information sessions on sexual and reproductive health matters for youth at community and school levels. This can be done through partnering with NGOs that could be involved in promoting the use of modern contraceptives in all the villages of Mutale such that youth in rural or urban locations can access contraceptives for a healthy reproductive living.

- There is also a need for policy makers to initiate the implementation of a Parent Education Programme on young peoples' sexual and reproductive health issues. The main purpose of the programme should be to bridge the poor communication between parents and youth on sexual issues as well as to help improve parents' skills for educating and communicating with their children on sexual and reproductive health issues.

5.3.2 Department of Education

- In conclusion, when reflecting on levels of knowledge it seems apparent that youth in Mutale municipality have good basic knowledge but there appear to be significant gaps and inaccuracies in this knowledge. For example many youth only know about the injection, pill and condoms, but very few recognise the importance of dual protection. As such despite high levels of basic knowledge a lot more work still needs to be done to ensure comprehensive knowledge. The study shows that youth lack information with regard to the use of contraceptive and contraceptive services. The study recommends that the DoE should jointly work with the DoH to launch school health services campaigns to educate parents and leaners giving them more information on contraceptive issues.

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5.3.3 Community Leaders

- It was clear that the elders in both villages do not talk to their youth with regard to contraceptive services because of their cultural beliefs and behaviours. The study recommends that elders and parents should receive detailed explanations on contraceptive usage, types of contraceptives available for adolescents as well debunking certain misconceptions about contraceptives through health education

5.3.4 Further Research

- As the research was conducted on a small scale in one district of one province on females aged 16 - 20 years and community elders, it is recommended that future research should be conducted in other parts of the district and province or the greater SA. Future studies should examine providers' views as well as the quality of contraceptive services in order for the health system to be able to provide good contraceptives service to young people in need. We further suggest more research on how to approach and discuss with men about the risks of unwanted pregnancy and excessive fertility.

5.4 Limitation of the Study

The study was limited to youth aged between 16 - 20 years old and community elders living in the villages within Mutale municipality. The study was conducted only in two villages in Mutale municipality and cannot be generalized to other clinical sites offering the same services. Furthermore, only participants who were home at the times when the selected households were approached were included, which means that those away from home at the time were systematically excluded.

5.5 Conclusions

The objectives were contextualized in relation to the study findings as detailed below.

5.5.1 Fear Associated with Disapproval and Intimidation from Parents and Nurses

In this study, youth expressed different views and concerns indicating that various

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factors contributed to poor utilization of contraceptive services. The major reasons cited for poor utilization of contraceptive services include fear of parental authority, that it is morally wrong, and fear of being ridiculed by nurses as also expressed by Lebese, Maputle, Ramathuba & Khoza (2013). The use of contraceptives and contraceptive services was seen by youth as an admission to their parents of being sexually active and tended to arouse fears of being punished by family and scoffed at by nurse,s thus negatively affecting their ability to seek out those services.

Many young people normally find it difficult to use the same facility that they believe their parents use because they are afraid that they could possibly meet their parents or any other family members. In this study, youth indicated that they were not visiting clinics due to fear of meeting their parents. This clearly shows that young people avoided collecting contraceptives from clinics due to parental fear. Similar to the study conducted in the US, it was revealed that a prominent confidentiality-related concern for many adolescents is fear of parental notification through provider communications or health benefits notices issued by private insurers (Reddy, Fleming & Swain, 2002). The study also established that the nurses at the clinic were handling youth in a rude or impolite way. This creates unfavourable conditions for young people to seek contraceptive services.

The youth because of fear of nurses end up not using contraceptive services. When young people go to the clinic they believe that their confidentiality will be maintained. Other young participants said that clinic nurses reveal their information of seeking contraceptive services to their parents and this makes them not go for contraceptive services. But they feared that if they visited the clinic nurses would not keep their confidentiality, they might tell their parents that they were using contraceptive services.

5.5.2 Absence of Descent Conversation About Contraceptives Between Youth and Parents

The major finding of this study was lack of communication between parents and their daughters on sexual issues. Considering the strict cultural, traditional and religious influence on reproductive health, it was assumed and hypothesized that the involvement of parents in the reproductive health of their daughters has negative influences on contraceptive use. Parents were more traditional and not in support of their daughters, especially those who were not yet married, using contraceptives. The

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elders said they would never talk to youth about contraception because it is not something that one needs to discuss with young people because what youth need is to become educated at school.

Young people believed that they were not using contraceptive services because of lack of honest communication between parents and their children. Young people expressed that they do not talk to their parents about contraceptive services. Parents were said not to listen, talk to and advise their children appropriately on sexuality issues because, either they did not have the time, or were afraid and uncomfortable having such discussions.

Lack of proper understanding or open communication channels between parents and their children was highly emphasized by many participants, including elders. There is no communication between parents and young people with regard to contraceptive services. The contraceptive use by youth without the knowledge of their parents is not guaranteed because of this lack of communication. And because of this gap, it resulted in poor utilization of contraceptive services by youth.

5.3.3 Elders' Concerns Related to Sexual Norms and Behaviour

Elders believed that the initiations school were giving guidance to young people so that they would not engage in sexual activity at an early age. The study revealed that nowadays adolescents no longer have respect for their bodies because they are engaging in sexual activities at an early age. They no longer respect their parents or any other adult like in previous generations. They no longer follow their norms and values wherein every youth use to regard each adult as their own parents and give them the necessary respect. The elders believed that if young people were taken to initiation schools where they are given rules according to their culture, they will not use the contraceptive services and abstain from sexual activities.

The youth are expected to respect and obey rules and regulations of the society related to sexual norms and behaviour. And to, refrain and abstain from sexual activities until such time they are mature or after marriage. For youth to be seen at the clinic seeking contraceptive services is regarded as off-limits and should be condemned by the community. Local traditional norms and culture restrict the youth from utilizing contraceptive services.

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Elders who participated in this study believed that contraceptive services were meant for people who already have children. Therefore, youth without children were not supposed to use contraceptive services, otherwise they would not be accepted by the community, especially elders, if they utilized contraceptive services. The elders believed that contraceptive services can cause infertility if they are used by young people without a child. This put more pressure on the youth who find it difficult to seek services from the clinic because they want to be accepted by elders in the community.

5.5.4 Factors Related to Contraceptive Services

Youth believed that there was no privacy at their local clinics, which were designed for adult clients, and service providers were not trained in adolescent sexuality and youth-friendly concepts. As a result, the youth were neither well-received nor comfortable in mainstream clinics seeking contraceptive services (MIET Literature Review, 2012). In this study, youth expressed that clinics were far from their homes and it was difficult to travel to the clinics, especially when one is going only for contraception. If there is no serious medical illness, youth avoid going to the clinics only for contraceptive services, because of long distance concerns. It was revealed in another study that clinic facilities might be located a long distance from where young people live and this resulted in poor utilization of contraceptive services (WHO, 2002).

It was also shown that the rural youth could not afford to go to the clinics frequently because of lack of transport in their areas. Others went once and because of lack of transport in their area were unable to go for other follow-up visits. Youth also believed that the time for contraceptive services at the clinic is not convenient to them because when the school closes during the late afternoon the nurses at the clinic were no longer interested in contraceptive services. They anticipated that the services would be offered even after hours. While the youth who need urgent care may be willing to leave school or work for such services, those who need preventive services, but who may be unaware of their importance, are often reluctant to take time off.

It was also found that long waiting periods at the clinic was a contributory factor for not using contraceptive services by youth. Young people often are not willing to wait for services; and if the facility is crowded, they are particularly worried that someone they know will see them while they are waiting. Lack of privacy was identified as one of the barriers why youth do not visit the clinics for contraceptive services. Taking into account

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that parents put restrictions on the use of contraceptives by youth, youth will not expose themselves by collecting the contraceptives in the presence of local patients in clinics (Biddlecom et al., 2007).

5.5.5 Factors Related to Contraceptives

In this study, the youth expressed that they have information on three types of contraceptive services which is injectable, pill and condom, but lack of information with regard to contraceptive services and their use. Some youth believed that contraceptives can result in causing infertility and they would remain childless for the rest of their lives. The contraceptives are good but because of the poor information young people have with regard to contraceptives it appears not user friendly. The youth also expressed that they did not use contraceptive services because immediately after the use they started to experience irregular bleeding which, according them, is not what they expect when using contraceptives.

The youth in this study revealed other knowledge of contraceptive services that they believe are useful as compared to the modern contraceptive services available. The local traditional and religious methods of contraception, such as tying a rope containing traditional medicines around the waist, mixing a cloth covered in the woman's menstrual blood with medicines from a traditional healer and burying it, and drinking tea or concoctions prayed over by religious leaders are some of the traditional methods that are being used by some of them.

5.6 Conclusion

This chapter discussed the recommendations, conclusion and limitations of the study in the context the objectives and findings of the study. The study found that youth in both villages mostly avoided accessing and utilizing contraceptives services due to limited information, lack of parental support and approval, and clinic nurses with negative attitudes towards dispensing contraceptives to the young people and inconvenient times at the clinic. Therefore, to improve contraceptive uptake among young people, availability of contraceptive choices should not be compromised; information should be given to youth, community elders and parents, and clinic nurses should be trained on how to serve young people and clinics should open at times that are convenient for young people to attend.

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REFERENCES

Abdool Karim, Q., Preston-Whyte, E., Abdool Karim, S.S. 1992. Teenagers seeking condoms at family planning services. Part 1: A user's perspective. *South African Medical Journal,* 82: 356-59.

Abouzahr C, Vlassoff C, Kumar, A. 1996: Quality health care for women: A global challenge. Health Care for Women International, 17(5): 449-467.

Agampodi, S.B., Agampodi, T.C & Piyaseeli, U. 2008. Adolescents perception of reproductive health care services in Sri Lanka. BMC Health Services Research, 8,98.

Andrea Whittaker. 1996. Quality of Care for Women in Northeast Thailand: Intersections of Class, Gender, and Ethnicity. *Health Care for Women International*, 17(5): 435-47.

African Youth Alliance (AYA)/Pathfinder. 2003. Youth-friendly Sexual and Reproductive Health Services: An Assessment of Facilities. Tanzania.

Akinsola, H.A.2005. Research Methods in Medical & Nursing Practice

Allen, L. 2001. Closing sex education's knowledge/practice gap: the reconceptualization of young people's sexual knowledge. *Journal of Sex Education*, 1(2): 109-122.

Ali, F., Maharaj, P. & Vawda, M.Y. 2013.Interpersonal relations betweenhealth care workers and young clients: barriers to accessing sexual and reproductive health care .Journal of Community Health. 38,150-155.

Amirrtha Srikanthan, Robert L. Reid, MD, FRCSC *Religious and Cultural Influences on Contraception Division of Reproductive Endocrinology and Infertility*, Department of Obstetrics and Gynecology, Queen's University, Kingston ON.

Arrow for change. 1999. Womens health and barriers of culture and religion. *Women's and Gender Perspective in Health Policies and Programmes* 5(3): 1-2.

© University of Venda

Babbie, E. 2007. *The Practice of Social Research* (11th ed). Belmont: Thomson Wadsworth.

Baloyi, G.O. 2006. The evaluation of the National Adolescent Friendly Clinic Initiative (NAFCI) Program in the Greater Tzaneen Sub-District, Limpopo Province: South Africa. University of South Africa. Master's thesis.

Bankole, A., Ahmed, F.H., Neema, S., Ouedraogo, C. & Konyani, S. 2007. Knowledge of correct condom use and consistency of use amongst adolescents in four countries in Sub-Saharan Africa. *African Journal of Reproductive Health,* 11: 198-220. http://dx.doi.org/10.2307/25549730.

Barometer, 2010: Reproductive Health Alliance, 6. http://www.hst.org.za/rra/.

Bearinger, L.H., Sieving, R.E., Ferguson, J. & Sharma, V. 2007. Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention, and potential. *Lancet,* 369: 1220–1231.

Bhana, D., Clowes, L., Morrell, R and Shefer, T. (2008). *Pregnant Girls and Young Parents in South Africa.* Agenda, 78-90

Bhuiya, I., Rob, U., Khan, M. E., & Kabir, A.A. (2003) *Reproductive Health services for adolescents:* Recent experience from a pilot project in Bangladesh.

Brindis & Davis, (1998) Improving Contraceptive Access for Teens, Volume IV: Improving Contraceptive Access for Teens.

Biddlecom, A, Munthali, A, Singh, S. & Woog, V. 2007. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health,* 11(3).

Biddlecom, A. & Fapohunda, B.M. 1998. Covert Contraceptive Use: Prevalence, Motivations, and Consequences. *Studies in Family Planning*, 29(4): 360-72.

Bisika, T., Short, M., Wontumi, G. & Truong, J. 2007. Repositioning Family Planning to reduce unmet needs. *African Renaissance,* 4(3&4): 83–101.

© University of Venda

University of Venda
Creating Future Leaders

Blaikie, N. 2000. Designing Social Research: the logic of anticipation. Massachusetts: Blackwell.

Bothma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. *Research in Health Sciences.* Cape Town: Heinemann.

Brink, H., Van der Walt, C. & Van Rensberg, G. 2007. Fundamentals of Research Methodology for Health-Care Professionals.

Brink, H. 2012. Fundamentals of Research Methodology for Healthcare Professionals (3rd ed). Cape Town: Juta & Co.

Brink, P.J. & Woods, M.J.E. 1998. *Basic Steps in Planning Nursing Research: From Questions to Proposal* (4th ed). Boston: Jonss 5tes & Bartlett.

Buga. G., Amoko, D. & Ncayiyana, D. Sexual behaviour, contraceptive practices and reproductive health among school adolescents in rural Transkei. *South African Medical Journal,* 86: 356-27.

Burke Holly MC, Ambasa-Shisanya C.(2011). Qualitative study of reasons for discontinuation of injectable contraceptives among users and salient reference groups in Kenya. *African Journal of Reproductive Health*, 15(2): 67–78.

Burns, N. & Grove, S.K. 2001. The Practice of nursing Research, Conduct, Critique and Utilization. Philadelphia: W.B Saunders.

Burns, N. & Grove, S.K. 2003. *Understanding Nursing Research* (3rd ed). Philadelphia: W.B. Saunders.

Burns, N. & Grove, S.K. 2005.The Practice of Nursing Research (5th ed). Philadelphia: Elsevier.

Burns, N. & Grove, S.K. 2007. Understanding Nursing Research: Appraisal, Synthesis, and Generation of Evidence.

Burns, N. & Grove, S.K. 2008. *The Practice of Nursing Research* (6th ed). Philadelphia: Elsevier.

Burns, N. & Grove, S.K. 2009. *The Practice of Nursing Research* (6th ed). Philadelphia: Elsevier.

Burns, N. & Grove, S.K. 2011. *Understanding Nursing Research* (5th ed). Philadelphia: W.B. Saunders.

Bushaija,E,Sunday, F.,Asingizwe,D., Olayo,R & Abongo O.B.2013.Factors that Hinder Parents from communicating of SexualMatters with Adolescents in Rwand. Rwanda Journal of Health Sciences. 2,12-19

Center for Reproductive Rights: Access to Contraceptives (2009): The Social and Economic Benefits and Role in Achieving Gender Equality. *Available at* .net/files/documents/pub_fac_slovak_socioeconomic%20

© University of Venda

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benefits_9%2009_WEB.pdf.

Chigona, A. & Chetty, R. 2007. Girls' Education in South Africa: Special Consideration to Teen Mothers as Learners. *Journal of Education for International Development*, 3(1): 1-17.

Cobb, J.N. 2001. *Adolescent Continuity, Change and Diversity* (4th ed). California: Mayfield Publishing Company.

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

Costello, M. 2001. A Client-Centered Approach to Family Planning: The Davao Project. *Studies in Family Planning,* 32(4): 302-14.

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 HealthPolicy and Status*. Reproductive Health Matters. 12(24):70–85

Creswell, J.W. 2003. Research Design Qualitative, and Quantitative, and Mixed Methods Approaches. Thousand Oaks, CA: Sage Publications.

Creswell, J.W. 2007. Research Design Qualitative, and Quantitative, and Mixed Methods Approaches. Thousand Oaks, CA: Sage Publications.

Creswell, J.W. 2009. Research Design Qualitative, and Quantitative, and Mixed Methods Approaches (3rd ed). Thousand Oaks, CA: Sage Publications.

Creswell,J.W., Plano Clark &L,V. 2011.Designing and Conducting Mixed Methods Research.Sage Publishers

Crosby, R.A & Yarber, W.L. 2004. Perceived versus actual knowledge about correct condom use among us adolescents: Results from a national study. *Journal of Adolescent Health*, 28(5): 415-420.

Dallimore, A. 2002. Adolescent Risk Taking Behaviour in an Era of HIV/AIDS infection.

© University of Venda

University of Venda
Creating Future Leaders

A case study of the youth in the Province of KwaZulu.

Department of Health. 1999. *Youth and adolescent health policy guidelines*. Pretoria: Government printer.

Department of Health. 2001. *National contraception policy guidelines*, Government Printer, Pretoria.

Department of Health. 2008.. The National HIV and Syphilis Prevalence Survey South Africa 2007. Pretoria: Department of Health.

Department of Health. 2012. The National Contraception and Fertility Planning Policy and Service Delivery Guidelines. Pretoria: Department of Health.

De Vos, A.S. 2012. *Research at Grassroots* (4th ed). Pretoria: Van Schaik.

De Vos, A.S (ed). 2005. Research at Grassroots 3rd .

Dickson-Tetteth, K. & Foy, D., 2000, 'The national Adolescent Friendly Clinic Initiative: Handbook of adolescent sexual and reproductive health care', *Academic Research Library* 23(2), 2–22.

Eastman, K.L., Corona, R. & Schuster, M.A., 2005, 'Talking parents, healthy teens: A worksite-based program for parents to promote adolescent sexual health', viewed October 2010, from http://apha.confex.com/apha/130am/techprogram/paper

Erulkar, A.S, Onoka, C.J. & Phiri, A. 2005. What is youth-friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe. *African Journal of Reproductive Health,* 9(3): 51–58.

Ehlers, V.J., Maja, T., Sellers, E. & Gololo, M. 2000. Adolescent mothers' utilization of reproductive health services in the Gauteng province of South Africa. *Curationis*, 23(3): 43-53.

Ehlers, V.J. 2003. Adolescescent mothers knowledge and perception of contraceptives

© University of Venda

University of Venda
Creating Future Leaders

in Tshwane, SouthAfrica. *Health SA Gesondheid,* 8(1): 13-25.

Ehlers, V.J. & Khoza, L.B.M, 2001.Reproductive health needs of adolescent mothers in the Lowveld region of the Northern Province of South Africa. *Health & Hygiene,* 12(8): 2-9.

Eva-Britta Råssjö, Robert Kiwanuka. 2010. Views on social and cultural influence on sexuality and sexual health in groups of Ugandan adolescents. *Sexual & Reproductive Healthcare*, 1(4).

Espey E, Cosgrove E, Ogburn T. 2007. Family planning American style: Why it's so hard to control birth in the US. *Obstetrics & Gynecology Clinics of North America,* 34: 1-17.

Flanagan, A., Lince, N., Durao de Menezes, I. & Mdlopane, L. 2013. Teen Pregnancy in South Africa: A Literature Review Examining Contributing Factors And Unique Interventions. Ibis Reproductive Health.

Flora L.K. Makundi. 2001. Quality of Care and Accessibility of Family Planning Services in Tanzania: Providers', Clients', and Non-Users' Perspectives". *Paper delivered at the annual meeting of the Population Association of America, Washington, DC*, March 29-31.

.

Godia,P. M. 2012. Sexual Reproductive Health Service Provision for Young people in Kenya; what is the best model?

Gomes, K.R.O.,Speizer, I.S., Oliviera, D.D.C., Moura, L.N.B. & Gomes, F.M. 2006. Contraceptive methods used by adolescents in Brazilian State Capital. *Journal of Paediatric and Adolescent Gynecology*, 21(4): 213-219.

Grinnell, R.M. & Unrau, Y.A. 2008. Social Work Research and Evaluation: Foundation of Evidence Base Practice. New York: Oxford University Press.

Guttmacher Institute & IPPF 2010, Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World, Guttmacher Institute, Washington.

Hamid, S.R.B,. 2006. Provider and health facility influences on contraceptive adoption

© University of Venda

in urban Pakistan. *International Family Planning Perspectives,* 32(2), 11-6.

Harrison, D. 2008. *Three ways to reduce teen pregnancy in South Africa.* Paper prepared for the HSRC Youth Policy Initiative Roundtable 5: *Teenage Pregnancy*. Reserve Bank, Pretoria.

Harrison, D. 2008. *A gauge of HIV prevention in South Africa: October 2008* Sandton: love LifRetrieved, 25 May, 2009, from http://www.lovelife.org.za/corporate/news/article.php?uid=1549.

Harvey, S., Henderson, T. & Branch, R. 2004. Protecting against both pregnancy and disease: Predictors of dual method use among a sample of women. *Women's Health*, 39: 25-43.

Heunis, C., Van Rensburg, D. & Ngwena, C. 2000. A youth multifunction centre in the Free State: An alternative to clinic-based HIV/AIDS prevention and care. *Curationis,* 23(4): 54-62.

Hoffman-Wanderer, Y., Carmody, L., Chai, J and Rohrs, S. (2013). *Condoms? Yes! Sex? No! Conflicting Responsibilities for Health Care for Professionals under South A* Ibis Reproductive Health: Young Women's Reproductive Health Brief Series.*frica's Framework on Reproductive Rights.* Cape Town: The Gender, Health & Justice Unit, University of Cape Town

Holt, K.., Lince, N., Hargey, A., Struthers, H., Nkala, B., McIntyre, J., Gray, G., Mnyani, C. and Blanchard, K. (2012). *Assessment of Service Availability and Health Care Workers' Opinions about Young's Sexual and Reproductive Health in Soweto, South Africa.* African Journal of Reproductive Health, 16(2), 283-294

Htt;//en.wikipedia.org/wiki/rural community Africa. *Summer 2005 Newsletter.* Johannesburg: Ibis Reproductive Health.

International Planned Parenthood Federation (IPPF), 2007. A Guide for Developing Policies on the Sexual and Reproductive Health and Rights of Young People in Europe. IPPF European Network; Safe Project..

© University of Venda

International Planned Parenthood Federation (IPPF), 2008. Provide: Strengthening youth friendly services. *Inspire Pack.* UK.

Irwanto. 2013. In the Shadow of Men: Reproductive Decision-Making and Women's Psychological Well-Being in Indonesia. Research Triangle Park, NC: Women's Studies Project, Family Health International.

Jere, B.R., Hans-Peter, K & Susan, W.C. 2002. Social networks and changes in contraceptive use over time: Evidence from a longitudinal study in rural Kenya. *Demography*, 39(4): 713–38.

Judith Senderowitz MA, Gwyn Hainsworth MED, and Cathy Solter, CNM. 2003. *A Rapid Assessment of Youth Friendly Reproductive Health Services* Number 4, September 2003

Jejeebhoy, S.J., Shah, I. & Thapa, S. 2005. Sex without Consent: Young People in Developing Countries. New York: Zed Books.

Jewkes, R., Morrell, R. & Christofides, N. 2009. Empowering teenagers to prevent pregnancy: Lessons from South Africa. *Culture, Health & Sexuality*, 11(7): 675-688.

John Ross. 2002. Contraceptive Method Choice in Developing Countries. *International Family Planning Perspectives,* 28(1): 32-40.

Kalo, J. 2007. Utilization of adolescent reproductive health services by young people in Vanuatu / Joe Kalo . Suva, Fiji: *UNFPA Office for the Pacific*, 13 p.; 30 cm.

Kanku, T. & Mash, R. 2010. Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung. *South African Family Practice,* 52(6): 563–572.

Katende, C., Gupta, N. & Bessinger, R. 2003. Facility-level reproductive health interventions and contraceptive use in Uganda. *International Family Planning Perspectives,* 29(30): 130-137.

Kaufman, C.E., De Wet, T.T. & Stadler, J. 2001, Adolescent pregnancy and parenthood

© University of Venda

University of Venda
Creating Future Leaders

in South Africa. *Studies in Family Planning,* 32(2): 147–160. http://dx.doi.org/10.1111/j.1728-4465.2001.00147.x, PMid:11449863.

Kayongo, S.B. 2013. Uptake of morden contraception among youth (15-24) at community level in Busia distric, Uganda.

Kempner, ME 2003: True integration of prevention programmes requires broad focus on sexual health. SIECUS report. *Academic Research Library,* 31(3): 44-51.

Kenya National Bureau of Statistics (KNBS), ICF Macro. (2009). Kenya Demographic and Health Survey 2008–09. Calverton, Maryland: KNBS and ICF Macro;.

Khoza, L.B. 2004. Adolescent's knowledge, beliefs and experiences regarding sexual practices. *Health SA Gesondheid,* 9(4): 9-11

Lacey, A. & Luff, D. (2007). *Qualitative Research Analysis*. Trent: Research and Development. Sheffield University.

Lebese, R.T., Maputle, S.M, Ramathuba, D.U. & Khoza, L.B. 2013. Factors influencing the uptake of contraceptive services by Vatsonga adolescents in rural communities of the Vhembe District in Limpopo Province, South Africa. *Health SA Gesongheid*, 18(1).

Lisa M Williamson, Alison Parkes, Daniel Wight, Mark Petticrew and Graham J Hart Kistnasamy, E.J., Reddy, P. & Jordan, J. 2009. An evaluation of knowledge, attitude and practices of South African university students regarding the use of emergency contraception and of art as an advocacy tool. *South African Family Practice*, 51(5): 423–426.

Little, L. 2007. Teenage health education: a public health approach. *Nursing Standard*, 11(49): 43-46.

Lewis Ndhlovu: Quality of Care of Family Planning Service Delivery of Kenya: Clients' and Providers' Perspectives. Final Report (Nairobi, Kenya: Division of Family Health, Ministry of Health, and New York: Population Council, 1995.

Lince, N. 2011. Early marriage and teenage pregnancy in South Africa. PowerPoint presentation. *Ibis Reproductive Health Conference*, Johannesburg. 26 July.

© University of Venda

University of Venda
Creating Future Leaders

Lincoln, Y. & Guba, E. 1985. *Naturalistic Enquiry.* Beverly Hills, CA: Sage Publications

Lincoln, Y. & Guba, E. 1999. *Establashing Trustworthiness.* In Bryman, A. & Burgess, R.G. (Eds), *Qualitative Research* 3.

MacPhail, C. & Campbell, C. 2001. 'I think condoms are good but I hate those things': Condom use among adolescents and young people in a Southern African township. *Social Science and Medicine,* 52: 1613- 1627.

MacPhail, C., Pettifor, A.E., Pascoe, S. & Rees, H.V. 2007. Contraception use and pregnancy among 15-24 year old South African women: A nationally representative cross-sectional survey. *Biomedical Central Medicine,* 5:,1-8.

Macleod, C. 2001. Teenage motherhood and the regulation of mothering in the scientific literature: The South African example. *Feminism & Psychology*, (4): 493-510.

Magnani, R., Macintyre, K., Karim, A.M., Brown, L., Hutchinson, P., Kaufman, C., Rutenburg, N., Hallman, K., May, J. & Dallimore, A. 2005. The impact of life skills education on adolescent sexual risk behaviours in KwaZulu-Natal, South Africa. *Journal of Adolescent Health, 36*(4): 289-304.

Magadi, M. & Curtis, S. 2003. Trends and determinants of contraceptive method choice in Kenya. *Studies in Family Planning*, 34(3): 149-159.

Maluleke,T.X. 2007.The youths' perception of sexuality in the Limpopo Province of South Africa.*Health SA Gesondheid.12, 3-16*

Maja, T.M.M. & Ehlers, V.J. 2004. Contraceptive practices of women in northern Tshwane, Gauteng Province. *Health SA Gesondheid,* 9(4): 40–51.

Marie, K. 2007. *First steps in research.* Pretoria: Van Schaik.

Mestad, R., Secura, G., Allworth, J.E., Madden, T., Zhao, Q. & Pelpert, J.F. 2011. Acceptance of long-acting reversible contraceptive methods by adolescents participants in the contraceptive CHOICE Project. *Contraception,* 84(5): 493-498.

© University of Venda

Mbugua, N. 2007. Factors inhibiting educated mothers in Kenya from giving meaningful sex-education to their daughters. *Social Science & Medicine*, 64, (5) 1079-1089.
Michie, S., Johnston, M., Francis, J., Hardeman, W., & Eccles, M. 2008. From theory to intervention: Mapping theoretically derived behavioural determinants to behaviour change techniques. *Applied Psychology: An International Review,* 57(4): 660-680.

MiET Africa. (2011). Literature Review: Youth-friendly Health Services, September 2011

Mmari, K.N. & Magnani, R.J. 2003. Does making clinic-based reproductive health services more youth friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *Journal of Adolescent Health,* 33(4): 259–270.

Monette, D.R, Sullivan, T.J. & De Jong, C.R. 2008. *Applied Social Research: A Tool for the Human Services*, (7th ed). Belmont, CA: Thomson Wadsworth.

Morrel, R. 2007. Do you want to be a father? School-going youth in Durban schools at the turn of the 21st century. In Shelter, T. Ratele, K. Strebel, A. Shabalala, N & Buikema, R. (Eds.), *From Boys to Men: Social Constructions of Masculinity in Contemporary Society* . Cape Town: Juta and Company. pp. 75-93.

Morse, J.M. (Ed).1992. *Understanding Social Research.* Newbury Park: Sage Publications

Mosha I, Ruben R, Kakoko D. 2013. Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study. *BMC Public Health*, 13:523.

Moya, C. 2002. Creating youth friendly sexual health services in sub- Saharan Africa.htt//www.popline.org/node/23534.

Mulaudzi, F.M., 2007, 'Indigenous health beliefs, attitudes and practices among Vhavhenda: A challenge to the promotion of HIV/AIDS prevention strategies', *Curationis* 3(3), 34–35.

© University of Venda

University of Venda
Creating Future Leaders

Muller, K.E. & Powers, W.G. 1990: Parent-child sexual discussions: perceived communicator style and subsequent behavior. *Adolescence*, 25(98): 469-482.

Mwaba, J.S. 2000. Perceptions of teenage pregnancy among South African adolescents. *Health SA Gesondheid,* 5(3): 30-34.

Nalwadda, G., Mirembe, F., Tumwesigye, N.M., Byamugisha, J. & Faxelid, E. 2011. Constraints and prospects for contraceptive service provision to young people in Uganda: Providers' perspectives. *BMC Health Service Research*, 11: 220.

National Research Council and Institute of Medicine. 2005. Panel on Transmission to Adulthood in developing countries, growing up global: The changing transmissions to Adulthood in Developing Countries, Washington DC: National Academic Press.

Nazar-Beutelspacher, A., Molina-Rosales, D., Salvatierra-Izaba, B., Zapata-Martelo, E., Halperin, D. 1999. Education and Nonuse of Contraceptives Among Poor Women in Chiapas, Mexico. *International Family Planning Perspectives,* 25(3).

Ndyanabangi,B.& Kip,W. 2000. Reroductive health and adolescent school students in Kaborole district, western Uganda:A qualitative study. *Journal of Health & Population in Developing Countries 3(2):1-20*

Neuman, W.L. 2011. Social Research Methods: Qualitative and Quantitative Approaches 7e.

Netshikweta, M.L. l999. *The problems associated with pregnancy amongst student nurses in the Nortern Province.* Unpuplished Mcur dissertation. Pretora: University of South Africa.

Ngabaza, S. (2011). Positively Pregnant: Teenage Women's Experience of Negotiating Pregnancy With Their Families. Agenda, 42-51

Ogle, S., Glasier, A. & Riley, S.C. 2008, Communication between parents and their children about sexual health. *Journal for Contraception,* 77(10): 283–288. doi:10.1016/contraception. 2007.12.003, PMid:18342652.

© University of Venda

Okanlawon, K., Reeves, M. & Agbaje, O.F. 2010. Contraceptive use: Knowledge, perceptions and attitudes of refugee youth in Oru Refugee Camp, Nigeria. *African Journal of Reproductive Health*, 14(4, Special Issue): 16-25.

Ouedraogo, C., Woog, V. & Ouedraogo, O. 2007. Les adultes faces aux comportements des adolescents difficultes et enjeux. *Occasional Report,* No. 32. New York: Guttmacher Institute.

Oxfam. 2007. Protocols for Community-based Youth-friendly Health Services for Rural Youth in the Context of HIV and AIDS. India.

Parker, Faranaaz, (16 January 2013). *Green Light for Sexual Offences Act development*, in Mail & Guardian, http://mg.co.za/article/2013-01-16-green-light-for-healthy-sexual-development (accessed 2 March 2013).

Pettifor, A.E., Rees, H.V., Kleinschmidt, I., Steffenson, A.E., MacPhail, C., Hlongwa-Madikizela, L., Vermaak, K., & Padian, N.S. (2005). Young people"s sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. *AIDS*, *19:* 1525-1534.

Philip B, Adongo. 1997. Cultural Factors Constraining the Introduction of Family Planning Among the Kassena-Nankana of Northern Ghana. *Social Science and Medicine,* 45(12): 1789-804.

Polit, D.F. & Beck, C.T. 2004. *Nursing Research Principles and Methods* (7th ed). Phildelphia: J.D. Lippincott Company.

Polit, F.D. & Beck, C. T. 2008. *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Hungler, B.P. 1991. Nursing Research Principles and Methods Philadelphia: Lippincott .

Poonkhum, Y. 2003. *Providing adolescent-friendly reproductive health services: The Thai Experience*.http://www.who.int/reproductive-health/publication/towards-adulthood/40. pdf Page 210-212. . 4/12/06. Punch, K.F. 2005. *Developing*

© University of Venda

University of Venda
Creating Future Leaders

Effective Research Proposals. London: Sage Publications.

RamaRao, S., Lacuesta, M., Costello M. Pangolibay, B. & Jones, H. 2003. The link between quality of care and contraceptive use. *International Family Planning Perspectives*, 29(2): 76–83.

Reddy, S.P., Panday, S., Swart, D., Jinabhai, C.C., Amosun, S.L., James, S., Monveki, K.D., Stevens, G., Morejele, N., Kambaran, N.S., Omardien, R.G. & Van den Borne, H.W. 2003. *Umthenthe Uhlaba Usamila - The South African National Youth Risk Behaviour Survey 2002.* Cape Town: Medical Research Council

Reddy, D.M., Fleming, R. & Swain, C. 2002. Effect of mandatory parental notification on adolescent girls' use of sexual health services. *Journal of the American Medical Association,* 288(6): 710–714.

Ochako Rhoune, Mwende Mbondo, Stephen Aloo, Susan Kaimenyi, Rachel Thompson, Marleen Temmerman and Megan Kays. 2015. Barriers to modern contraceptive methods uptake among young women in Kenya: A Qualitative study. *BMC Public Health,* 15:118, DOI 10.1186/s12889-015-1483-1.

Remare, E. & Catherine, K. 2012. Physical access to health facilities and contraceptive use in Kenya: Evidence from the 2008–2009 Kenya Demographic and Health Survey. *African Journal of Reproductive Health*, 16(3): 47–55.

Reeves, J. 2007. 'Tell me your story': Applied narrative research with young fathers. *Children's Geographies,* 5(3): 253-265.

Richter, L. 2006. Studying Adolescence. *Science* 312: 1902-19050.

Rogstad, K.E., Ahmed-Jushuf, I.H. & Robinson, A.J. 2002. Standards for comprehensive sexual health services for young people under 25 years. *International Journal of STD and AIDS,* 13: 420–424.

Rubin, A. & Babbie, E. 2005. *Research Methods for Social Work*, (5th ed). Australia: Thomson Brookes/Cole.

Samantha W., 2013. A Review of Teenage Pregnancy in South Africa, Partners in Sexual Health.

Schreiber, C.A., Harwood, B.J., Switzer, G.E. et al. 2006. Training and attitudes about contraceptive management across primary care specialties: A survey of graduating residents. *Contraception*, 73: 618-622.

Seiber, E. & Bertrand, J. 2002. Access as afactor in differential contraceptive use between Mayans and Ladinos in Guatemala. *Health Policy and Planning,* 17(2): 167-177.

Senderowitz Judith, Hainsworth Gwyn, Solter Cathy. 2003. A rapid Assessment of Youth Friendly Reproductive Health Services. http://www.pathfinder.org/publications. Accessed 10 April 2012

Setiloane, C.W.M., 1990, Contraceptive use amongst urban and rural youth in South Africa – a comparative study. *Curationis,* 13(4): 44–52.

South African National Youth Policy (2009-2014)

Statistics South Africa. Mid-year population estimates 2011. Accessed 3/01/2013. Availableat:http://www.statssa.gov.za/Publications/statsdownload.asp?PPN=P0302.

Stephen, R.B. & Tsui, A.O. 2003. Contextual influences on reproductive wellness in Northern India. *America Journal of Public Health*, 93(11): 1820-1829.

Stephenson, R.B., Beke, A., Tshibangu, D., 2008. Contextual influences on contraceptive use in the Eastern Cape, South Africa. *Health and Place*, 14: 841-852.

Streubert, H.J. & Carpenter, R. 1999. *Qualitative Research in Nursing: Advancing the Humanistic Imperative* (2nd ed). Philadelphia: Lippincott.

Tesch, R. 1990. Qualitative Research: Analysis Types and Software Tools. New York: Falmer Press.

© University of Venda

Thin Zaw, P.P., Liabsuetrakul, T., Htay, T.T. & McNeil, E. 2012. Equity of access to reproductive health services among youth in resource-limited suburban communities of Mandalay City, Myanmar. *BMC Health Services Research,* 12: 45.

The World Bank 2006, World Development Report 2007: Development and the next generation, The Worls Bank, Washington DC.

Tuoane, M., Diamond, L. & Madise, N. 2003. Use of family planning services in Lesotho: The importance of quality care and access. *African Population Studies,* 18(2): 105-132.

United Nations. 2008. *The Millennium Development Goals Report, 2008*. New York: United Nations.

Unrau,Y.A., Gabor, P.A. & Grinnel, R.M. 2007. *Evaluation in social work: the art and science of practice.* London; Oxford University Press.

UNFPA. Youth- friendly health services. www.unpa.org. Accessed on 12 September 2011.

Velasco. 2001 "Calidad en los Servicios de Anticoncepción de El Alto, Bolivia," accessed online at www.fhi.org/en/wsp/wssyn/syn4.html, on Dec. 10, 2001. 67.

Ventura,S. J.,Abma, J. C., Mosher, W.D. & Henshaw, S. K. 2008. Estimated pregnancy rates by outcome for the United States, 1990-2004. *National Vital Statistics Reports*, 56, 1-25. Division of Vital Statistics, Guttmacher Institute, USA.

Wah-Yun, L., Chirk-Jenn, N.G., Sohaimi, F.K., Fadzil, K S. & Eng-Suan, A.N.G., 2007, 'Sexual issues: Let's hear it from the Malaysian boys.' *The Journal of Men's Health and Gender* 4(3): 283–291. doi:10.1016/j.jmhg.2007.04 010

Warenius, L.U., Faxelid, E.A., Chishimba, P.N., Musandu, J.O., Ong'any, A.A., & Nissen, E.B.M. 2006. Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reproductive Health Matters*, 14, (27) 119-128.

© University of Venda

Welman, C., Kruger, F. & Mitchell, B. 2005. *Research Methodology* (3rd ed). Cape Town: Oxford University Press

Wilkinson, P., French, R., Kane, R., Lachowycz, K.,Stephenson, J. Grundy, C. Jacklin, P, Kingori, P., Stevens M. &Wellings K. 2006. Teenage conceptions, abortions, and births in England, 1994-2003, and the national teenage pregnancy strategy. *The Lancet*, 368: 1879-1886.

Weideman, E. 1996. Sex: The tragedy of unwanted pregnancy.Drum Issue 217.October 31,pp38-39.

Williams, C.X. & Mavundla, T.R. 1996: Teenage mothers' knowledge of sex education in a general hospital of Umtata district. Curationis, 22(1):58-63.Wood, K. & Jewkes, R. 1997. Violence, rape, and sexual coercion, *Gender and Development,* 5: 41–46.

Williamson, N. 2013. A review of Teenage Pregnancy in South Africa- Experiences of Schooling, knowledge and access to sexual and reproductive health services. *Partners in Sexual Health, 1-6.*

Wood, K & Jewkes, R. 2000. Blood blockages and scolding nurses: Barriers to effective use among teenagers in South Africa. *Medical Research Council, Pretoria. Technical Reports*:1-27.

Wood, K. & Jewkes, R. 2006. Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters*, 14: 109-118.

Wood, K., Maepa, J. & Jewkes, R. 1997. *Adolescent Sex and Contraceptive Experiences: Perspectives of Teenagers and Clinic Nurses in the Northern Province*. Final project report prepared for Health Systems Trust (SA), Durban, South Africa.

Wood, K., Maforah, F. & Jewkes, R. 1998. "He forced me to love him": Putting violence on adolescent sexual health agendas. *Social Science and Medicine,* 47: 233-242.

© University of Venda

University of Venda
Creating Future Leaders

World Health Organization. 1998: Report on the Global HIV/AIDS Epidemic. Geneva: 12th world Aids conference.

World Health Organization. 1999. Programming for adolescent health and development. *Technical Report Series* No 886. Geneva.

World Health Organization. 2002. *Adolescent friendly health services* - An agenda for change. UK.

World Health Organization. 2006. Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva.

World Health Organization. 2009. Evolution of the National adolescent-friendly clinic initiative in South Africa. Geneva

World Health Organization. 2010. Update on family planning in Sub-Saharan Africa. In repositioning family planning. Guideline for advocacy action. Page 1-8.http://www.who.int/ reproductivehealth/topic/family-planning/fp-advocacytool-kit.pdf (accessed on 20-01-2010).

World Health Organization. 2011 Adolescent Pregnancy. Geneva: WHO. http://www.who.int/makingpregnancy_safer/topics/adolescent_pregnancy/en/index.html (Accessed 14 December 2011).

Wulf, M. 2004: Parents and children healthy conversation. *Academic Research Library*, 20(5): 2-27.

Zimmerman, M. 2003. Women's health and urban life. *Journal of Health and Social Behaviour*, 11(1): 22-41.

Ziyani, I.S., Ehlers, V.J. & King. L.J. 2003. Socio-cultural deterrents to family planning practices among Swazi women. *Curationis,* 20(3): 39-48

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ANNEXURE 1

APPROVAL OF RESEARCH PROPOSAL BY UNIVERSITY OF VENDA HIGHER DEGREES COMMITTEE

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS A.V MULAUDZI
SCHOOL OF HEALTH SCIENCES

FROM: PROF J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 22 OCTOBER 2014

DECISIONS TAKEN BY UHDC OF 10TH OCTOBER 2014

Application for approval of Master's research proposal in Health Sciences: **A.V Mulaudzi 11629996**

Topic: "Factors contributing to poor utilisation of contraceptive services by youth in the rural communities of Mutale municipality in Limpopo Province."

Supervisor:	UNIVEN	Prof. V.O Netshandama
Co-supervisor:	UNIVEN	Dr. R.T Lebese

UHDC approved Master's proposal

Prof J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

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ANNEXURE 2

ETHICAL CLEARANCE - UNIVERSITY OF VENDA

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms AV Mulaudzi

Student No:
11629996

PROJECT TITLE: **Factors contributing to poor utilization of contraceptive services by youth in the rural communities of Mutale municipality in Limpopo Province.**

PROJECT NO: SHS/14/PDC/10/1803

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof VO Netshandama	University of Venda	Supervisor
Dr RT Lebese	University of Venda	Co-Supervisor
Ms AV Mulaudzi	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: March 2015
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

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ANNEXURE 3

APPLICATION TO DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

P.O Box 4087
Thohoyandou
0950
11/06/2015

The Manger
Limpopo Province Health Department
P/Bag 9302
Polokwane
0700

Sir/Madam

APPLICATION TO DO A RESEARCH

I Mulaudzi Azwindini Valentia student number 11629996 am a Masters student at the University of Venda hereby request for permission to conduct research as part of my study entitled **Factors contributing to poor utilization of contraceptive services by youth in rural communities of Mutale municipality in Limpopo Province.** The purpose of this study is to determine the factors that contribute to poor utilization of contraceptive services by youths in selected rural communities of Mutale municipality in Limpopo Province. The study process and outcomes might influence collaboration between government and non-governmental organisations and promoting reproductive health and contraceptive use by young people hence reducing teenage pregnancy. The following documents are attached:

- Approval from the University Higher degrees
- University Ethical clearance certificate

Thank you in anticipation

Sincerely

Mulaudzi A.V ..... VO Netshandama .....
MCUR Candidate SUPERVISOR .....

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ANNEXURE 4

PERMISSION FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Mulaudzi AV
University of Venda
Private Bag X5050
Thohoyandou
0950

Greetings,

RE: Factors contributing to poor utilization of contraceptive services by youth in the rural communities of Mutale municipality in Limpopo Province.

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

Date 18/12/15

18 College Street, Polokwane, 0700. Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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ANNEXURE 5

APPLICATION TO VHEMBE DISTRICT DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

PO Box 4087
Thoyandou
0950

District Executive Manager
Department of Health
Vhembe District
Dear Sir/Madam

Re: Request to conduct a research study at Masisi and Manenzhe clinic in Mutale Sub District Limpopo Province

My name is Mulaudzi Azwindini Valentia. I am a nursing student doing Magister Curationis at the University of Venda. As the part of the university requirement, I am expected to conduct a research study and I would like to conduct the study in your village. My research topic is "Factors that contribute to youth utilisation of contraceptives in the rural communities of Mutale sub district, Limpopo Province". The objective of the study is to explore and identify the views of the community on adolescent sexual health. The Masisi and Manenzhe villages were chosen because they will provide the study with relevant participants.

The participants will comprise all female youth who are 16 - 20 years, elders in those communities, and health care nurses in the villages. Information will be treated with respect and confidentially. The study, with its findings, will be made available to the institution when it is completed.

In order to proceed with study, I kindly request you permission to conduct the study at your clinics. Your co-operation in this regard will be highly appreciated. For any further additional information please do not hesitate to contact me on 082 628 4266.
Yours faithfully

Mulaudzi Azwindini Valentia

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ANNEXURE 6

PERMISSION FROM VHEMBE DISTRICT DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Ref : 4/2/1
Enq :Mukhaha N
Tel/Cell : 0736479861/0159622237
DATE :27/01/2016

To :Ms. Mulaudzi AV
UNIVERSITY OF VENDA
THOHOYANDOU

From : Acting Director PHC
Department of Health
VHEMBE DISTRICT

SUBJECT: PERMISSION TO CONDUCT RESEACH STUDY.
(Factors contributing to poor utilization of contraceptive services by youth in the rural communities in Limpopo Province)

1. The above matter has reference.

2. The Department of Health Vhembe District acknowledges receipt of your communiqué regarding request for permission to conduct research study title (Factors contributing to poor utilization of contraceptive services by youth in the rural communities in Limpopo Province) at PHC facilities namely Masisi, Manenzhe clinic.

3. Kindly be informed that you are authorized to gain access and conduct your studies at the facilities. You are therefore expected to comply with the regulations that govern public institutions.

4. Kindly be informed the Department of Health is not liable for any harm or injuries that may occur whilst you are in the facilities.

5. Hoping you will find this in order.

.....
ACTING DISTRICT EXECUTIVE MANAGER

27/01/2016
DATE

Private Bag x5009, Thohoyandou, 0950

Tel: (015) 962 1000, Direct Line (015) 962 0265. Fax: (015) 962 2373 Website: www.dhsd.limpopo.gov.za

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ANNEXURE 7

APPLICATION TO TSHIKUNDAMALEMA TRIBAL AUTHORITY TO CONDUCT THE STUDY

PO Box 4087
Thoyandou
0950

The Headmen
Tshikundamalema Tribal Authority
Tshikundamalema Mutale
Dear Sir/Madam

Re: Request to conduct research study at Masisi and Manenzhe village in Mutale Sub District Limpopo Province

My name is Mulaudzi Azwindini Valentia. I am a nursing student doing Magister Curationis at the University of Venda. As the part of the university requirement, I am expected to conduct a research study and I would like to conduct the study in your village. My research topic is "Factors that contribute to youth utilisation of contraceptives in the rural communities of Mutale sub district Limpopo Province". The objective of the study is to explore and identify the views of the community on adolescent sexual health. The Masisi and Manenzhe villages were chosen because they will provide the study with relevant participants.

The participants will comprise all female youth who are 16 - 20 years, elders in those communities, and health care nurses in the villages. Information will be treated with respect and confidentially. The study, with its findings, will be made available to the institution when it is completed.

In order to proceed with study, I kindly request you permission to conduct the study at your communities. Your co-operation in this regard will be highly appreciated. For any further additional information please do not hesitate to contact me on 082 628 4266.

Yours faithfully

Mulaudzi Azwindini Valentia

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ANNEXURE 8

PERMISSION FROM TSHIKUNDAMALEMA TRIBAL AUTHORITY TO CONDUCT THE STUDY

MASISI HEADMAN

TO: MULAUDZI AZWINDINI VALENTIA

You have been granted permission to conduct a study in our area of jurisdiction under the topic "Factors contributing to poor utilization of contraceptive services by youth in the rural communities of Mutale municipality Limpopo Province."

HEADMAN MUNDALAMO NJ
MASISI VILLAGE
2015 -02- 0 8
P.O. BOX 321, MASISI, 0959
LIMPOPO PROVINCE

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ANNEXURE 9

INFORMATION SHEET FOR KEY INFORMANTS

INTRODUCTION AND BACKGROUND

Good Day

My name is Azwindini Mulaudzi. I am a student of the University of Venda, doing a study as part of the fulfilment of admission to my Master's Degree in Nursing. The aim of this study is to determine youth utilization of contraceptive services in rural communities of Mutale municipality. The interview will last for an hour if you agree to take part. I will ask you questions about the factors that contribute to youth utilization of contraceptive services at Mutale municipality. The questions are not a test; there is no right or wrong answer. It is your opinion that is essential for the study. My role as a researcher is to listen and understand your point of view, and not to pass judgements. If you feel uncomfortable in answering some of questions, feel free to say so, you will not be penalised.

CONFIDENTIALITY

The information that you will give will be kept confidential. All participants will be given code and those codes will be used when trashing interview. These codes will only be known by the researchers.

I undertake that all information provided by you will be used only for the purpose of the study. Everything that you will provide will be treated as private and confidential and will be respected.

No one will know how you answer the questions apart from the researcher. The answers given by the participants will be combined and analysed according to the common theme and categories. The combined information will be written in a form of report.

CONSENT

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Ethical clearance will be obtained from the University of Venda Ethical committee. Permission to carry out the study will be found from the higher degree committee of the University of Venda and Limpopo provincial Department of health as well as Community clinical Liaison officer.

I will ask you to sign an informed consent form, both to participate in the study and to cord the interview and if you are to consent the researcher will appreciate your participation and the information you will give.

BENEFITS AND RISKS OF PARTICIPATION

Please note that participation in this study is voluntary and the will be no direct benefits to anyone who participates. There will no be penalties if you want to withdraw from the study or not willing to answer some of the question if they violate your human rights. However, I would really appreciate it if you share your thought and feelings on the questions asked.

RECORDING OF INTERVIEWS

I would like to request your permission to use audiotape during the interview as it is not possible to record or capture all answers and important information quickly. I might misrepresent your responses to some of the questions that you will be asked if recording is not done. It is important for you to know that the tapes, digital voices data and notes will remain confidential and only listened to by the researcher. Your identity will not be disclosed.

I am only interested in your honesty responses to the questions. Tape and digital voice data of the interview will be transcended and transcripts of the interviews will be bearing the codes and not the names of the interviewee. The information will be analysed and organised into a report according to the themes. The tapes and digital data files will be kept in locked safe requirement, the tapes and voices digital data will be two years after the publication of the research findings.

CONTACT DETAILS

I will be happy to answer any question or clarity you have about this study and this study will be approved by the Research Ethical Committee of the University of Venda. If you have further questions about the research or interview contact me at 082 628 4266 or 015 962 1000 during working hours.

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Mulaudzi Azwindini
Cell: 082 628 4266

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ANNEXURE 10

INFORMED CONSENT FORM FOR SUBJECT INTERVIEW

I have been given information sheet on the project above. I have read and understood the information sheet and all my questions have been answered satisfactorily. I understand that is up to me whether or not I would like to participate in the interview and that there will be no penalties if I decide not to participate. I understand that I do not have to answer any questions that I am not comfortable with and that I can stop the interview at any time. Furthermore I can decide whether or not the interview should be tape recorded and that there will be no penalties if I don't want the interview to be recorded.

I understand that information from the tapes and voice recording will be transcripts will be given codes and my name will not be used. I also understand that if the interview is recorded the tapes will voice digital data will be destroyed two years after the publications of the research report.

I understand that the researcher involved in this project will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that the comments I make will not be shared with anybody else. The information gather will be used for scientific and educational purpose. I consent voluntarily to participate in the interview for this study. I have been given telephone number that I may call if having any questions or concern about the research.

Participant Name: ..... Signature: .....

Witness: ..... Date: .....

Researchers Name: ..... Signature: .....

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ANNEXURE 11

CONSENT FORM FOR PARENTS OF YOUTH BELOW 18 YEARS

Dear Parent/Guardian

Introduction

Good morning/afternoon. My name is Mulaudzi Azwindini Valentia. I am working on a research study on factors that contribute to poor utilization of contraceptive services among youth (16 - 20 years) in rural community of Mutale municipality. I would like to involve your child in this study.

Purpose of the Study

The purpose of the study is to determine the extent to which youth (16 - 20 years) in rural communities utilize various forms of contraceptives and contraceptive services. I want to be sure that you understand the purpose and your responsibilities in the research before if you want to be in it. Please ask me to explain any words or information that you may not understand.

Procedures

The interview will last about between 45to 60 minutes, but participants may stop it at any time. I will ask participants to describe various forms of contraceptives and contraceptive services. I will also ask them how they would like things to be done differently with contraceptive distribution at community level.

Who Will Participate in the Study?

I expect to interview youth in the age group 16 - 20 years, elders from the community and nurses at the clinics.

Possible Risks

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I do not expect that your child is at risk of any bad things happening to her by participating in this interview. All information will completely remain confidential. No child will be identified by name. I will ask them to respond honestly and to the best of their ability. There is no need to worry if your child does not know the answer to some of the questions. I will not discuss your child s responses with you or any one. I will not report to anyone whether you declined your child to participate in an interview.

Possible Benefits

There will be no direct benefit to your child from participating in this study. However, the information that your child will share with us will help community- based family planning program mangers find out the areas where improvements can be made so as to make CBD services. By your child participating in this interview, she will have a chance to share her experiences with decision makers.

Confidentiality

I will protect information your child will share with share with us to the best of our ability. I will not use your child's name in any reports. I will not tell anyone about their participation. I will not tell anyone the answers your child will give in this interview.

Questions and Rights as a Participant

If you have any questions about the research or your child's participation in the research, you may contact: Ms. Mulaudzi Azwindini Valentia 082 628 4266.

Confirmation of Your Consent to Participate

Do you understand all I have just told you and do you permit your child to participate in this study? I f you agree to participate in this study, you will need to sign this form.

Yes **No-Stop**

Should you or your child feel discomfort due to participation in this research, you should contact your health care provider.

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Parent or Guardian Agreement

Participation in research is voluntary. I understand that I can choose not to have my child participate in this study, or to withdraw my child from participating at any time. I also understanding the declining participation will not interfere with my child's declined contraceptive services at community level.

I will discuss this research study with my child and explain the procedure that will take place.

I give my consent to allow my child to participate:

.....

Print Name

....

Signature of Parent/Guardian Date

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ANNEXURE 12

CONSENT FORM FOR CHILDREN 16-17 YEARS

Oral Explanation

I am a nurse who would like to know from you the factors that contribute to poor utilization of contraceptive services among young people in your area. I would like you to tell me about your understanding about youth and contraceptive services. I would like you to tell me about what can be done to prevent teenage pregnancy. In addition I would like to videotape you during the interview. Anytime you could change your mind and not be in the study anymore.

To Child

1. I want to answer questions about factors that contribute to poor utilization contraceptive services
2. I want to tell you why young people are not utilizing contraceptive services
3. I will let you tape record me during the interview

Yes **No-Stop**

Date: .....

Child's Signature: .....

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ANNEXURE 13

INTERVIEW GUIDE FOR YOUTH

1. What are the benefits you think one can derive from contraceptive use?
   Ndi dzi fhio mbuelo dzine muswa a nga dzi wana ngau shumisa vhutea muta?
2. What don't you like about contraceptives?
   Ndi zwifhio zwine ni si zwi fune nga ha vhutea muta?
3. What other various forms of contraceptives /and contraceptive services are available in rural areas?
   Ndi zwofhio zwinwe zwine zwa shumiswa zwa vhutea muta kha muvhndu wa hanu?
4. How did you learn about contraceptives and contraceptive services?
   Inwi no vha nono pfa ngafhi nga ha vhutea muta?
5. Who do you talk to about contraceptives and reproductive health?
   Ndi nnyi ane na amba nae nga ha vhutea muta?
6. Do you ever talk to elders about contraceptives alternative
   Nono vhuya na amba na vha hulwane nga mafhungo a vhutea muta? Arali no no amba ndi zwi fio zwe na amba zwone?
7. What do you think are the factors that contribute to non-use of contraceptive services by youth at rural communities?
   Ndi zwifhio zwine na vhona zwi tshi itisa uri vhaswa vha songo shumisa zwa vhutea muta?
8. What local and indigenous knowledge of contraceptives is available to youth?
9. What do you think should be done to improve contraceptive uptake by youth in rural area?
   Ndi zwifhio zwine na vhona uri zwi nga khwinisa kushumisele kwa vhutea muta kha vhaswa?

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ANNEXURE 14

INTERVIEW GUIDE FOR ELDERS

1. What other various forms of contraceptives and contraceptive services are available in rural areas?

   Huna ndila naa ya sialala ine vha vhona vhaswa vha tshi nga thusalea kha sia la vhutea muta?

2. What information do you talk to youth with regard to contraceptive and contraceptive services?

   Ndi a fhio mafhungo ane vha laya vhaswa nga ha vhutea muta?

3. What can you say about and the use of contraceptives by the use of today?

   Ndi zwifhio zwine vha nga amba nga ha vhaswa vha namusi na vhutea muta?

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ANNEXURE 15

DIFFERENT METHODS OF CONTRACEPTIVES THAT ARE OFFERED IN THE CLINIC

CONTRACEPTIVE METHOD	ACTION
1. MEDROXYPROGESTERONE	• It suppresses the secretion of pituitary gonadotropins which, in turn, prevents follicular maturation, producing long-term anovulation in the reproductive women. • It produces typical progestational changes in the in the cervical mucus • It increases the viscosity of cervical mucus, thereby increasing the difficulty of sperm penetration
2. NOREISTERATE ENANTATE	• Protection against conception is based primarily upon an alteration of the cervical mucus. • It will prevents the ascent of the sperm into the uterine cavity
3. TRIPHASIL	• It acts by suppression of gonadotropins • It causes changes in the cervical mucus (which increase difficulty of sperm entry into the uterus) • It causes changes in the endometrium which reduce the likelihood of implantation
4. NORDETTE	• It causes changes in the cervical mucus (which increase difficulty of sperm entry into the uterus) • It causes changes in the endometrium which reduce the likelihood of implantation
5. MICROVAL	• It acts primarily through the mechanism of gonadotropin suppression, resulting in the prevention of ovulation. • The viscosity of the cervical mucus is increased, hindering penetration of the sperm.
6. OVRAL	• It causes thickening of the cervical mucus which decreases sperm penetration and to endometrial alterations that impair implantation.

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7. IMPLANTS

- It prevents pregnancy by releasing the hormone "progestogen or etonogestrel" which mimics the function of the hormone progesterone
- Thickens the cervical mucus to block the pathway of sperms to the egg
- Thins the endometrial lining so that it cannot implant a fertilized egg
- It prevents regular ovulation to prevent fertilization

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ANNEXURE 16

EXAMPLE OF AN INTERVIEW TRANSCRIPT (YOUTH)

Key: R=Researcher
P=Participant

PARTICIPANT NO: 1 (YOUTH)

R: Good morning!

P: Good morning!

R: My name is Azwindini Valentia Mulaudzi, how are you doing today?

P: I am Matodzi and I am doing very well. I am asking you how you are doing today.

R: Thank you for meeting you, I am doing very well. It is like it is very quiet in your area.

P: It is not always like this, may be today is because is during the course of the week and is during the day. Over the weekends, you cannot like this place if you do not like noise.

R: What can make one not to like this place over the weekends?

P: Over the weekends and during late hours is so busy because most of the people will be going to the tavern and the music there is very loud.

R: I can see now that this place is not as quiet as I think. I am a student at the University of Venda and conducting a study on factors that contribute to poor utilization of contraceptive services among youth. I would like you to be part of my study. There are few questions that I will ask you relating to the topic I have mentioned.

P: Huh I don't think I have any problems with that, it is not for the first time that people ask me questions in relations to their studies but their questions were not the same as yours.

R: The questions that I am going to ask you will remain between you and me and people who are going to assist me in this research. Your name is not going to be mentioned anywhere or published in my study. What do you know about of contraceptives?

P: Contraceptives are family planning methods that are used to prevent pregnancy. It can be used by males or females. They are also found in our clinics.

R: What are the methods that are found in your clinic?

P: There are many methods like condoms, injections, pills and loop but it is not done

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at our clinic. If you ask for loop they say they will refer you at the hospital for insertion.

R: I see. If you ask for loop they say they will refer you at the hospital for insertion. How do you feel about that?

P: Our area is very far from the hospital. If you are referred at the hospital it is going to be very costly. Myself I cannot even afford to go to the hospital because of financial constraints, only option will be to choose on the methods that are available at the clinic rather than choosing what you want. I think the clinics must have all the methods that are available so that we can choose from a large variety of choices.

R: How are you protecting yourself from pregnancy?

P: Aaah! Sometimes I don't protect myself and some other time I use condom with my boyfriend. I once used two months' injection. My problem with this contraception is the waiting time at the clinic. The condom does not waste your time during collection. And with condom I am afraid that other says that it can burst or remain inside.

R: You have tried several methods of contraceptives can you tell me about the two months injection?

P: I used the two months' injection for four months only the reason being that when you are still young the injections will kill the ovaries and end up not having children in future. An injection is very good for those who do not want to have children anymore. For young people it is not good.

R: What do you think are the best methods for contraceptive for young people?

P: I think it depends on a method chosen because there is that method that affects young girls and those which do not. Condoms are fit for those who have never given birth or married unlike Depo and pills.

R: With condom, you said it is good but you are afraid to use it. Can you explain more about that?

P: I have never experience the bursting of the condom myself. I only heard this from the friends. And because of this experience I am not comfortable with a condom but it is very good to use because you do not have to wait for nurse to help you at the clinic and you can find it anywhere even at the spaza shops.

R: Can you tell me about the factors that contribute to poor utilization of contraceptive services?

P: There are many factors that can make one not utilize contraceptive services. Like

here at Masisi some of the nurses who are working here are from our communities and at times they use to ask us if our parents knows about this; and sometimes they even threaten to tell our parents. So with that reason it is not easy to go to the clinic where there are a lot of people who knows about you and your family.

R: I see. Sometimes they even threaten to tell our parents. Can you explain more about that?

P: The nurses at the clinic are very good when you are sick. They can take good care of you while examining you. The only problem is when you are seeking contraceptive services and I think they do that to young people. It's like they do not want us to use contraceptive services.

R: Uh-huh

P: If you are a youth nurses ask if your parents know that you come to the clinic for contraceptive services. To us as young people is very scary because when we decide to use contraceptive we do not consult our parents it's our own decision. When we decide for contraceptive is my deal with the person who is offering me the services not my parents.

R: What else do you think can contribute to poor utilization?

P: Eish! You know what? It is also difficult for us because usually family planning services are conducted during early hours of the day and to us as scholars it's not favourable because we attend school till late for example we finish our afternoon studies at 15:30. And when we come to the clinic at that time some nurses refuses to offer contraceptive services during late afternoon hours.

R: Yes I see.

P: It is like when you bring a child for immunisation they will turn you back if you come during the afternoon. The worst thing that I hate going to the clinic is that you will stay there for hours and hours. Remember contraceptive services are not something that you can stay there the whole day like you are waiting to be seen by a doctor. It is just a matter of issuing what you have agreed upon with your nurse and off you go.

R: Tell me more about the working hours at the clinic.

P: What I know about the working hours at the clinic is that they open at seven in the morning and close at five in the evening but they are also working during the night. At night they only need to attend to emergency cases.

R: Uh-huh

P: They usually help the family planning cases during the morning. That is why it is

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not good for us coming from school. It is not every nurse that will refuse you the offer to be helped during the late afternoon. Others offer the service without any problems.

R: Have you ever been turned back at the clinic for going after hours?

P: No I have never been turned back but I was told that I must come to the clinic at early hours of the day. And I told that nurse that I cannot ask permission at school for contraceptive services because I am not ill. Skipping lessons for contraceptive services is not good you better skip the injections and get the lessons at school.

R: How do you feel about coming for contraceptive services in the morning?

P: I do not agree with the idea because if they want us to utilize that service they must provide enough time even favourable time for us. They must not tell us what they want.

R: It is like there is more that you know that can contribute to poor utilization. Can you explain more?

P: Yaa! There is a lot that I think because you know what I once use this contraceptive services, by that time I was using injection for two months and some of the reasons that make me to quit using them is distance. Our clinic is very far from where we are staying. If you do not have money to go to the clinic you find yourself missing the date for next repeat.

R: Yes, I see!

P: And next time when you go to the clinic with that missing dose the nurses can even turn you back. So it's very boring to attend those services.

R: The reason that makes me to quit using them is distance. Can you tell me more about that?

P: The people who are coming to this clinic are from different areas, and those areas are far apart. When you want to come to the clinic just for family planning services is not easy because you need to have money for transport.

R: Uh-huh.

P: It is not easy to walk by foot though that is the other thing which we are using to travel to the clinic.

R: What do you think are the benefits derived from using contraceptives?

P: Yeah! If you are using contraceptives it may benefit you because you are not going to fall pregnant while still studying. And your parents will not be able to recognise that you are moving around with boys because there would be no pregnancy. It only gives problem as it only prevent pregnancy and not disease so

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even if one is on contraception; one still needs to take care.

R: Can you explain more about taking care?

P: I think it is also advisable that a person has to follow precautionary measures to prevent sexual infections; one has to use condoms and even abstain where possible to prevent disease.

R: Can you tell me more about precautionary measures.

P: Precautionary measures I mean to be careful about prevention of pregnancy and other sexual transmitted diseases. A person can do that by using family planning or not to engage in sexual activities at all though it is not easy.

R: To be careful about prevention of pregnancy and other sexual transmitted diseases. What are those diseases?

P: I mean disease like vaginal discharge, genital ulcers, thusula and other diseases. I think is not a matter of preventing pregnancy only because instead of sexual transmitted diseases there is this big dreadful diseases HIV/AIDS.

R: Can you tell me more about the benefits of using contraceptives?

P: Hhmm! Except that of preventing pregnancy and enabling one to finish school, I can't remember of anything now. But think is possible to stay or remain as a young person who is responsible for your own life.

R: Can you tell me about the things you don't you like about contraception?

R: Hey: I hate it because most of people say that it is difficult for a person to conceive if you were using contraception.

R: Uh-huh

P: I heard that people who are on contraception use to menstruate for a long time or a person can stop menstruating. I don't want to experience any of those things because buying sanitary pads is a stress.

R: I see.

P: Another thing is that our male partner always complains that they do experience waist pains and also that become cold when we have sex with them.

R: People who are on contraception tend to menstruate for a long time. Can you elaborate on that?

R: My cousin was using three months injection, she menstruate from the day she started the injection until she went back to the clinic. Then she was given pills that stopped that bleeding. That is why I am saying this contraceptives especially injections they cause bleeding. Hey can you imagine menstruating the whole months it no longer saves the purpose. Now you are applying divorce daylight

because there is no one who can wait for a person who is always bleeding.

R: What else you don't like about contraceptives?

P: Sometimes I just think that contraceptives are for married couples. Especially when I think that they may cause a person not to have children in future. Because if you become childless before you had only one child, hey it's a problem. I do not like the fact that they cause childlessness. I don't want to remain childless because of the fact that I have used contraception.

R: Can you tell me more about childless and contraception?

P: There are people in my area were they say they do not have children because they have used the contraception while they were still young people.

R: Can you say something about contraceptive and childlessness?

P: Mm. This contraceptive service will only help you to finish schooling with no problem. The problem will come when you feel you want a baby when the baby is not coming. They are saying, if you are injected for a year you will have to wait for five years in order to have a child. This means that if you are injected for two years, you will have to spend ten years in order to have a baby. There are people today who are childless because of using these contraceptive services. That is the worst thing that I don't like about the use contraceptive services.

R: What other various forms of contraceptives and contraceptives services are available in your area?

P: In our clinic they are offering modern, both oral and injectable contraceptives and the use loop which is not yet done at our facility but promoted.

R: What more do you know?

P: I have heard of people who say you can also prevent pregnancy by using thread/rope around the waist which you got from the sangoma. And also condoms are dual means of prevention as they prevent both illnesses and pregnancies. There is spiritual healer who is helping people with water that they say they prevent pregnancy. But I never visited him I just heard about it.

R: How did you learn about contraceptives?

P: The first time I heard about this, it was from a friend. In fact I've never heard about this at home. Is just these days it's always heard from the media, e.g. TV, Newspapers etc. My friend was one who encourages me to start using contraceptive services before I quitted.

R: Could you say something about quitting contraceptive use?

P: I said earlier on that the contraceptives services were introduced to me by my

friend. Due to the fact that I had that they cause barrenness I quitted. And because of other things that people think they do like bleeding I don't like them anymore.

R: Who do you talk to about contraceptives?

Continued/…

P: Tjo! It is not easy to talk about contraceptive services. According to our culture it is a taboo to talk about this issue at home. Mostly we are sharing this with our friends. If I can try and talk about contraceptives and contraceptive services with my mom she can cut off your head. In case where you have some doubts or questions about contraception, you better talk to your elder siblings. Myself I talk with my friends.

R: Do you ever talk to elders about contraceptives alternative?

P: My mother is never comfortable bringing up the discussion on contraceptives with me. She has to first tell you a rumour of neighbours who have their daughter fall pregnant before she drags you into what she wants to tell you.

R: Yes I see

P: To start a topic of sexuality many parents find it very difficult to start with their own biological children. That is it is not easy to discuss issues of that nature with parents.

R: Uh-huh

P: Because when you talk about contraceptives it is like you are talking about sex and according to our custom you don't share that topic with your parents. It shows that you are disrespectful and an embarrassment to your family. You know that our parents wish the best for us and wish if we can stay as virgins until we get married. So to talk about contraceptive services with parents it's not easy as that is not what they want us to do. Parents always wish the best for their children.

R: Can you explain more about your custom?

P: Hm! You know people have different customs, so according to my customs you cannot discuss sex related issues with your parents or elders because they believe that sexual intercourse is meant for adult or married people. So when you discuss that with them, which grounds are you going to base yourself on? It is not easy to discuss such issues. And according to our custom you need to wait engaging in sexual activities until you get married. Young people do not engage in sexual activities, it is for adults.

R: What do you think should be done to improve contraceptive uptake by youth in rural area?

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P: Here in our area the clinic is far away (±10 km) from the residence and thus it needs money for one to reach the clinic. Due to the fact that the area is too far from the clinic, it makes youth not to utilize contraceptive services.

R: What more can you tell me?

P: Eish! Even the means of transport is poor and we have poor road structures. If may be distance and the road to the clinic was accessible, we were going to use this. Again, following the western culture I think the parents should be empowered about sex education so that they can encourage their teens to use contraception.

R: Is that all that you think can be done?

P: Not necessarily is all there is a lot that needs to be done in order to improve the contraceptive services among the youth in our area.

R: Can you elaborate on that?

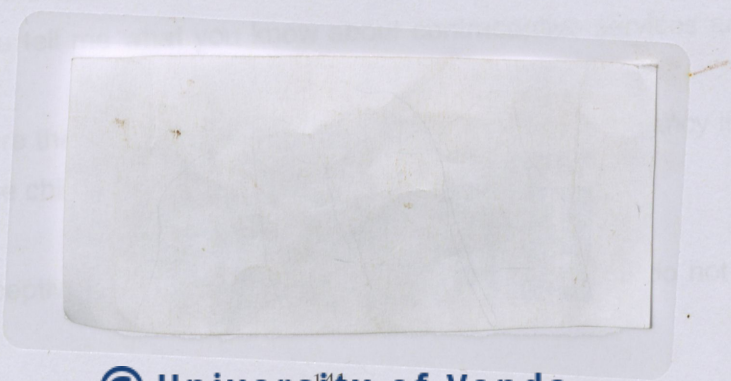
P: I have realised one thing here in our area, like many young people are falling pregnant. Last year at our school there were more than twenty students who were pregnant. So to avoid teenage pregnancy those students need to be given information about contraceptive and contraceptive services.

R: What is the problem with this high number teenage pregnancy?

P: This is very big problem in our area because we are not developed. As such we need to develop our own community. If students are becoming pregnant at early age, there is a big chance of not finishing their studies because of the baby who will need to be cared.

R: Can you explain more about teenage pregnancy and development?

P: If young people are becoming pregnant in large number it will be very difficult for that particular village to move forward. The people that we are looking for development are young people. When they become pregnant at an early age, they break the vision of the village because the eyes of citizens are on us as young generation.



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ANNEXURE 17

EXAMPLE OF AN INTERVIEW TRANSCRIPT (ELDER)

Key: R=Researcher
P=Participant

Participant 1 (Elder)

R: Good morning

P: Good morning my daughter

R: How are you doing today?

P: Hey, I am fine the problem is sun is very hot my dear

R: I think this is the season for hot weather. We must accept all seasons of the year because each season is important we must leave with them all. If it is not hot we will not get rain and start ploughing.

P: You are right this season complement each other they are all important to us we need them all.

R: My name is Azwindini Valentia Mulaudzi I am a student at the University of Venda. I am busy with my studies and here I am conducting a research study on factors contributing to poor utilization of contraceptive services by youths in rural communities. I would like to ask you some questions related to my topic of study.

P: Aah! Do you think we can answer questions for a person at University while we did not even turn at the door of the school?

R: Yes, this is not for person who has undergone certain trainings but who has live a life in this community who has female children growing under her care and also seen female children in the community. It is related to what we have agreed on some few weeks ago.

P: If that is the case I do not have any problem I will tell you what I know.

R: Can you tell me what you know about contraceptive services and youths in your area?

P: Those are the birth control; they are used to prevent pregnancy if you are not ready to have children.

R: Uh-huh

P: Contraceptives were there before the modern ones. We do not know about

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those modern ones but there are different African ways of preventing birth.

R: I heard you saying there are different African ways of preventing birth; can you elaborate on those factors?

P: Ooh! You know in our African ways if we find that a woman is having more than four or five children and the family is stricken with poverty or is unable to take care of the family financially though we believe that there is no grave for hunger, that women will be advised to do family planning. But if the women and husband are able to take care of their family they can give birth as much as they want.

R: Yes I see

P: What we use to do or advise the older men is to play outside the women. That is to withdraw during ejaculation. This one is very difficult for young people because they are not taught to practice this as this was done during boys initiation schools at the mountain and our children today are going at the clinic for initiation where there is no advice given.

R: Women stricken with poverty or unable to take care of the family financially. How does this affect the use of contraceptives?

P: We do not allow the women and men who are able to take care of their families to limit the number of children that God has blessed them. We want them to continue giving birth.

R: What can you tell me about youth and contraceptives?

P: Youth are not supposed to use contraceptive because they do not have families yet. The contraceptives are for those who are married who are planning for their families. How can a young person plan for?

R: Uh-huh

P: The youths were exempted from using contraceptive because according to our culture the contraceptives are for married people. There is no young person who is supposed to use contraception.

R: It sounds interesting can you tell me more about other methods that you know?

P: Another thing that is used to prevent pregnancy is when we use the menses. The menses are put on a cloth, you can put them on top of or you can put them down in a closed container. Inside the cloths you mixed with medicines.

R: Yes I see

P: When closing that container it means you have closed fertility that person will not conceive. When a person want to conceive those mixtures will be removed

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from where they were kept and open the bottle or container and destroy what is inside. The last thing that I know is a rope that is tied around the waist.

R: Uh-huh

P: That rope is having some charm on it. There are herbs mixed and tied on your waist. That charm on the rope is the one that is preventing pregnancy.

R: What information do you talk to youth with regard to contraceptive and contraceptive services?

P: I will never talk to youths any information related to contraception.

R: You are saying you will never talk to youth any information related to contraception, can you explain to me the reasons of not talking to youths with that information?

P: Eee ee! Do you know the children of today, if you know them you will understand what I am taking about? Firstly I will never talk to them because those children they do not regard us as human beings. If you try to show them a way, this young people will show you a way instead. Those children they are very disrespectful. I will never talk to them or give them any advice in life. The last thing that makes me not to talk to young people about the use of contraceptives is that they are still young and need to have their families tomorrow. If I can tell a young person today to go and use contraceptives it's like I am saying she must go and look for man. That person will be very stubborn if she is sent by me. It is better for her to go there on her own not sent by me.

R: Tell me about those children who are disrespectful what do you mean?

P: The disrespectful children I mean those children who did not go to the mountain or vhushani. If a female child did not see the elders and given some words of wisdom that child is very hard to handle.

R: If a youth has gone to vhushani can that one receive contraceptive information from elders?

P: Not necessarily that, we prefer young people to get married first and have two or three children and from there she can use the services. We are doing this because if our traditional way of contraception does not return her fertility she will be having the children unlike a young person who has never conceive or bear children.

R: What can you say about the youth today and contraceptives?

P: The youth for today must use the contraceptives. Why I am saying that, because our children are running after man.

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R: You are saying youth today are running after man, can you explain to me?

P: Yes I can explain those children they are not sleeping at home especially on Fridays. There are a lot of taverns here in our area, over the weekends you cannot see a child at home. You will see them on Monday when they remember to go to school. The soldiers are staying just around our area they are moving around this community, so our children are robbed because of money. They are running around with them.

R: Can you tell me more about youth and contraception?

P: Hhmm! When I look at the future of young people, I can say that they must prevent pregnancy. I am saying this because life today depends on education, if you are not educated there will be no future. Our children today do not have manners when they see man to them is more than life itself.

R: Could you say something more about children who see man more than life to them?

P: When I said that, I mean our young people today they like man too much. Or they like to engage in sexual activity at an early age. If we do not allow them to use contraceptive services we will have a very big problem in our community because all our children will end up being pregnant.

R: Thank you very much for your time. It was a very good time talking to you. Thank you once again for your contributions

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ANNEXURE 18

CONFIRMATION BY LANGUAGE EDITOR

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14 February 2016

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MCur thesis by **Azwindini Valentia Mulaudzi**, titled: "**Factors Contributing to Poor Utilization of Contraceptive Services by Youth in the Rural Communities of Mutale Municipality in Limpopo Province.**" The manuscript was also professionally typeset by me.

Sincerely Yours

Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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