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What are Wits female students' perceptions of the impact of hegemonic masculinity on their decision-making for birth control?

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A report submitted to the Wits Centre for Diversity Studies, Faculty of Humanities, in partial fulfilment of the requirements for the degree Master of Arts by course work and research report.

Abstract

This paper explores the Wits female students' perceptions of the impact of hegemonic masculinity on their decision making for birth control. The paper explores power dynamics within heterosexual relationships, and how this impact the process of decision- making pertaining to contraceptive use. Women are represented as victims of their environment when it comes to sexual health and contraceptive use, this takes away the agency of women. This paper is aware that when there is oppression, there is also resistance therefore women are not absolutely oppressed. The social practices of heterosexuality and other institutions contribute to the maintenance of hegemonic masculinity. This study's aim is to understand how women navigate heterosexual matrix and how it contributes to their decision-making process. Research on factors that contribute to decision making are often focused on couples, and married people negating adolescents. South Africa's high HIV rates suggests that adolescents are some of the most affected. Therefore, interrogating power dynamics in adolescents will assist contribute to conversations and knowledge around multiple factors that contribute to decision making process for young women. Semi-structured interviews were used to capture the perceptions and experiences of young women from the University of Witwatersrand, and how they navigate the spaces that relate to sexual and reproductive health.

Findings highlight gender inequity within heterosexual relationships, and bodily integrity. They also highlight the barriers that are related to sexual activity among adolescent women, how the stigma leads to the lack of information, and discrimination against adolescents in public health clinics and hospitals. The culture of the public health system is compared to private health system. Findings also showed factors that contribute to adolescent understanding and navigation of self within relationships relates to growth physical, emotionally, and experientially. The data set

presented an emphasis of advantages triumphing over disadvantages of contraceptive. A shift in narrative was highlighted which suggests that women challenge the heteronormative ideals within society and women's agency is emphasized in their talk about sexual experience and navigating heterosexual relationships at large.

Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:  Date: 04 October 2021

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Abbreviations

Aids- Acquired Immunodeficiency Syndrome

ANC – African National Congress

ASRH- Adolescent Sexual and Reproductive Health

CA- Children's Act

CEDAW- Convention on the Elimination of All Forms of Discrimination Against Women

CTPA- Choice of Termination of Pregnancy Act

GBV- Gender-Based Violence

HIV- Human Immunodeficiency Virus

LMICs- Low and Middle-Income Countries

NHA- National Health Act

SOA- Sexual Offence's Act

SRHR- Sexual and Reproductive Health Rights

STDs- Sexually Transmitted Diseases

TOP-Termination of Pregnancy

WHO- World Health Organization

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1 Chapter 1

Introduction

1.1.1 Background

Teenage pregnancy is viewed as a burden in Sub-Saharan Africa. This view has led to multiple interventions that are intended to educate young women about teenage pregnancy and ways to avoid it. Contraceptive use is one of the most common interventions and it is becoming a normative part of our everyday lives. Although contraceptives are free of charge in public hospitals, young women face various barriers to access, which include but are not limited to religious and traditional beliefs; the views and attitudes of health care workers, community; and one's sexual partner. As a young adult who has used public health services, I experienced feelings of shame for being curious about sexual health. When I went to public clinics, I felt shame for deciding to engage in contraceptive use; some nurses would express their judgment, and this would exacerbate the shame and guilt I felt for considering family planning. Whenever the date for my next appointment would approach, I would feel anxiety creeping in as I was scared that the nurse would be harsh towards me. This study was impacted by my personal experience and by other people around me.

There are multiple factors that contribute to an individual's decision to engage in sexual activity and sexual health. Firstly, one considers their partner: many females report that their first sexual experiences were with their first boyfriend, and they decided to engage in sexual intercourse with that individual (partner) because they were either comfortable with them or because they were coerced into it. Many reports that focus on sexual coercion report that a considerable percentage of adolescent females engage in sexual intercourse prematurely because of their peers or their intimate partners. Sexual coercion by an intimate partner is very prevalent among adolescent

females; sex is used as a tool to prove one's commitment to their partner as well as their love for their partner. Reports about this phenomenon also point out that many of those girls often fall pregnant because they were not ready to engage in sex, or they had no knowledge of what sexual intercourse entails. Research suggests that many adolescents who engage in sex prematurely often get information from their peers, or they are dependent on their partners for knowledge regarding sexual intercourse and its consequences thereof.

Contraceptive use is also similar to sexual engagement because many reports argue that young females in South Africa are not adequately informed about contraceptives, they depend on their peers and the mass media for information. This adds to the challenges they face with their sexual partners as they cannot argue for something that they do not fully understand. The misinformation is not only limited to the female partners, but male partners themselves get information from their peers and mass media and they use that to make decisions about contraceptive use. The most popular misconception is that people who engage in contraceptive use are people with multiple partners and that contraceptives (condoms and hormonal contraceptives), make the sexual experience less enjoyable. Due to that, many male partners then tell their partners to discontinue the use of contraception or to not even start with them at all. This point has made me think about how it then also mirrors a situation where a male partner would use hormonal contraceptive use by the female as an opportunity to discourage the use of a condom, yet a female may want to double up but the male partner wants to exercise authority over that decision by encouraging lack of use of condoms as a substitute for normal contraceptive. It further takes away that agency a female partner has in decision making and also then leads to a lack of protection from STDs. Nurse attitudes also contribute to whether or not adolescents engage in sexual health services, because there is stigma around adolescents engaging in sexual activities. This stigma is not only limited to

healthcare workers but the society at large shames adolescent females who engage in contraceptive use, which then brings shame to the individuals and their families.

Gender norms have a big influence on how people behave around others as well as how they understand their identity. South Africa is a patriarchal country that promotes heterosexuality and male domination. Connell uses the term 'hegemonic masculinity' to define practices that promote and maintain male dominance. The challenges that adolescent females experience with regard to contraceptive use are informed by hegemonic masculinity because many of the practices mentioned above feed into the promotion of male dominance implicitly and explicitly. Therefore, in the study, I will be exploring how female students view the impact of hegemonic masculinity concerning birth control.

Sexual health is a basic human right, and historically women were deprived of their sexual and reproductive rights, as they were viewed as child bearers. As time passed, reproductive rights and sexual health have been recognized as an essential part of women's rights. Section 27 of the constitution states that "every person has the right "to have access to health care services, including reproductive health care; No person "may be refused emergency treatment" (Hassim, Heywood, & Berger, 2007).Some communities remain restrictive to women and their reproductive ability and sexual desires, whilst other communities are growing to be more socially aware of women as not only baby-making machines but also sexual beings.

Gender studies highlight the importance of interrogating gender as a social construct in order to understand social contexts. Feminist studies argue that by using gender as a tool of analysis, one is able to understand social inequalities and that gender can be used to understand the oppression of women. There are multiple definitions of gender, but this study uses Judith Butler’s theory of performativity. In her theory of gender, she argues that gender is not a cultural expression of

biological sex, as it is commonly defined. Butler argues that heterosexuality created and maintains gender and sexuality through a binary form, and one should not see the significance of one category as less than the other but should rather see them as non-causal relations that intersect with one another. In this study I interrogate gender and not sexuality, the distinction made in the statement above is important because some studies use gender and sex interchangeably.

Social inequity is a huge phenomenon in South Africa where women are found at the bottom of the hierarchy with children, therefore using Judith Butler's theorization will help unpack some of the implicit practices informed by hegemonic masculinity. Butler's aim was to reveal the ways in which social norms of gender work through performance to maintain and promote heterosexual hegemony, which has the same objectives as hegemonic masculinity (Jagger , 2008). This study uses Butler's theory of gender in an attempt to understand intimate performances of gender and how they contribute to or disrupt the heterosexual matrix.

Teenage pregnancy has been viewed as endemic in Sub-Saharan Africa (Macleod, 1999). Unintended pregnancy has proven to be a burden that young women face. This study is aimed at contributing to a better understanding of how females understand and navigate their roles in intimate relationships and how these contribute to the power dynamics within relationships. Literature indicates that reproductive health is a continual concern throughout one's life. Much research has explored the impact of reproductive health in early life and how it continues to affect a person's life. Programs to facilitate family planning services, wide-ranging and inclusive sex education, and services that assist to prevent STIs/STDs are not enough and they are an essential requisite in the South African context (UN, 2016). The United Nations (2016) points out that various sectors need improvement in order to provide sexual and reproductive health care services, these rely on the availability of relevant health supplies and extensive sexual education that does

not shame young children for being interested in their sexuality and having sexual desires. This means that there need to be amendments made to the syllabus that offers sexual education, and there needs to be extensive training for teachers and health care workers on how to carry out sexual education (UN,2016).

1.2 Research Problem

"Sexual health and reproductive rights remain one of the weakest areas in the context of human rights protection in Africa" (Mirugi-Mukundi, 2015, p. 43). Although international laws state that Sexual and Reproductive Health and Rights (SRHR) are basic human rights, this does not translate to direct access to SRHR in African countries. Culture and traditional norms dominate most societies in Africa and some cultures do not view reproductive rights as rights that should be afforded to women, because women's sole purpose is marriage and bearing children (Mfono, 2009). Many social factors contribute to sexual health and reproductive rights barriers, some of which will be discussed in the literature review.

The epidemic of teenage pregnancy has grown to be a concern because HIV-AIDS also shows a high prevalence in adolescent infections. Research around the factors that contribute to the high level of HIV/AIDS infections has shown that adolescents engage in risky sexual behaviors consensually and at times due to coercion (Wood & Jewkes, 2006). Sexual and Reproductive Health Rights (SRHR) states that people have the right to choose and autonomy over their bodies, to do whatever they want, whenever and however (World Health Organization, 2010). Although these rights are explicitly stated in international laws, in Africa practicing them is often complicated by factors like culture and religion. For instance, reproductive rights are viewed as a basic right for every woman, and WHO argues that they should be protected, but cultural practices

like paying dowry for a bride disregards the international policies as reproductive rights are transferred to the husband and his family (Longman & Bradley, 2015), thus, depriving women of their bodily integrity is a form of violence and infringement of rights.

In the past decade, South Africa has experienced an epidemic of gender-based violence constantly rising, this alarming rate has been investigated by many researchers in many different fields. Some research suggests that gender-based violence is a result of gender inequality. Jewkes and Morrell (2002) argue that hegemonic masculinity has a large impact on gender inequality and that gender-based violence results from the discomforts caused by a digression from the normative expectation of hegemonic masculinity (Jewkes & Morrell, Sexuality and the limits of agency among South African teenage women:Theorising femininities and their connection to HIV risk practices, 2002). Research shows that gender inequality results in the oppression of women and other masculinities that do not conform to ideal masculinity (Connell, Masculinities in global perspective: hegemony, contestation, and chaging structures of power., 2016). Much research has been conducted about hegemonic masculinity and its influence on the oppression of women, with violence as a common denominator, therefore placing women as victims of the society without acknowledging their agency (Margherio, 2019). Hegemonic masculinity is a social formation that governs institutions, systems, and society at large (Connell & Messerschmidt, 2005). These interactions all promote male domination, and it is the power dynamics in these institutions, systems, and individual interactions regarding the use of contraception that I will interrogate.

Past studies have established that young women struggle to access contraceptives in South Africa, and others discontinue the use of contraceptives because of the treatment they incur in health services sectors (Jewkes & Morrell, 2002; Margherio, 2019; Wood & Jewkes, 2006). South Africa is a patriarchal society with high levels of gender inequity, and male domination. We have been

socialized to see gender as a natural part of our lives, and through repetitive acts of gender roles, and expectations we come to understand ourselves using gender (Butler, Performative acts and gender constitution: an essay in phenomenology and feminist theory , 1988). This study uses Judith Butler's theory of gender performativity as a theoretical lens to interrogate hegemonic masculinity's influence on decisions made by females. Gender performativity suggests that gender is not who we are, but it is what we do (Butler, Performative acts and gender constitution: an essay in phenomenology and feminist theory , 1988). According to Hoskin (2019) gender can be used to understand the social stratification of certain contexts. Feminists argue that the private space is political (Collins, 2000), therefore investigating intimate relationships can help one make inferences about broader social structures.

1.3 Purpose of the study

The purpose of this study is to contribute to the conversations around female integrity and agency. Multiple studies have highlighted that much of the research conducted around contraceptive use and pregnancy prevention presents women as victims of their environment and this takes away their sense of agency (Margherio, 2019). For this study, I want to acknowledge the sense of agency that women have, and it is not my aim to take away their agency or overlook their subjectivity.

The study aims to highlight the importance of centering everyday life experiences as these provide alternative knowledge which allows for a different scope of analysis of the dominant cultures and the social construction in which people are interpellated (Althusser, 1971). Collins (2000) argues that centering black American women's experiences in the academic space provides new knowledge. I believe that centering the experiences and perspectives of female students at the

University of Witwatersrand will help bring in a different perspective of how young women understand the influence of hegemonic masculinity in their decision-making processes.

1.4 Research Question

What are Wits female students' perceptions of the impact of hegemonic masculinity on their decision-making for birth control?

Chapter Overview

Chapter one provides the background of the study. In this chapter I discuss my positionality and the influence my personal experience had on the development of the study. Sexual activity among adolescents is considered a taboo. This had an influence on access to contraceptives, young women face various challenges relating to access to contraceptives. Teenage pregnancy and gender-based violence are big challenges within the South African context, and gender studies suggest that hegemonic masculinity has an influence on the high rates of gender-based violence.

Chapter two contextualizes contraceptive use among adolescent females in South Africa. It highlights the barriers to contraceptive use. Nurse training plays a big role in how they treat patients, missionary training of nurses which put nurses as social police that socialize patients into an ethos of life is still carried on post-racial discrimination days. Patient and nurse relationships relating to adolescent contraceptive use are seen as one of the biggest influences that hinder young females from using contraceptives. Religion also contributes to the barriers that young females face. The chapter speaks of Christianity because South Africa is predominantly a Christian society.

Chapter 3 is the theoretical framework which highlights the important theory and literature that is linked to the study. Judith Butler's theory of gender performativity is essential in this study as it

highlights the importance of interrogating heterosexual practices that contribute to the oppression of women. This chapter emphasizes the importance of not confining women into one univocal definition as this maybe exclusionary to others. The young women in the study were chosen because according to the South African and University principles they are deemed as women, but their identities are not limited to the understanding of the study. The chapter discusses the understanding of sexuality and gender and their importance for the study. It also discusses hegemonic masculinity in the South African context. Hegemonic masculinity is used to understand some of the inequalities among genders and their impact in oppressing women, which is essential for the study.

There is a discussion of sexual and reproductive health rights and how they apply to contraceptive use in South Africa. Women have the right to bodily integrity, which suggests the right to do whatever with their body. Although the international policies highlight the importance of women's rights, there are cultural implications which cannot be accounted for. In African societies like South Africa culture has a bigger influence, culture transfers women's reproductive rights to the groom's family. The study focuses on women's experiences, and feminist scholars argue that oppression is found in different environments. It is worth noting that although hegemonic masculinity places women at the lowest in the social hierarchy the different factors that make up one's identity allows them to be either privileged or oppressed in different contexts. So I used intersectionality to position the participants in the study.

Chapter four focuses on the research methodology for the study. The study uses qualitative research method. The aim of the study was to explore the Wits female students' perceptions of the impact of hegemonic masculinity on their decision-making for birth control. It focused on women who are or were in heterosexual relationships while using contraceptives. The aim was to

interrogate the power dynamics within heterosexual relationships and the impact the South African health care system has on the decisions that students take regarding contraceptive use. Participants in the study were chosen according to the characteristics essential to the study's aim. The sample of my study was planned to be ten participants but due to Covid19 and technological constraints I settled for eight participants. The interviews were conducted via Zoom, MS Teams, and WhatsApp. In Chapter four there is also a discussion of reflexivity and ethical considerations. The study received clearance from the Wits ethical committee (clearance number DIV201021).

The data analysis method used is thematic analysis by Braun and Clarke (2006). The study used the six steps of analysis which are, familiarizing yourself with the data, generating initial codes, searching for themes, reviewing the themes, defining, and naming the themes, and producing the report. The data analysis method was useful for the next chapter as it assisted me to come up with findings from the data set.

The fifth chapter is findings and discussion. In this chapter I use intersectionality to position the participants within the study. I report on the findings that emerged from the data set. These themes are, heterosexual hegemony, bodily integrity, growth, public health versus private health, pros over cons and sex and agency. The findings suggest that there are multiple factors that contribute to decision making process regarding birth control. Although there are external factors that contribute to this process, participants have noted that their say is superior to anyone else's because they should decide what happens with their bodies. The responded emphasized that letting partners know about contraceptive use is courtesy. Growth was also highlighted as an influential factor in decisions they take within relationships. They highlighted those previous relationships as learning experiences that contributed to their growth.

All participants highlighted that public health are not adolescent friendly when it comes to sexual health services. Private health participants stated that private health services allowed for patients to have options, and they also reported that their first interaction with a private sexual health care worker they were fully informed before taking a decision about birth control. In contrast with public health participants who reported that they started gaining information after several visits to public clinics. While contraceptives have side effects, participants reported they would rather deal with side effects than be pregnant.

In the discussion the study uses theory, and the information from the study's data set to form an understanding of how young females navigate the barriers and dynamics that result from engaging in contraceptive use. The participants understood gender as a social construct which contextualizes heterosexuality as a hegemony. The participants' understanding of gender as a construct aligns with Judith Butler's theory of gender performativity. This suggest that respondents are aware of the social stratification in which they are in. In this section I use the themes that were reported in the findings to consolidate the theoretical framework with the study.

Chapter 6 is the conclusion, the study found that decision making is impacted by an intersectionality of social factors, cultural factors, religious and personal beliefs, and principles. The participants are aware of the social dynamics and their promotion of heterosexual hegemony in South Africa. They state that they do not subscribe to heterosexual gender norms, they believe in doing what each person is capable of within the relationship. The respondents also state that their experiences within relationships as adolescents have shifted as they have grown to be more assertive than their first experience with dating. Nurse attitudes play a big role in hindering young women from engaging in safe sex and contraceptive use. These findings suggest that the stigma around adolescent sexual activity needs to be abolished in order for progress to occur. Growth

among respondents highlight the importance of knowledge which suggest that health care workers should provide young women with enough information for them to be able to make informed decisions relating to sexual health.

2 Chapter 2

2.1 Literature Review

This chapter's aim is to contextualize contraceptive use among young females in the Sub-Saharan and South African context. The chapter will highlight the barriers to contraceptive use, the attitudes that people have towards contraceptives, and also the influence that gender has on decision-making relating to contraceptive use.

Contraceptive use is intended on reducing unwanted pregnancies, this is known to be the primary reason for reproductive health. In South Africa contraceptives were introduced with the intention to control the African population (Mfono, 2009). Due to racial discrimination family planning services were offered mainly to white women, they were given options to choose what methods they wanted and why they wanted them. The non-white population was given methods that health practitioners chose for them, they were often coerced into engaging in contraceptive use (Mfono, 2009). Women working in factories were forced to be on the injection in order to keep their jobs (Brown, 1987). Many of the women were put on the injectable hormone contraceptive because it required less from the patient, other than to keep coming for injection after two or three months (Wood & Jewkes, 2006). The apartheid system created a system that served the majority white population, health services were focused majorly on white individuals. The black population often had health facilities that were far from where they are, and the transport was hard to access therefore making it hard for them to get health care services. In 1994 the government tried to make reparations by creating a post-apartheid model for health system change (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Some of the intentions carried out by the ANC at this time was a success, "the public health system was transformed into an integrated, comprehensive national service, driven by the need to redress to historical inequities and to provide essential health care to disadvantaged (especially rural) people" (Coovadia, Jewkes, Barron, Sanders, & McIntyre,

2009, p. 828). Public health legislation was also passed allowing for safe and legal abortion and emphasizing the role of health care in caring for people post-rape (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). In spite of the successes in carrying out the post-apartheid policy, there have been challenges that hinder progress, namely inadequate human resource capacity, poor stewardship, leadership, lack of management, improper infrastructure (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). These challenges are discussed in the article by Coovadia et al., (2009).

Literature around sexual and reproductive health in South Africa shows that there is a disjuncture between policy and practice in public health care services, this is emphasized more on adolescent sexual and reproductive health (ASRH) (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016).

Adolescent sexuality is extremely judged, it is regarded as a moral issue (Abiodun & Balogun, 2009; Dietrich, et al., 2013; Eriksson, Lindmark, Haddad, & Axemo, 2014; Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016).Adolescents are aged between 10 and 19 years, and many of the nurses feel that the adolescents are still too young to be engaging in sexual activities (Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016). According to the Child Act, Act 38 of 2005, adolescents can consent to receive contraception from the age of 12, while on the other hand the Sexual Offences Act, Act 32 of 2007 states that the age of consent to sex is 16 years and mandatory reporting is required for anyone younger (Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016). Sexual and reproductive healthcare workers often find themselves in a complex situation where they are unsure which route to take relating to providing sexual and reproductive health care services to adolescents.

Health care workers are seen as front-line workers, and they have a big impact on policy implementation because they create their day-to-day processes to manage work, especially because they are often understaffed (Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016).Their implementation decisions are heavily influenced by the cultural context and the work settings. Law and policy are written as guides for implementation, and decisions often follow the guidelines provided by policies, thus a deviation within the South African health care providers is very prominent. As nurses navigate between law, policy, and what they think should be the correct way of doing things that aligns with the extremely morally charged territory of their belief systems the adolescents face a challenge of an unwelcoming environment at health care centers (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Previous work suggests that actual practices by nurses in South Africa 'on the ground' are often determined by their attitudes and knowledge than by law and policies (Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016, p. 72). Many nurses face legal knowledge and structural restrictions when it comes to adolescent sexual and reproductive health services, others argue that they have not been trained on the children's rights and obligations under the new SRH framework, therefore, they operate by their moralities (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016).

Policies like the Batho Pele principles and the Patients Right Charter provide a framework for policy and practical implementation strategies for public service delivery (Government Gazette, 1997). The Batho Pele White paper on transforming public service delivery introduced an approach that treats citizens as though they are customers so that it improves service delivery (Government Gazette, 1997). Treating citizens as though they are customers requires service providers to take into account the citizens' views when making decisions about services. Customers are treated with respect and service providers should respond sympathetically whenever the

standard of the services is not met (Government Gazette, 1997). The Batho Pele has eight principles that promote the improvement of service delivery in South Africa, these apply to healthcare services as well, and the principles are;

1. Consultation- citizens should be consulted about the level and quality of public services they receive and, wherever possible, should be given a choice about the services they are offered.
2. Service standards- citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.
3. Access – all citizens should have equal access to the services to which they are entitled.
4. Courtesy- citizens should be treated with courtesy and consideration.
5. Information- citizens should be given full, accurate information about the public services they are entitled to receive.
6. Openness and transparency- Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.
7. Redress- if the promised standard of service is not delivered, citizens should be offered an apology, a full explanation, and a speedy effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.
8. Value for money- public services should be provided economically and efficiently in order to give citizens the best possible value for money.

The Patient's Rights Charter is another health framework that was introduced to improve healthcare service delivery. For many years a huge majority of the South African population has

experienced a violation of human rights. The Department of Health has committed to ensuring the right to health care services for all South African citizens. The Constitution of the Republic of South Africa, 1996 (Act No 109 of 1996), proclaimed the PATIENTS' RIGHTS CHARTER as a standard for which health care service providers can help achieve the right to health (Health Professions Council of South Africa, 2006). The following are the patients' rights as stipulated in the charter;

- Healthy and Save Environment
- Participation in decision-making
- Access to Health Care
- Knowledge of one's health insurance/medical aid scheme
- Choice of Health Services
- Treated by a named health care provider
- Confidentiality and Privacy
- Informed Consent
- Refusal of treatment
- A second opinion
- Continuity of care
- Complaints about health services

The policies outline how citizens ought to be treated, regarding public health services. Studies have shown that it is not all the time where healthcare workers carry out all the responsibilities, they are given by the health care frameworks. Arguments relating to the success or failure of carrying out the implementation of the policies state that there is a multitude of factors that contribute to nurses' behaviors and attitudes. Reports assert that public health facilities face a

lot of pressure because they are understaffed, the facilities are not sufficient, so oftentimes the workload is beyond one individual. Nurses have reported that they do not give sufficient services to patients because they are often in a hurry to help the next patient, as the capacity of nurses does not match the capacity of patients. Many of the patients that suffer the most consequences are adolescents because even though nurses face a burden of infrastructure and structural setups within the communities, they are based in, it has been reported that the decline in adolescents seeking help in public facilities is because of nurse attitudes, many public health facilities are not youth-friendly (Abiodun & Balogun, 2009; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Ehlers, 2003; Muller, Rohrs, Hoffman-Wanderer, & Moult, 2016). Adolescent sexual and reproductive healthcare workers are reported to be unwelcoming because they feel that adolescents should not be engaging in sexual activities, this goes against the Batho Pele principles and the patient health charter because nurses make their own judgments which often lead to adolescents not receiving the services they require. The response teenagers receive when they seek ASRH instills fear in them and often leads to them not going back to the healthcare centers. This is an infringement on the right to health, and it is a deviation from the health care frameworks provided by the policies which aim to deliver the best service to the patients. The Batho Pele principles promote treating citizens as though they are customers, which suggests that you want to keep them because if the service is not at the level, they require they may leave and take their business elsewhere (Government Gazette, 1997). Reports have shown that the adolescents do not get this type of treatment, and they have often turned away which means they are denied the service (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Dietrich, et al., 2013; Ehlers, 2003; Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016; Maharaj & Cleland, 2005; Varga, 2002).

2.2 South African public sexual health services

Pre-1700s South African population depended on indigenous healers for health services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009). There was racial segregation of medical training in the 19th century, as more white doctors were trained (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009). The small portion of black doctors that were trained led to an insufficient health service provision for the non-white population.

Before 1994 much of the health service budget was assigned to the private health sector which was mainly for the white population. The training provided to black health practitioners (doctors and nurses) was ill-prepared as it did not provide them with the right experiences to deal with patients. This has led to the imagery of nurses being viewed as cruel (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009). "Training of nurses, from the earliest missionary days, was regarded as a socialization process, initiating students into both an ethos and way of life. Groomed as a middle-class elite, the task of the nurses was to moralize and save the sick and not simply nurse them" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009, p. 829). Nurses were trained to view themselves as authorities who had complete control of their patient's lives, giving them the permission to decide what treatment patients deserved what treatments they did not (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical

roots of current public health challenges, 2009). Although the ANC set out to make changes in relation to the health system in South Africa, the system they set out to change still carried on as a legacy of the apartheid era, the nurse and the patient relationship has not been rectified. Nurses are known to be rude, cruel and many times unhelpful to public hospital patients, especially young females who seek sexual health services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009).

The South African constitution section 7(2) requires the state to respect, protect, promote and fulfill the rights in the Bill of rights. With regards to health care services this means that the state must

- *Respect* the right of access to health care services by not unfairly or unreasonably getting in the way of people accessing existing health services, whether in the public or private sector.
- *Protect* the right by developing and implementing a comprehensive legal framework to stop people who get in the way of existing access of others.
- *Promote* the right by creating a legal framework so that individuals are able to realize their rights on their own.
- *Fulfill* the right by creating the necessary conditions for people to access health care, by providing positive assistance, benefits, and actual health care services (Hassim, Heywood, & Berger, 2007).

  The public health policy states that it is the responsibility of health care workers to ensure that all individuals are provided with the right health care services in a fair manner (Hassim, Heywood, & Berger, 2007). Research shows that many young females in South Africa

mention nurse attitudes as one of the reasons why they either opt for backdoor illegal abortion or discontinue contraceptives totally (Varga, 2002; Varga, 2003; Wood & Jewkes, 2006). South Africa is predominantly a Christian society, which means that premarital sexual activity is regarded as taboo, and although there are policies that point to the freedom for adolescents to seek sexual health in public hospitals, nurses feel that engaging in talk about sexual activity with "children" is inappropriate (Jewkes, Vundule, Maforah, & Jordaan, 2001). Maharaj and Cleland (2005) point out that nurses in the public health care sector in KwaZulu Natal refused to provide abortion services or to be trained to be able to carry out such services (Maharaj & Cleland, 2005). This speaks to the cultural and religious influences that impact how health care workers carry out their work which is what the missionaries trained nurses on, to see their position as not only health care workers but also as gatekeepers who should teach people about the way of life (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009). One of the participants from Wood and Jewkes (2006), stated that it is culturally inappropriate to engage in sex talk with young girls “One nurse explained ‘it’s our tradition, neither can you talk to your mother and say, 'I'm pregnant' or 'I want to go for family planning, it's something one can't talk publicly about" (Wood & Jewkes, 2006, p. 32). This denotes that nurses intersect their professional identities with their social identities as they consider themselves adults first before they are nurses, therefore becoming a barrier that hinders adolescents from engaging in contraceptive use (Wood & Jewkes, 2006).

Research suggests that family planning nurses provide little to no information on method choice, side effects, but rather they scold women for engaging in contraceptive use, and this applies to

women of all ages (Jewkes, Vundule, Maforah, & Jordaan, 2001). Reports around family planning and sexual health for adolescents point to nurses being the primary reason why adolescents discontinue contraceptive use and fall pregnant because they scold them for engaging in sexual activity and they often ask patients to come with their parents or show proof of permission from parents (Wood & Jewkes, 2006).

The constitution and the Batho Pele policies state that health care is an essential right and should not be seen as a privilege, therefore not discriminating against those that require health care services should be a priority for nurses or healthcare workers (Government Gazette, 1997; Health Professions Council of South Africa, 2006; Maharaj & Cleland, 2005; Mirugi-Mukundi, 2015; Warenius, et al., 2006). As discussed above there are multiple factors that contribute to the restrictions of ASRH in South Africa, nurses have reported the lack of training and being bombarded with emails that give them guidelines as one of the biggest challenges that they face relating to ASRH. The CA, CTPA, and SOA are often challenging to navigate for nurses as they provide contradictory guidelines for the healthcare workers (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Maharaj & Cleland, 2005; Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016; Wood & Jewkes, 2006). The contexts in which the clinics are based also contribute to the factors that hinder adolescents from getting sexual and reproductive health services.

Context is very important because other nurses believe in offering the services to adolescents but because of where they are based, they follow the rules of nurses from that region (Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016). Health care workers who are not opposed to TOP often have a challenge discussing TOP because they don't want to seem as though they are promoting what is deemed morally inappropriate in that society. This statement shows that not all nurses are opposed to providing ASRH to adolescents but at times they are limited by their environment and

the structural framework within the workplace (Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016). One cannot put the blame entirely on the health care workers, because at times they try to serve the community and they are either restricted by the lack of knowledge or training relating to the service they have to offer, and other times the moral intensity within an area dictates how nurses operate (Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016).

2.3 Gender influence on contraceptive use among female adolescents in South Africa

Gender plays a role in the decision-making process for contraceptive use, therefore interrogating gender roles and power dynamics within a framework of gender is useful for the study. Gender roles have place people in positions in familial, peer, and social setups, gender roles also come with different social expectations (Varga, 2003). As a result, gender roles regulate behavior, and they are an integral factor in sexual and reproductive experience (Varga, 2003). According to African culture, womanhood is determined by her ability to bear children for her husband, while manhood is determined by the man's ability to plant his seed (Mfono, 2009).

Early childbearing is complex as some consider premarital sexual activity taboo, while some societies use early childbearing as a way to ensure the fertility of both genders (Varga, 2003). This phenomenon also points out gender inequities as many young women are discriminated against for having children before marriage while they embrace early fatherhood as it suggests masculine maturity (Varga, 2003).

Reports suggest that many young women engage in early sexual activity because of sexual coercion from male partners, they engage in sexual activities prematurely to prove their commitment to their partners (Varga, 2002). Engaging in sexual activities at a young age comes with multiple responsibilities, one being that females have the responsibility to avoid pregnancy.

This becomes a challenge because some partners do not believe in the use of contraceptives because of misconceptions like women who engage in contraceptive use are cheating, or because of misinformation about the side effects of contraceptives (Varga ,2003; Jewkes, Vundule, Maforah, & Jordaan, 2001). Some women fail to negotiate for safe sex as they are intimately involved with older partners, therefore having to resort to other ways of avoiding unwanted pregnancy (Ehlers, 2003).

In African cultures respectability is essential and it is used to police behavior within society, for women their fidelity and fertility are some of the ways in which they earn respectability (Varga, 2003). Women are expected to be sexually available for their partners, they are expected to be monogamous. A high level of education also earns them some respect as well as bearing children after marriage (Varga, 2003). Reports suggest that non contraceptive use, unprotected sex, and the continuous high levels of teenage pregnancy are due to the cultural expectations that are enforced by the cultural importance of female fertility (Varga, 2003).

The double bind of sexual availability for ones' partner and avoiding pregnancy pushes young women to conceal contraceptive use to their partners (Varga, 2002). This is then compounded by the sexual health care services sector as it is not young women-friendly (Margherio, 2019). This has also been reported to be a contribution to the high mortality of both mother and child as they opt to use unsafe methods in avoiding the ill-treatment by health care workers (Wood & Jewkes, 2006).

There are various types of hormonal contraceptives that can be used by women. While some prefer pills that require daily uptakes, some prefer injections. Some prefer implants which are often easier to use for those who conceal the contraceptive use to their partners. "The injections and implants

are easier to use because women only need to visit the clinic after two to three months for a checkup or another one.

2.4 Authoritative figures that contribute to the decision-making process

Various people including family, friends, teachers, and healthcare workers influence adolescents' access to services and information (Morris & Rushwan, 2015). Many adolescents are not independent as some are still in school and live with their parents (Gage, 1998). Their decisions are influenced by authority figures within their social settings, be it adults or family. Religion, culture, and educational systems also act as governing figures for adolescents' behaviors; therefore, it is noted that multiple factors contribute to the decision-making process of adolescents with regards to sexual activities and reproductive health (Gage, 1998).

Research suggests that parents must engage with adolescents about sexual health and promoting safe sex engagement (Gage, 1998). This is important as parents will help promote healthy sexual behaviors. Although this is deemed important many parents do not engage in sexual talk with their children because socially it is viewed as inappropriate to speak to children about sex (Abiodun & Balogun, 2009). The intergenerational difference is one of the primary reasons why parents do not engage in sex talk with their children because as they grew up sexual activity was viewed as an act that only married couples engaged in. In the pre-20th century, many cultures viewed sex as an act that was done solely for reproduction, therefore engaging in sex for pleasure and not procreating is still stigmatized (Mfono, 2009). Multiple factors impact the decisions of adolescent females when it comes to sexual health. Some girls go on to do abortions in illegal backstreet places because their parents told them to because parents are ashamed of what their community members

would say. So instead of going to a public hospital or other official healthcare centers, they send their children to backstreet abortion clinics (Varga, 2002).

The high prevalence of high-risk sexual behavior among adolescents has suggested the normalization of contraceptive use and the practice of safe sex, although many programs do engage with teenagers about this, they also suggest that authority figures of adolescents should also be informed of safe sex practices, and they should openly engage with their children (Abiodun & Balogun, 2009).

Many reports suggest that adolescent females fall pregnant at a young age because of a lack of knowledge relating to sexual activity. Some adolescents reported that they never were told about menstruation, their mothers only told them they are now old, and they should expect to experience monthly bleeding when it does happen they should not be alarmed as it is a normal grown-up thing to happen (Dietrich, et al., 2013). It has been reported that some females got pregnant on their first sexual experience with their first sexual partner who is usually older than them (Dietrich, et al., 2013). Adolescents who engage in intimate relationships with partners who are older than them are faced with the challenge of the inability to negotiate safe sex (Dietrich, et al., 2013). Economic circumstances also contribute to adolescents engaging in sexual activities with partners who are older than them, as transactional sex becomes a way for many to survive ((Selikow & Mbulaheni, 2013). Some reports suggest that the environment in which one is situated plays a big role because young females who are born in low economic communities grow up to see that older ladies who are unemployed often have multiple partners with who they have transactional relationships, and it is argued that without any other authoritative role models young girls grow up to envy the women with multiple partners (Zembe, Townsend, Thorson, Silberschmidt, & Ekstrom, 2015). The urge to get luxurious gifts and live a better life often leaves some girls with a burden of sexually

transmitted diseases and HIV as the older partner often dictates how the sexual intercourse will take place (Gage, 1998).

2.5 Religion

In the South African context, the church has a big influence on social norms and how people carry themselves (Eriksson, Lindmark, Haddad, & Axemo, 2014). Christianity takes the view that sex is an act that should be done by married heterosexual couples (Eriksson, Lindmark, Haddad, & Axemo, 2014). Religion promotes abstinence before one gets married, this is viewed as a good Christian act.

Christianity states that premarital engagement in sexual activity is a sin, and many young females who do engage in sexual activity before marriage do not engage in contraceptive use from the fear of being shunned by community members and at times health care workers (Wood & Jewkes, 2006). Wood and Jewkes (2006) report that some health care workers impose their religious beliefs on their patients, relating to contraceptive use, abortion, and premarital sex (Wood & Jewkes, 2006). Health care workers still follow what Coovadia et al., (2009) call socialization, policing how patients live their lives and either judging them or scolding them. Adolescent female students speak about how nurses tell them what they are doing is a sin, killing children (abortion) and engaging in premarital sex (Varga, 2002).

Multiple factors contribute to the process of decision making for adolescent females with regards to contraceptive use. The factors are but not limited to the public health care system, gender norms within a society, authoritative figures for adolescents, religion. The public health care attitude and environment towards adolescent females is one the major reasons females do not engage in contraceptive use. Nurse attitudes toward patients in South Africa can be traced back to missionary training where nurses were trained to not only nurse but also moralize patients. Cultural beliefs

often intersect with professionalism in public health care centers as nurses take their beliefs as principles to use even when they are at clinics and hospitals. Gender norms also contribute to the decisions that young females take with regards to contraceptive use. Socially young women are caught between a double bind, they are expected to be sexually available for their partners, but they are also expected to avoid pregnancy. Many young women date older partners for the first time, and this puts them in a risky position as they are younger than partners. Adolescents are not fully autonomous as they still stay with their parents, therefore decisions they take are impacted by their environment.

In order to understand the experiences of people one needs to understand the context in which they find themselves in. South Africa is dominated by masculine ideals which promote heterosexual hegemony. Therefore, in order to understand gender dynamics within this society one needs to understand that gender intersects with race, ethnicity, socioeconomic status. In exploring gender dynamics feminists argue that the intersectionality of identities often leaves women lowest in the social strata (Collins, 2000). This study wants to interrogate how power dynamics within gender impact decisions that women take regarding contraceptives, in order to do so one must understand the formation of gender dynamics and its maintenance. Judith Butler's understanding of gender is a useful theory as it helps unpack how daily social practices contribute to the maintenance of heterosexual hegemony.

3 Chapter 3

3.1 THEORETICAL FRAMEWORK

In *Bodies that matter* (Butler, 1993), states that bodies are viewed differently, others are viewed as more important than others. South Africa has been faced with gender-based violence epidemic where women's bodies are violated on a daily basis by their intimate partners, family members, relatives, and strangers putting their bodies in a lesser position than those of men. literature has found that were not part of academic research in the past, and when they were eventually added into space, they were put on the terms governed by masculine ideologies (Collins, 2000). Feminism arose in an attempt to make women visible in the academic space. In attempting to represent

women and their experiences, the first wave of feminism was critiqued for only promoting the needs and grievances of white middle-class women (Mendez, 2015). The second feminism arose to rectify the issues raised from the first wave with their main objective as the emphasis on the importance of bodily integrity (Mendez, 2015). They argued that men exerted their power through self-interest and individuality and in order for women to achieve liberation and equality they should also exert themselves the same way (Folbre, 2004). Although the second-wave feminism movement was aware of the struggles that many women face, their movement was still dominated by the interests of white middle-class women, therefore leading to the rise of the third wave. The third wave was aware of the intersectionality of factors that contribute to the oppression of women (Mendez, 2015). All the feminist movements saw a social issue that pertained to the oppression of women and attempted to tackle it, but they had shortcomings.

Mendez (2015) argues that although feminism is viewed as an international movement it is important to note that the movements are a response to a contextual issue, therefore there are different feminisms fighting for different struggles in different contexts, but their common denominator is fighting for gender equality (Mendez, 2015). Butler (1990) uses Michel Foucault's argument which states that "juridical systems of power produce subjects they subsequently come to represent (Butler , 1990, p. 2). She argues that feminism that seeks to represent women can also be the movement that oppresses and discriminate against women (Butler , 1990). This can be seen with the 1st and 2nd wave feminist movements mentioned above, they saw an injustice and they tried to rectify it, but their approaches were only limited to the needs of a certain group, therefore, contributing to the continual oppression of other women who did not share the same struggles as them. Butler argues that the use of "women" as a univocal term that denotes the same identity is exclusionary. In this study, the young women that were chosen are from the same University and

their identities vary but for the purpose of the study, they were chosen because according to the South African and the University contexts as female students. It is important to note that their identities are not limited to the understanding that this study bears.

Butler argues that gender intersects with race, sexuality, ethnicity, class, ethnicity, and religion (Butler , 2004). This study is guided by this view, by focusing on students from the University of Witwatersrand in South Africa within a South African context. South Africa is a patriarchal society that promotes the objectives of hegemonic masculinity (Jewkes, Vundule, Maforah, & Jordaan, 2001). South Africa has also been known for its violent culture, many studies say this be attributed to the apartheid system which used violence as a tool of control (Jewkes & Morrell, 2002). Violence has been used as a tool to exert power and enact masculine attributes (Morrel, Jewkes , Lindegger, & Halmall, 2013).

3.2 Sexuality

Sexuality as a term has caused conflict, anxiety, and confusion for many as there are multiple meanings attached to it (Weeks, 2010). Sexuality is often oversimplified and attributed to sexual pleasure and procreation, this defies the thought that sexuality is a spectrum as it suggests that two sexualities can be inferred using genitalia (Nelson & Longfellow, Introduction, 1994). Understanding sexuality is important because it influences daily life experiences. Sexuality plays a big role in the oppression of bodies, the essentialist approach to sexuality often results in discriminative behavior like femmephobia and homophobia (Hoskin, 2019). Hoskin (2019)

defines femmephobia as the systematic devaluation of femininity as well as the regulation of patriarchal femininity (Hoskin, 2019). The purpose of femmephobia is to preserve the gender binary which upholds the power of masculinity over femininity. Femmephobia is used to police females who digress from the ideologies of patriarchal femininity. Patriarchal femininity refers to the normative feminine ideals that promote the maintenance of masculinity as powerful over femininity (Hoskin, 2019). Femmephobia is not only promoted by males but females also promote this phenomenon through practices such as emphasized femininity were women who follow the normative ideas of gender binary police and discriminate against those that deviate from these. This diversion often leads to violent forms of discrimination like corrective rape where men use rape as a tool to correct sexualities, they deem taboo (Kurth, Spiller, & Brown Travis, 2000).

A woman is defined with reference to a male counterpart, men are placed as the golden standard for sexuality (Conrad , 2006;Whitford, 1991). Measuring women's sexuality against men precedes the binary of women seen as either good or bad (Conrad , 2006). This raised the term of the Madonna/Whore dichotomy where the Madonna is the pure, ideal female that is “marriage material” whilst a whore is a woman who proudly defies the patriarchal standards, a woman who is sexually liberated (Conrad , 2006; Hoskin, 2019). This binary justifies the violence against women who defy patriarchal norms because they are bad. Gender policing that justifies such violence uses factors like dress code, sexual liberation and often uses religious scripts to blame women for the violence they incur (Hoskin, 2019). Ruether (1974) in Conrad , 2006 states that western cultural discourse about sexuality relies on Christian thought which essentializes sexuality (Conrad , 2006). In Christian history, sexuality has been to " the nature of virtue and truth (Weeks, 2010, p. 3). Christianity has viewed sexuality as a committed covenant (Farley, 2006). In these covenants, there has been policing of femininity and womanhood where the essence of what it

means to be a woman has continuously interrogated further subordinating women and their positionalities within societies (Cahill, 2007).

Sexuality is essential for the promotion and maintenance of hegemonic masculinity (Weeks, 2010). Female sexuality is one of the fields which allow men to exert power over women without their consent (Kurth, Spiller, & Brown Travis, 2000). Gender and sexuality have been explained using science, which essentializes them to biological attributes (Moore & Travis, 2000). Biological attributions by popular culture are often used to fit individuals into boxes which makes their identities rigid. Science has been used to add credibility to some social expectations of gender and sexuality (Moore & Travis, 2000). The use of science to define sexuality and gender has led to what is termed patriarchal dualism (Nelson , 1992). Patriarchal dualism asserts the subordination of women and the domination of men over women. It assumes that women are less than men (Nelson , 1992). Patriarchal dualism has been influential in Christian communities as it justifies the control of women's bodies (Nelson , 1992). This dualistic view of gender also gave rise to the categorization of women into the following: Virgin, Wife, and Whore.

3.3 Hegemonic Masculinity

Raewyn Connell defines hegemonic masculinity as the masculinity that dominates society and argues that there are different hegemonic masculinities, but their common feature is violence. She argues that hegemonic masculinity promotes violence as a trait that all men possess (Connell, 2016). Hegemonic masculinity views masculinity as the standard norm and defines femininity as the other (Connell, The men and the boys, 2000). Hegemonic masculinity promotes certain behaviors in males, for instance, sexual prowess, aggression, dominating in the workplace (Connell, 2016). Hegemonic masculinity promotes male domination and any threat to hegemonic masculinity is often met with negative responses like violence (Morrell, Jewkes , & Lindegger,

2012). Connell and Messerschmidt (2005) highlight the hierarchical position of power of masculinity over femininity and discriminates against masculine ideologies which do not conform to the ideal hegemony of masculinity.

Hegemonic masculinity requires men to exert power over women, and any masculinity that does not promote the subordination of women is also subordinated (Morrell R. , The times of change: Men and masculinity in South African, 2001b). This form of masculinity is promoted and maintained through all aspects of men's lives, and it requires that men publicly affirm their masculinity by engaging in activities that confirm the ideal form of masculinity (Ratele , 2008). Hegemonic masculinity promotes patriarchal norms that require one to conform to the ideal form of masculinity that highlights global hegemony, so if you are gay/bisexual and you affirm your masculinity and may benefit from masculinity but you are viewed as subordinate masculinity (Morrel, Jewkes , Lindegger, & Halmall, 2013).

Connell argues that hegemonic masculinity depends on two assumptions for its maintenance, firstly it depends on the multiplicity of masculinities and then relies on the hierarchical setup of masculinities, with the hegemonic subordinating others (Connell, 2016). Masculinities are not fixed, and neither is the hegemony, others can be globally marginalized and yet be hegemonic in their own context. For instance, Black masculinities are marginalized globally, yet black heterosexual men have the most power in their own social settings (Mula, 2015). In the United States, hegemonic masculinity is categorized as not feminine and a physically aggressive heterosexual male (Mula, 2015). Black masculinities face restrictions like access to marriage, which is a big denotation of hegemonic masculinity. Hegemonic masculinity’s characteristics are white, cisgender, breadwinner, husband, father, able-bodied, and wealthy (Morrel, Jewkes,

Lindegger, & Halmall, 2013; Mathews, Jewkes, & Abrahams, 2014; Morrel, Jewkes , Lindegger, & Halmall, 2013; Mula, 2015; Ratele , 2008).

3.4 Hegemonic Masculinity in South Africa

South Africa is a patriarchal society. It was named a violent culture because it sanctions the use of violence to tackle issues (Gass,Stein,Williams, &Seedat, 2011). The violent culture in South Africa has been attributed to the country's racial discriminative history because apartheid policies used violence against non-white populations. The apartheid system used structural violence to control the non-white population and put structures in place to ensure they were financially dependent on the white government (Morrel, Jewkes , Lindegger, & Halmall, 2013). This system left many black individuals illiterate with no formal education, making them unsuitable for better-paying jobs (Mathews, Jewkes, & Abrahams, 2014). Morrell (2001) suggests that there are multiple forms of masculinity, and he states that masculinity is dependent on the context that people grow up in. He states that in South Africa there are three types of masculinities: White, Black, and African in this hierarchical order. Black masculinity encompasses colored heterosexual men, Indian heterosexual men, and urban-based heterosexual African men, whilst African masculinity is related to rural African men (Morrell R. , The times of change: Men and masculinity in South African, 2001b).

In the South African context, hegemonic masculinity is characterized by a man's ability to provide for his family (Ratele , 2008). Like other hegemonic discourses, hegemonic masculinity uses stereotypes to maintain its domination and promote its ideologies (Stewart & McDermott, 2004). A deviation from hegemonic stereotypes can serve as a threat to masculinity and often leads to retaliation using violence or other ways that will highlight the dominance of men (Mathews,

Jewkes, & Abrahams, 2014). As mentioned above, violence underpins hegemonic masculinity therefore acts of violence can be used to symbolize one's masculinity. Jewkes et al., (2015) argue that hegemonic masculinity requires one to show his power to society; this explains some of the violence that happens publicly.

Femmephobia is also a form of violence that legitimizes violence against people who are not heterosexual. Femmephobia is a form of policing where femininity that digresses from the normative feminine ideology is frowned upon (Hoskin, 2019).

Hegemonic masculinity suggests that females are subordinate to males and that males have control over females (Connell, 2016). This is perpetuated through practices like lobola where a groom pays the bridal price; this commodifies the woman and they are treated as the property of males. This often leads to discourses that suggest that females are property of their husbands and their husbands own their birthrights, and their bodily integrity (Mathews, Jewkes, & Abrahams, 2014). This in many cultures suggests that a woman's role is to satisfy her husband's needs, that a woman cannot say no to her husband. There are debates around marital rape, where questions are asked if men can rape their wives (Khau, 2007). Many cultures do not consider a man forcing himself on his wife as rape because it is the women's job to satisfy her husband. It has been reported that any reports of rape have been dismissed just as abuse has been dismissed as a private matter that should not be discussed in public places (Boonzaier, 2006). Discourses around abuse have led to the concept of a "culture of silence" which results in multiple femicides, where women are conditioned to stay silent about their bedroom interactions and they are taught to persevere if any abuse arises (Boonzaier, 2017).

The discussion above conceptualized hegemonic masculinity and used examples of gender-based violence, marital rape, homophobia, and femmephobia to show how hegemonic masculinity

oppresses women and other subordinate masculinities. Helman & Ratele (2016) also discuss the effects of hegemonic masculinity on other male identities. Ratele (2008) states that other masculinities suffer emotional turmoil as they have to constantly prove their masculinity to society, others take on the identities of hegemonic ideology to avoid punishment. This study finds the understanding of hegemonic masculinity as essential because hegemonic masculinity has been used as an analytic tool to investigate gender inequality. Hegemonic masculinity is useful to highlight and emphasize gender disparities that are found within literature and use these as tools to interrogate power dynamics.

3.5 Sexual and Reproductive Health Rights, Contraceptives

Reproductive health forms an integral part of women's health. The World Health Organization states that, unlike men, women have human rights that are specific to them which need to be guarded and promoted (Mirugi-Mukundi, 2015). The International Conference on Population and Development (ICPD) defines Reproductive health as

> "The state of complete physical, mental, and social well-being… In all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when, and how often to do so…to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice… and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (Mirugi-Mukundi, 2015, p. 45).

Reproductive health is concerned with the health and safety of women, it promotes bodily integrity. Bodily integrity refers to the right to autonomy over one's body Physical violation of an individual's body is unacceptable as it infringes on their right. Bodily integrity states that one has control over their body, they make decisions of what they want to do with their body and how they want to do it. Culture is one of the factors that contribute to the violation of an individual's body, as there are practices that force women and men to participate in practices that may hinder bodily integrity. For example, in the Xhosa culture, it is a cultural requirement for young boys to go through the right of passage to manhood. To prove one's manhood, one has to go through initiation to be accepted as a man in the community (Mgqolozana, 2009). For women, there are practices like female circumcision, and genital cutting which violate the right to autonomy over one's body (Longman & Bradley, 2015). It has been established that reproductive health is a basic right that everyone should have (United Nations, 2016; Longman & Bradley, 2015; Mirugi-Mukundi, 2015). This right implies that people have the right to practice satisfactory and safe sex, it also states that men and women have the right to be informed of sexual practices and information that promotes the full ability of reproductive health. Macleod (2003) states that sexual and reproductive health is a global concern. Literature suggests that Sub-Saharan Africa carries over half of all maternal deaths in the world (Mirugi-Mukundi, 2015). The World Bank asserts that 74% of maternal deaths are preventable with proper access to the required interventions to address pregnancy needs (Mirugi-Mukundi, 2015). But due to improper infrastructure, inadequate information, and ill-treatment, patients' preventable deaths occur.

ICPD promotes a high standard of sexual and reproductive health which implies that individuals have the right to make decisions concerning reproduction, and this experience should be free of discrimination, coercion, and violence (Mirugi-Mukundi, 2015, p. 45). Although this is a universal

requirement for states and their health systems many places do not follow it. For instance, in South Africa contraceptives were introduced as measures to control the population (Mfono, 2009). The South African health system is a legacy of the apartheid system, although measures to promote better health care services for everyone in the country and providing access for the previously marginalized is still a challenge (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009, p. 829). Some of these legacies that are still prevalent post-apartheid are the socialization of healthcare providers.

> Nurse training from the earliest missionary days, was regarded as a socialization process, initiating students into both an ethos and a way of life. Groomed as a middle-class elite, the task of the nurses was to moralize and save the sick and not simply nurse them. They were taught to see themselves as subordinate to doctors and as authority figures in control of the lives of their patients (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009, p. 829).

Research shows that many nurses in public health care are African and they are religious, they deem it their responsibility to preserve the integrity of motherhood and family, so their motherhood and womanhood play a role in how they provide sexual health services to adolescent women (Wood & Jewkes, 2006). African children are socialized to respect their elders and to never talk back at them, this instills fear in young SRHR patients because nurses are as old as their parents therefore, they cannot talk back or stand up for themselves when they are judged or illtreated (Wood & Jewkes, 2006). The religious views that healthcare workers have hindered the efficacy of SRHR services, as some believe that contraceptive use is against their beliefs and they project these beliefs onto patients (Varga,2002). This shows the power imbalance between the service providers and patients seeking the services, this forms a part of the multiple impending factors that

contribute to the experiences young women face when seeking sexual and reproductive health care services.

Women's reproductive rights include the right of access to appropriate health care services that will ensure they go through pregnancy safely and give birth to a healthy infant (Mirugi-Mukundi, 2015). Literature shows that not all women have the privilege to enjoy pregnancy as they are judged by nurses or ill-treated by doctors either because of their race or their age. A human rights-based approach to reproductive health stipulates those human right norms and principles should direct relationships between individuals and groups with rights and the duty bearers (actors with an obligation to fulfill those rights, such as states, policymakers, and health care workers) (Mirugi-Mukundi, 2015, p. 46). This approach includes values of human dignity.

Sexual health "is a state of physical, mental, and social well-being concerning sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence" (WHO, 2019).

Sexual Rights include: "The right to choose whether, with whom, and how one engages in sexual relations; The right to privacy, freedom of expression, bodily autonomy and integrity; The right to comprehensive sexual and reproductive health information and services, empowering people to make safer, consensual, and fulfilling choices around sex and relationships; The right to make free and informed choices about one's sexuality, sexual orientation, and gender identity, and live free from discrimination, coercion and violence" (Rights, 2014)

The term, 'reproductive justice,' rose in 1994 after a group of black women decided to represent themselves as women of color (Native American, African American, Latina, and Asian American).

These women felt that women's rights did not cater to them, it did not represent who they are as it promoted the needs of white women whose socio-economic status differed from theirs (SisterSong, 1997). Reproductive justice takes on a human rights approach which positions sexual and reproductive rights as a human right; calling for bodily autonomy that goes beyond choice and also includes access to services as the first mandatory step in achieving reproductive justice by recognizing that race, socio-economic status, and sexuality play large inaccessibility for sexual and reproductive health services for women (SisterSong, 1997). Human rights principles go beyond guiding states with domestic laws and practices to follow obligations, but it is also useful for educating all stakeholders including health care workers, lawyers, policymakers, and judicial officers at the domestic level about appropriate laws (Brookman-Amissah, Ngwenya, & Skuste, 2015). This statement asserts the intersectionality of human rights, reproductive rights, and sexual rights. It states that following a framework that is aware of this intersectionality will result in a fair and inclusive system for providing SRHR services.

Population control methods have been placed on women and have used women's bodies as vehicles to control the population. These have negatively affected women's health and rights to sexual health and pleasure. Contraceptive methods have previously been used to promote political agendas, like the reduction of the black population in the South African context.

As stated by Mfono (2009), the introduction of contraceptive methods in South Africa was to control reproduction by women of color and women from low-income communities. Yet the political state of the country allowed for white women to be given preference over any other population in any service production. Black women had to find alternative health care provisions like traditional methods of contraception and backstreet illegal abortion clinics. Many have

reported that it was not by choice that they opted for alternative methods, but it was due to the refusal of service (Varga, 2002)

Contraceptives and abortion have been conceptualized as private female choices, this oversimplification of the choice places the responsibility of pregnancy prevention on women (Petchesky, 1986 as cited in Dunlop 1987). This highlights the complexity of choice because women are expected to make decisions about pregnancy yet if those do not comply with the expectations of society and one's sexual partner, they are crucified for it. Therefore, contraceptives should not just be a women's job, but they should have male involvement, but equal engagement is necessary, partners should be in total agreement with one another.

Research on contraceptive use has placed women in the oppressed position, where they contract HIV or become pregnant because of the factors from their community, and the influence of their partners. This is partially true, but it is also argued that some women resist this oppression by making active decisions with or without their partners' knowledge to protect themselves (Margherio, 2019). Margherio (2019) argues that women have agency as any decision they take rests with them. The sex and reproduction centers at local clinics have been reported to have bad relationships with many women because of the treatment they receive therefore they opt for other traditional uses like going to a traditional healer (Varga, 2002).

Butler (1993) argues that bodies are not seen in the same light, some bodies are worth protecting and grieving for, whilst other bodies are not seen as grievable (Butler, 1993). Hegemonic masculinity suggests that male bodies are more valuable than female bodies, to protect female bodies one ought to follow the objectives of hegemonic masculinity. Bodies that deviate from the normative ideals of heterosexuality are punished. Hegemonic masculinity is underpinned by exerting power through violence. In South Africa, a man’s ability is proven through exercising

power over women, showing manhood by sexual prowess, and being able to provide for one's family. Hegemonic masculinity places women in subordinate positions than men, culturally women should follow men's commands. Sexual and reproductive health rights state that women have the right to decide what they want to do with their bodies, but in African societies, these rights are overruled by cultural practices. The groom and his family are given the reproductive rights of a woman after paying lobola.

Contraceptives were introduced for population control. Contraceptive use among adolescents in South Africa is associated with many negative outcomes, like discontinuation of contraceptive use because of health workers' attitudes and other prohibitions. It is worth noting that the introduction of contraceptives also had positive outcomes, and the continual research towards providing better methods has contributed to the decrease in HIV/AIDS infections. Many organizations and policies relating to sexual and reproductive health have been developed to improve the sexual health of not only adolescents but the population at large. For instance, safe sex and condom use are promoted to decrease HIV infections and protect against STIs and STDs. Instruments like CEDAW and the Right to Health which is a concept included in numerous international agreements such as the Universal Declaration of Human Rights and the International Millennium Goals consist of indicators aimed at increasing knowledge about HIV, reducing the HIV infection rate, and decreasing the pregnancy rate of adolescents between ages 15-19 (Morris & Rushwan, 2015).

3.6 Intersectionality

Intersectionality was originally used to reject the idea of women's experiences being represented as universal experiences (Price, 2011) Kimberlé Crenshaw introduced intersectionality to feminism, she intended to highlight the importance of disrupting the dominant analytical tools that

are used in studying the hierarchies and identities of social divisions (Crenshaw, 1991). Intersectionality frameworks are centered on the assumption that social divisions and categories like race, gender, and class are interconnected on individual experiences', social representation, and social structures levels (Carstensen-Egwoum, 2014). Theories like intersectionality are aimed at shedding light on the hidden mechanisms that work to maintain and promote power and oppression (Carstensen-Egwoum, 2014).

Social identities are not necessarily independent of each other and are not mutually exclusive. They can interact with one another as a result, manifest themselves in pairs, triads and tetrads as illustrated by Kimberlé Crenshaw's conceptualization of overlapping social identities (Crenshaw, 1991) Because people actively practice their identities, that means they are not passive inheritors of these identities. This then means intersections are uniquely capable of creating oppression and domination(Boonzaier F. , 2017; Butler, 1988; Chodorow, 1995; Collins H. , 2000).

It is important to note that gender is critically linked to social statuses, this will open up opportunities to explore gender as a set of power relations (Stewart & McDermott, 2004). *Women can face reproductive health disparities based on the intersection of one or more marginalizing social identities (i.e., gender, race, and class), which are linked to inequitable divisions of social, cultural, economic, political, and historical power* (Smith, Sundstrom, & Delay, 2020, p. 364) The power imbalance threatens women's autonomy by maintaining norms, laws and strategies that control women's reproduction, for example, termination of pregnancy restrictions, inadequate sexual and reproductive health services, and reproductive coercion (Mula, 2015).

Women having bodily integrity is highly controversial globally and locally (Mfono Z. N., 2009; Mirugi-Mukundi, 2015; Morris & Rushwan, 2015; Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016; Price, 2011; Smith, Sundstrom, & Delay, 2020; Warenius, et al., 2006; van Regenmortel & van Harte, 1977).Patriarchy reflects power dynamics within gender norms which highlight the unequal distribution of power within decision making about health, for example, make decisions about whether they should practice safe sex in an intimate relationship. Reports have shown that many women are restricted when it comes to birth control, whether they are hindered by interpersonal relations, or structural laws, and health care providers (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009; Dietrich, et al., 2013; Ehlers, 2003; Gage, 1998; Helman & Ratele, 2016; Jewkes & Morrell, 2002; Muller, Rohrs, Hoffman-Wandderer, & Moult, 2016; Smith, Sundstrom, & Delay, 2020; Warenius, et al., 2006).

Intersectionality is important because it helps researchers to offer an alternative route to which researchers can explore and interrogate power dynamics that are embedded within social phenomena and cultural practices (Stewart & McDermott, 2004). As a tool of analysis, it helps to unpack interrelations between identities which show how the intertwining of identities work to either promote dominance or promote oppression (Boonzaier, 2006; Boonzaier & Van Schalkwyk, 2011; Boonzaier F. , 2017; Butler , 2004; Connell, 2016; Connell & Messerschmidt, 2005). The study aims to explore people's perceptions. The qualitative research method is best suited because it explores the experiences of people, their interpretation of the experiences. It is useful because it captures the complex ideas of the social world, placing the focus on human interactions. The study collected information from eight people from the University of Wits, data was collected using

video conferencing MS Teams, Zoom, and WhatsApp text messaging. The following chapter will be discussing the research methodology employed in the study.

4 Chapter 4

4.1 Methodology

Research methodology

This chapter describes the methodological approach of this study. A description of the aims of the study will be discussed, followed by the context of the study. This chapter will also be a discussion of the chosen research design, the method of sampling used as well and the data collection process. The method of data analysis will also be discussed concluding with reflexive remarks and ethical considerations.

Qualitative research emphasizes the exploration of individual experiences (Cope, 2014). Qualitative researchers argue that there are multiple realities and highlight the importance of context (Braun & Clarke, 2013). Qualitative research methods are best suited to this study because it explores the experiences of people and their interpretation of the experiences. The use of qualitative methods enables a researcher to capture the complexity of the social world, placing the focus on human interactions. Qualitative research treats people's understandings as valuable knowledge that is useful for the alternative knowledge which will help dismantle power dynamics within the dominant academic space.

1.1 Research Aims

This research study aimed to investigate the Wits female students' perceptions of the impact of hegemonic masculinity on their decision-making for birth control. It focused on females who have used contraceptives who are or were in heterosexual relationships whilst they used contraceptives. This study aimed to explore the power dynamics within heterosexual relationships and the impact that the South African health care system has on the decisions that students take regarding contraceptive use. This study was aimed at exploring how power relations function to regulate behavior.

1.2 Research Rationale

Literature has indicated that what is considered private practice, like the interactions between intimate partners, can tell you about the social world they are found in. This means that research about the "private" space can be used to interrogate and make inferences about the social dynamics of society. This study highlights the importance of centering everyday life experiences as these provide alternative knowledge which allows for a different scope of analysis of the dominant cultures and the social construction into which people are interpellated (Althusser, 1971).

1.3 Participants

Participants were recruited using purposive sampling. Purposive sampling refers to a non-probability sampling method where the researcher decides what is needed in research and chooses people who align with the objectives of the study. The type of purposive sampling used is what is known as homogenous sampling. As a researcher I came up with characteristics for my study, the sample I need was Wits female students who have used or are using contraceptives. Other requirements were that they have previously or are currently in heterosexual relationships. The age was also specific. I chose people between the ages of 18 and 25. Although the age group of the participants can be described as young adults, the research is based on their narratives of when they were adolescents. Adolescents are categorized to be between the age of 10 and 19 (Morris & Rushwan, 2015). As it is known we are currently facing a Corona pandemic and because of this we could not physically recruit participants, so I shared a participant recruitment sheet with people I had on my social media platforms, and I received feedback from those that were interested. We then agreed on using video conference apps like Zoom and Teams for the interviews.

This sampling technique allows for qualitative researchers to get an in-depth understanding of the phenomena in question. It also allows for the researcher to include an array of participants which may result in more knowledge gained from the study (Braun & Clarke, 2013). The purposive

sampling technique has been critiqued for not providing generalizable findings, but it is also recommendable because combined with qualitative research it allows for detailed information and an extensive understanding Stake 2000).

The sample of my study was ten Wits female students, but due to Covid19 and technological constraints, I have interviewed eight participants. Out of the eight participants, seven interviews were used because the other participant had only used condoms and not hormonal contraceptives which were the main focus of this study. The interviews were conducted via Teams, Zoom, and WhatsApp due to Covid 19 regulations. Two of the participants were interviewed via text messaging because of data and technical challenges.

1.4 Data collection

The data were collected using semi-structured interviews of an average of 30 minutes. This method of data collection is appropriate for this research because it allows for the fluidity of conversation between the researcher and participants (Fitzpatrick, 2013). Interviews allow for a dense interaction, where people share their experiences in private without judgment. Semi-structured interviews allow participants to share and describe what they feel is important (Creswell, 1998). I developed an interview schedule that had questions to guide the conversation. With permission from participants, the interviews were recorded. For the two participants whom I interviewed using WhatsApp text, I took screenshots of our conversations and kept them as part of my transcripts as they are already in the text. The interviews were conducted in January and February 2021, via the methods mentioned above.

1.5 Reflexivity and ethical considerations

Some guidelines ensure that the researcher is not ethically or morally compromised. These are ethical considerations that a researcher should refer to during the process of data collection, analysis, and reporting of data.

The data is stored in a password-encrypted laptop, and on a cloud called OneDrive for backup and safety. I have given all my participants pseudonyms to ensure anonymity. The researcher is a subjective individual who brings her values to the research and is important for the researcher to state her positionality because qualitative research suggests that there is no objective reality and that therefore emotions cannot be totally detached from one's experiences (Boonzaier & Van Schalkwyk, 2011). Therefore, a qualitative researcher should always be reflective. One other way to ensure reflexivity is by ensuring that as a researcher you are ethical.

This research was conducted on people, therefore ethical clearance from the Wits ethical clearance committee was obtained and the clearance number is DIV201021. Although there are human participants the risk level is minimal. As a researcher, I have the responsibility to ensure that I cause no harm to the participants, and also uphold the ethical code of obtaining consent before I engage with the participants. Because of Covid19, I had to conduct the interviews via electronics and not in person and have received written consent from all my participants. Reflexivity is important in qualitative research because it contributes to making the research vigorous. Reflexivity is defined as a critical consideration of the researcher's positionality and the research process (Fitzpatrick, 2013). It the awareness that the researchers' values and beliefs have a bearing on the research outcome, and one way to ensure the credibility of data is by having a reflexive journal where the researcher will note all of her feelings and thoughts about each day of data collection and each day of data analysis (Boonzaier & Van Schalkwyk, 2011). During the study, I

kept a journal where I noted some of my thoughts and feelings. I have taken a biographical reflexivity stance; this means that my personal story has had an influence on the study and Fitzpatrick's (2013) idea of biographical reflexivity was essential for my study. As a person with a history of contraceptive use, I can be considered an insider but also an outsider because I am the researcher. Therefore, I employed what Carrim and Nkomo (2016) call a co-inquiry approach, in which a researcher shares some information which she may consider useful to create rapport and make others comfortable to share their own stories. My participants are aware that I have also used sexual health services, and at times this made them comfortable when they were aware that I know some of the experiences they incurred. Fitzpatrick (2013) notes the importance of creating rapport with participants and the approach of co-inquiry can be used to develop rapport and to also ensure the participants that their truth is valuable and valid and that the interview space is a good space to share in.

1.6 Data analysis

The method of data analysis used is thematic analysis. This method of data analysis was previously defined as a poorly demarcated method of analysis and only recently has its value been recognized as a tool of analysis (Braun & Clarke, 2019). Thematic analysis is used to capture the experiences of participants and help elucidate social experiences. This is an important foundational method that qualitative data researchers ought to learn to conduct rigorous research (Boonzaier & Van Schalkwyk, 2011). Braun and Clark (2013) provide researchers with the appropriate steps to take to do the analysis. In thematic analysis, the researcher was able to see, analyze and state themes that came up from the transcribed interviews with the participants. I followed an inductive approach in the analysis, which means that the themes that I came up with were not decided on before I coded the data.

I used Braun and Clarke's (2019) six steps of thematic analysis which are familiarizing yourself with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes, and producing the report (Braun & Clarke, 2019). During this process I went back to the data, multiple times, doing what Wimmer and Dominick (1983) refer to as trial and error.

I identified the themes that came up in the research which were relevant to the interests of my current study and I discussed them in the study. The analysis I used in the study is relevant for the research because it allows me to report on the participant's experiences, their meanings, their social and personal realities.

1.7 Process of Analysis

The process of analysis for the study is reviewed in Braun and Clarke (2006). The six phases of analysis. The first phase is familiarising yourself with your data. The data collection and transcription were both conducted by me, which means that I had a prior engagement of the data before beginning the analysis (Braun & Clarke, 2006; 2019). I engaged with the data by reading and rereading data, I further actively engaged with data by searching for meanings, and patterns among participants' responses (Braun & Clarke, 2006). I started taking notes and highlighting some points for coding which I reverted to throughout the process of analysis.

The second phase is generating initial codes, this phase begins when you have read and familiarize yourself with the data, and have jotted points that speak to the codes you will develop (Braun & Clarke, 2006). The codes are what the researcher finds interesting, these are described as the raw data that will be assessed meaningfully with regards to the research interest (Braun & Clarke, 2006). Through coding I came up with multiple points of interest and came across the data. I used highlighters to generate the first bunch of codes that I would use to come up with themes.

The third phase is searching for themes. In this phase, I used the list of codes that I had to try and come up with themes. My first attempt at this phase was putting together the extracts that I felt were similar or formed a pattern. I then canceled out the other codes that I felt were not relevant.

The fourth phase is reviewing themes. In this process, I was working to refine the candidate themes that I came up with in phase three. My aim was to ensure that the data extracts and themes were coherent. I carried on with this process till I felt that all the relevant extracts were added to the themes.

The fifth phase is defining and naming themes. In this phase, the researcher is expected to define and refine the themes of the data set (Braun & Clarke, 2006). So in this phase, I was identifying what each theme's essence was about, and I had to establish the relevant aspect of the data that each theme encapsulates (Braun & Clarke, 2006). I read through the themes to ensure that the theme's definition was coherent with the data set captured for the theme. Braun and Clarke (2006) advise researchers to test this phase by describing the scope and content of the theme in a couple of sentences (Braun & Clarke, 2006). I used this advice to revise my themes and to ensure that what I captured was relevant for the study.

The last phase is producing the report, this stage begins when one has come up with definite themes and is the final analysis and write-up of the report (Braun & Clarke, 2006). My process of analysis was conducted with the help of my supervisor who approved of the themes which assisted in ensuring the stability of the research.

Qualitative research methods allow the researcher to explore the in depth meanings of the data set, and thematic analysis assists the researcher to come up with findings that will be consolidated with theory in order to come up with a sound argument for the study. The study followed the six steps

of analysis provided by Braun and Clarke (2006). These steps assisted me to come up with themes that were pertinent within the data set, these themes will be reported in the next chapter, and a section of discussion will be followed by findings.

5 Chapter 5- Findings and Discussion chapter

This chapter discusses the positionality of the participants within the study, the intersectionality theory is used. It then further discusses the themes that emerged from data analysis, which was guided by thematic analysis.

The study used intersectionality as a guide for positioning the participants within the study, intersectionality emphasizes the interrelation of multiple characteristics which contribute to one's privilege or oppression. The themes that emerge from the data set that was collected through semi-structured interviews via Microsoft Teams, Zoom, and WhatsApp. The analysis was guided by Braun and Clarke's (2006) thematic analysis. The themes that emerged concerning the study were heterosexual hegemony, bodily integrity (my body my rules), growth, public health culture vs private, pros over cons, and lastly, sex and urgency. These are discussed respectively in the order above. The study uses the word adolescents to refer to the experiences of the participants because it is engaging with experiences they had earlier in their lives, when they were still adolescents.

Participants' Positionality

Foucault argues that power is not absolute, and it is not top-down but rather can be interchangeable depending on context (Foucault, 1978).. Intersectionality allows for oppression and opportunity, so people are oppressed and privileged differently (Carstensen-Egwoum, 2014). Intersectionality allows for the research to position the women in this study within different positions because of how their identities work together to either place them in a privileged or oppressed position. The literature has shown that women are placed on a lower pedestal than men (Boonzaier F. , 2006; Butler , 1990; Hoskin R. A., 2019; Jewkes , et al., 2015) but this does not mean the women are absolutely oppressed as there are different intersecting factors which may allow them to be privileged in other contexts, this will be discussed further in the following paragraphs. Considering

their different social backgrounds, ethnicities, socio-economic statuses, their position within societies allows them to have different perceptions about social issues.

Various participants demonstrated a relatively privileged social identity with regards to socio-economic status as they had the luxury to choose whether to go for public health care services or private health care, with the latter being a better choice. Private health care facilities offer exceptional services to their patient timeously. They ensure patient confidentiality, safety, satisfaction, sensitivity to the patients' needs, tend to patient queries thoroughly and patiently, much like restaurants where customer satisfaction is their priority. As the Batho Pele suggest citizens need to be treated as though they are customer, and to ensure that they do not take their business elsewhere you ought to make sure that all their health needs are met, narratives around private health care suggest that the participants are happy with the service they received. When asked about their first experience with contraceptive use, and whether they felt like they had enough information the first time they engaged in contraceptive use, they reported yes, “When I went to get contraceptives for the first time I spoke to my doctor about it and he told me the pros and like the cons and hence I made a choice to not take the injection and take the pill”-Jade. On the other hand, some participants reported public health care services were their only viable option as they could not afford private health care. This demonstrated the socio-economic standing which resulted in some of them having to discontinue use due to the humiliating and mortifying treatment they faced in public health care centres.

Out of the seven participants, Thandiwe reported that she only started contraceptives after giving birth. This was mainly because she was afraid that people from her community would see her, and the nurse at the local clinic was related to her. As a result, she was afraid that if she went for SRH services, the nurse would tell her parents, thus shaming her parents in front of the community. This

is an indication of culture and regional position playing a pivotal role in Thandiwe's decision making regarding contraceptive use which ultimately resulted in her having an unplanned pregnancy.

This contributes to the oppression of women and the control over their reproductive justice. She further says that her last experience at the clinic was very bad, as a nurse told scolded her for having an infection without investigating what could have caused the infection. The nurse assumed it was caused by unprotected sex, despite Thandiwe having reported that she did not have a boyfriend at the time so the infection could have been from a public toilet. Muller, Rohrs, Hoffman-Wandderer, and Moult, (2016) state that nurses make judgement calls about whether or not a person deserves service and Wood & Jewkes, (2006) reported that nurses scolded women when they went to get contraceptives and other SRH related services because nurses did not believe in contraceptives. This shows how the intersectionality of different factors like where one comes from, their age, race plays a part in where they are placed in the social strata. Other participants like Jade, Lebogang, Nompumelelo and Reeva, spoke about the public health system as spectators, for instance, they spoke about experiences of people they knew or people they had accompanied to seek SRH in public facilities. Lebogang.Reeva, Nompumelelo and Jade, regarded themselves as privileged because they did not have to go to public hospitals and clinics to seek sexual and reproductive health services. Reeva spoke about an experience where she had accompanied someone else to a public clinic for TOP and she described the public health system as "traumatic" because she says the lines were too long, the nurses were not welcoming, the treatment was demeaning and stigmatizing as they were made a spectacle around other people at the clinic because they were not granted confidentiality and privacy as everyone was aware of why they were there. Reeva's friend could not afford to go to a private institute, therefore, had to accept the

service they were receiving. The patient health care charter states that patients have the right to confidentiality and privacy (Health Professions Council of South Africa, 2006).The socio-economic status of the friend, her age, the place where the clinic was based, and her gender simultaneously contributed to the maltreatment she received.

When asked about their thoughts of their experiences with the health care system, Jade, Lebogang, Nompuemelelo and Reeva, alluded to not being the right people to share experiences with because they felt their experiences do not reflect the South African health care system, since they did not have negative experiences. Reeva and Nompulelo also spoke about the cost of contraceptives, whilst Annalise, Charmaine and Thandiwe spoke about the nurse attitudes and treatment being one of the biggest influences on their decision making regarding contraceptive use.

Heterornomativity promotes patriarchy, for hegemonic masculinity to be dominant there needs to be a constant reassertion through the performance of identities like "women knowing their place" and the control over women's bodily integrity and reproductive justice also asserts male dominance (Mula , 2015). As discussed by Foucault that power is not absolute, it can be interchangeable, this can be seen among the participants, that although they are aware that being a woman often places them in an oppressed position compared to men, they know that rights to contraceptive use and termination give them control over their bodies. The narrative around bodily integrity suggests that the participants have the power to decide what they want to do with their bodies without the influence of men. Even though those that use public health services meet structural hindrances they also have the power to decide without male influence. The consensus among the participants was that informing a partner is merely courtesy but it is not essential.

Patricia Collins, highlights the importance of sharing the lived experiences of women of colour to disrupt the hegemonic discourses around social phenomena (Collins, 2000). She argues that gender

cannot be interrogated without the consideration of race, class, culture and sexuality because all these aspects contribute to the privilege and oppression of people (Collins, 2000). The validity of everyday experiences as part of academic literature is emphasized by many feminist scholars (Boonzaier & Van Schalkwyk, 2011; Butler, 1993; Collins, 2000). They argue that using this black feminist thought to understand black women's experiences is important because it can also be used to understand other forms of oppression of both women of colour and white women (Boonzaier & Van Schalkwyk, 2011; Crenshaw, 1991; Finchilesu, 2006; Hall, 1992; Wyatt, 2008). Intersectionality is concerned with challenging and highlighting oppression. Intersectionality emphasizes the intertwining of different characteristics which form individual and social identities (Crenshaw, 1991).Hegemonic masculinity promotes masculinity but using hegemonic masculinity as a tool of analysis to interrogate power dynamics within interpersonal relations has proven useful as it showed how patriarchy benefited from the oppression of women and the subordination of men who are subordinate to the ideal masculinity (Butler , 1990; Connell, 2016; Hall, 2002; Hoskin R. A., 2019; Jewkes , et al., 2015; Morrell R. , Jewkes, Lindergger, & Hamlall, 2013; Ratele , 2008).

The narratives by participants suggest that hegemonic masculinity is a dominant discourse that impacts daily living experiences, but also proves that power is not absolute because although women are placed at the bottom of the social hierarchy women still resist some hegemony. The participant's perceptions about bodily integrity prove this point as they suggest that women have power and control over their bodies. Literature suggests that other women conceal their contraceptive use to their partners, as the partners do not approve of the use (Ehlers, 2003; Margherio, 2019). Concealing contraceptive use is another form of resistance that gives women the power and privilege to practice reproductive justice.

The participants of the study are all women of colour but the different characteristics that contribute to their identity formation place them in different positions. Their age, socio-economic status, ethnicity, gender, regional area all intersects to either put them in privileged or oppressed positions. These positions are not absolute, those who can afford private health care are in a more privileged position whilst those who cannot are placed in an oppressed position. The narratives of the participants suggest that as they grow and get more educated they gain more power and control over their bodies.

5.1 Findings

5.1.1 Heterosexual hegemony

All of the participants showed an understanding of gender roles within a heterosexual relationship as rules set out by society to govern what females and males should do. A considerable number of them did not ascribe to the heteronormative norms and expectations within society. They discussed their awareness of these roles and expectations, but they also clearly stated where they stand as individuals in relation to the social expectations.

> Okay so what I think is that society has made it normal that there are certain roles that need to be played in a relationship that is assigned to gender particulars, if you are a guy in a relationship or if you are a girl in a relationship and I for one do not subscribe to those ideals or norms because I think at the end of the day before we are any gender which we can also argue that is societally constructed we are also human beings, so if my feelings as a guy is so important then I feel like as a lady in the relationship your feelings should also matter so I feel like society has made it normal that as a woman in a relationship you are less valuable.(Annalise)

There is an understanding that as social beings there are things that people are socialized into and cannot easily separate themselves from. For instance, women were more domesticated than men when they were growing up, so they may be more inclined to do more domesticated things. Although the respondents each claimed that they do not ascribe to gender norms, they also suggest that there are things that happen "naturally" in other words are beyond the influence of hegemonic masculinity. For example, in things like cooking, Reeva states that although she believes in sharing the chores equally amongst her and her partner there are things that feel natural for her to do.

> Then there's things that happen, maybe say "naturally". I tend to be the one who cooks that, for instance, makes meals in the house and that's because in general I want healthy meals secondly and I can make quick meals whereas my husband when he wants to cook if he is cooking mincemeat, he takes up to an hour you see. So, I tend to be the one who prepares our meals…. but with other things, we partner it. (Reeva)

Gender norms have been socially engraved so much that even when there is no external force to ensure they are being followed people tend to follow them. This is clearly shown in Reeva's statement about how other chores happen naturally for her. Although she does not subscribe to the traditional heterosexual gender norms, she still believes that a man should be the one to woo her and should be the one to pay lobola for her, these are traditional expectations that come with the gender scripts. This is due to socialization, how children are brought up is gendered, they are assigned chores according to what gender they are. Females are often more domesticated while males are taught to be aggressive, and their chores are often outside the household.

> I think it comes from the upbringing we have from when we grow up, they instill these different values to girls, girl children and then in boy children and we grow up we these things internalized to say that once you in a relationship well I grew up, for example, a guy would say no when I grew up I didn't clean my mom was taking care of me, my sisters were taking care of me so as a woman in the relationship you must play that same role that you must always be the one who is domesticated you know.(Annalise)

Annalise speaks to how one's socialization translates to one's behavior, the social expectations of girls and boys are different, hence it is easier for Reeva to take on the chore of cooking, rather than

allow her husband who does not have as much training as she does when it comes to domestic chores like cooking. Annalise's statement also shows how social norms and gender roles are engraved within people even though they are not in the same environment as they were before, but their behavior is informed by their socialization. This speaks to how the interrogation of an intimate space can allow a researcher to infer meaning into the social dynamics of the context in which the intimate relationship is found.

There is also discourse around gender inequity, where some of the participants discussed that there is an imbalance that favors males over women. They highlight that women are subordinate to men within relationships and in society at large, which also affects the opportunities that women are afforded.

> There's an imbalance there of course especially for women not especially but particularly for women. There's a power dynamic that is tilted to the side of man which makes it harder for women to have autonomy or have a stance or have much of a voice in the relationships. (Nompumelelo)

Nompumelelo's response suggests that men are given power over women, and the power dynamics put women in a disadvantaged position where women cannot have a say. This also suggests that the opportunities that males and females are afforded are not equal, men are given more opportunities than women. Typically, the woman is expected to obey the male, and if she digresses from these expectations, she is either ridiculed or discriminated against. The ascendency of men over women relates to discrimination against women as one of the participants Annalise highlights that society has made it normal that a man is not monogamous, he can cheat but as a woman, you

must be put together. This puts a double standard because the expectation that women must be put together, warrants the society to discriminate against the woman if she is "not put together". This speaks to the imbalance among genders because it is allowed for a male partner to have multiple partners, but it is shunned when a female partner does the same.

> It's like sort of like made normal that a guy is not monogamous a guy can cheat but as a woman, you must be put together. (Annalise)

In speaking about how society is very accepting of male partners to cheat, Annalise also notes the society has normalized putting women at a lesser value than men in relationships. She states that women are expected to be at the receiving end of all the worst things, they must tolerate cheating and be forgiving. Whilst men are given the agency to say that they don't have to stand something.

The participants also spoke of the other side of the coin, which is the social expectations for men. Men are expected to be superior to women, they are supposed to be providers, to prove their manhood they must always conform to the expectations of hegemonic masculinity. If men do not ascribe to heterosexual norms, then they are not regarded as men.

> The society has its certain rules like this is what men are expected to do and if they do the opposite or if they do something different then we are like are you man enough? (Lebogang)

Lebogang speaks to how gender norms are not only policing femininity but to maintain the heterosexual matrix they also guard masculine behaviors and if there are any deviations, then those individuals are often isolated from the rest. Men are expected to be providers for their families, it is through their ability to provide that they prove their domination. Reeva as a woman who does

not subscribe to the normative heterosexual norms believes that women should also assist the men and put in some effort.

> I don't like the thing where men are always expected to provide and to find out that they go always go above and beyond with a wife that is making demands and stuff I think if we are both budget people. Let's both go to work. So, the financial part should be a fifty-fifty thing right. I mean even if though he earns more which usually happens between me and my husband, but I still feel I should put on something. (Reeva)

Jasmine also agrees with Reeva that people have different capabilities and that if a woman can do what is normally regarded as a 'male chore' or ability and a male can do what is often regarded as a womanly thing to do, she says that if both parties are happy with what they are doing then it should not be dictated by society.

> In general, I don't believe in gender roles, I don't believe that I have to wait for someone for a man to change the light bulb you know so for me I think the fact that we were socialized into believing that the man is the head of the family and you are the neck. (Jasmine)

In speaking about gender equity, the participants also noted that there are roles that you can choose to follow one can take on any role they want so long as they both agree as partners.

> I guess there can't be two bulls in one kraal, but there needs to some sort of equity don't now exercise your power over me because you are male but now I must not exercise my power over you because I don't know whatever reason. I guess I don't believe in gender roles man, whoever is able to do whatever they are doing at that particular moment and moment they may do it. And it must not be a thing of just

> because you are male then you are obligated to pay for our date or just because I am female, I am the one that's responsible for making sure that your food is cooked or whatever. If you want to cook, cook if I want to pay for the date then I will pay for the date period. (Jasmine)

Jasmine acknowledges that there are bound to be conflicts because people are not the same, she argues that instead of the conflicts arising because one wants to use power over the other because of their gender. She contends that rather there should be a common ground and an understanding between partners. This suggests that there will be compromises to make because people do not agree with each other about everything.

5.1.2 Bodily integrity (My body my rules)

All participants noted that an intimate relationship is a partnership, but they also state that as a woman you have a say over your body and what you decide to do with it lies with you. "Personally, no my body my choice kind of thing" (Nompumelelo), she states that her stance is that whatever she does with her body is her concern. Other participants also reiterate this point, for example, Annalise said, "As a woman, it's still your decision because it's your body and you are the person who is going to be carrying the baby and whether the guy wants this or doesn't want that you have to make a decision for yourself."

The respondents emphasized the importance of putting yourself first as a woman. A pattern that emerged among participants is that although they are or were in relationships, their voice as women triumphs that of men because much of the responsibility with hormonal contraceptives lies with them. Therefore, speaking about contraceptive use is a matter of courtesy as the larger responsibility of withholding pregnancy has much greater importance for them because if one falls pregnant it is her who has to pause their life to carry the pregnancy through.

> You can still talk to your partner to say that hey I'm heading to the clinic I want to start using this and I want to double up I don't just want to use pills I also want to still continue using condoms. (Annalise)

Although Annalise in her statement says you can still talk to your partner, it sounds as though she is also agreeing that the conversation with your partner is a courtesy because you are telling him that you are heading to the clinic for this. The male partner is just being told that this is what I am doing with my body and I am doing this to protect both of us but also myself because this will affect me more. There was also a discussion on the dynamics of the "courtesy." Participants felt that they would only speak about their contraceptive use if they were in long-term relationships. In short-term relationships or sexual engagements, they felt no need to let the partner know if they are on contraceptives or not.

> For me, I think it is a me thing it's a decision that I'm making on my own so if it's like something random I don't see the need why I should tell you. I think I will only tell you when I am in like a stable relationship and in like a long-term relationship with someone then I will tell you. (Jasmine)

The dynamics of a relationship also impact how much say a partner has, from the statement above Jasmine points out that a person she engages with on a short-term basis does not influence her, they may not even know if she is on contraceptives or not. However, if she is in a long-term relationship with a person, she can tell him if she is engaging in contraceptives. One participant was set on keeping what happens with her body to herself, when asked if she felt it was important to have a conversation with a partner about her engagement in contraceptive use, she said,

> Personally, no my body my choice kind of thing but a lot of people in relationships do you have these conversations and also depends on your relationship there's always a risk you taking in disclosing to a man you dating especially in heterosexual relationships cause man immediately jumps to the side effects your body's going to be saggy your body's going to be this blah blah or are you cheating on me is this why you are using a …. But if I mean my stance is it's your body your choice you don't have to discuss it with anyone but if you feel like you want to, I don't know people's relationships that's the thing but my stance, is you decide for yourself about your body. (Nompumelelo)

This point also raised the common discourse around contraceptive use where contraceptive use is associated with infidelity, which speaks to the misinformation around contraceptive use in general. Men often assume that women engage in contraceptive use because they have multiple sexual partners, and they are trying to protect themselves from pregnancy. Nompumelelo discusses this in her response, she states that women are taking a risk by telling their partners because partners often respond to contraceptive use with the information they get from their peers and it is usually misconceptions. Annalise also agrees as she points out that there are misconceptions around sexual intercourse and condom use, she speaks of condoms as part of contraceptives she argues that "People often hold 'silly ideas' that sex is not nice without a condom. At the end of the day, there are these notions to say that oh sexual intercourse is not nice with a condom"- (Annalise). Another respondent also talks about the idea of sex not being enjoyable when using a condom, she also states that this is a thought that a sexual partner she had "Prince was like *hayi* I don't like condoms it's destructive". (Reeva)

5.1.3 Growth

This emerged when participants spoke about their experiences with their first intimate partners as well as with previous experience in relationships. They state that previous experiences have taught them lessons that have allowed them to grow and find their voices within relationships. They have grown in terms of asserting themselves and having a voice within a relationship.

> Okay initially I would voice out whatever grievances I had in relation to the relationship…it came to a point where I was internalizing that whole situation and I started suppressing my own voice…so I went back to that so say you know what I am going to start voicing out everything that I want to voice out again and I did that but I can just say in a nutshell it was not always acknowledged and it came to a point where I had to leave because I cannot be in a situation where I have to be suppressed and repressed.(Annalise)

Another participant spoke to this point where she said that having learned about social politics and learning about herself, she has grown to be more assertive and knows when to leave a situation that does not allow her voice to be heard.

> I have grown more I've learned more not only about like the social-political stuff but also about myself so I 'm much better at you know asserting myself I know how to remove myself from situations where I feel like I'm not being heard or I've tried voicing my opinion and it keeps getting ignored or turned into something else but personally I am quite assertive I know when to back up because I know men are most people are set in their ways so sometimes you will express stuff and you realize people don't really care so I am able to also see that like the sense of discernment that I didn't have when I was younger. (Nompumelelo)

From what the participants said this also suggests that at a younger age they put up with whatever the relationship brings for them but after the growth, they know when it is time to leave, and they both said that they now know that when relationships do not allow them the platform to have their opinions be heard then they leave. Annalise said that she is proud to say that she is not as naïve as she was before, which also speaks to the culture of staying in the relationship with the hope that things will change.

> I am definitely proud to say I am not naïve as I was before I am not naïve at all as I was before so I know that I won't suppress myself in any shape or form whatever the case may be, so I think I will be going into a new relationship with a foundation of lessons. (Annalise).

The respondents agreed with each other, as they all stated that their previous relationships taught them lessons that make them more assertive. This also shows that with adequate knowledge and growth individuals make different decisions. The participants for this study are university students therefore they are more knowledgeable about social politics, themselves, their positionalities, and many other things. Meaning that the more knowledge a person incurs the more informed their decisions become. This also denotes that growth is not only physical, but it can also be growth in experience and knowledge.

> It actually opened up my eyes and I was like no in my next relationship there are things that I did that I felt like I was not heard and they never changed and I was still waiting like all know tomorrow he will hear me tomorrow he will change tomorrow this thing will be fixed tomorrow this thing will be fine but then I was like going forward I'm not going to be giving people 10 chances 10 times expecting that, if you're not going to give me the platform maybe let's say or if we're not going to be on the same page then we might as

> well just move forward because there's someone out there who will understand and who will give you those things that you want so like the previous relationship shaped how I went into the next relationship. (Lebogang)

5.1.4 Public health versus private health culture

Forty percent of the participants used public health and sixty percent used private sexual health care services. Although this was the case, all the participants were aware of the public health culture, either from speaking with peers or having accompanied someone to a public health care facility.

> I don't think I've had like a negative, have a negative thing to say about them because when I went to go get my contraceptives for the first time, I spoke to my doctor about it he told me the pros and the cons he was like okay if you want (inaudible) and hence I made a choice not to take the injection and take the pill… I've seen it's amongst a lot of my friends and a lot of my peers that they would rather not go get a morning after all because of the embarrassment of dating someone it's even the same like sometimes I personally would choose to go to a male pharmacist if I want to plan B as compared to going to a female pharmacist you know less side-eyes less embarrassment I guess. (Jasmine)

There is a stigma associated with public health care, especially sexual health care. The sexual health care facilities are not adolescent-friendly, many young females feel like they are being judged for being sexually active.

> The particular nurses that I have encountered because in terms of going to a public clinic I've never had a nurse who was really really welcoming and friendly and just yoh that was informative for me to make an informed decision it was a case of okay these are the options what do you want to take it or leave it kind of situation. (Annalise)

The stigma can act as a barrier for young women who want to engage in contraceptive use because in local rural and township clinics the nurses are people who know your family and they know you. Engaging in premarital sex is taboo in many communities, and a nurse who you know, being aware that you are engaging in sexual activities brings shame to you as an individual but also to your family. For Thandiwe, she could not go to the clinic for contraceptives because the nurse who offers sexual reproductive health care is a family member, so she feared that the nurse would tell her mother about her sexual behaviors.

The negative attitudes towards sexually active adolescents have led to the isolation of adolescents who only come to the clinics when they are pregnant. Thandiwe reported that she only started using contraceptives after giving birth. One could argue that this treatment of isolating adolescents contributes to the high rate of early childbearing because adolescents engage in sex and they are not allowed to choose whether or not they want contraceptives.

Thandiwe stated that the way she was treated at the clinic influenced her decision to discontinue contraceptive use. When asked if the treatment she received at the clinic influenced her decision regarding contraceptive use she answered, “It definitely has, I stopped using contraceptives last year because my last experience with them was awful.” She further says

> Last time I went to the clinic I had a very bad experience, mind you I went there because I had lower back pain. And when the nurse did a urine test, she found out I had an infection.

> First thing she said, ja you guys don't use condoms. That time I didn't even have a boyfriend, I might have got the infection from the toilet. She didn't even ask me *ukuthi* why did it come out positive for infection. (Thandiwe)

The culture of public health facilities has led to participants only speaking about negative experiences. The majority of participants when asked about their experiences with the South African health care system spoke of the negative aspects related to public health care. Although the question was asking about the overall experience of an individual with the health care systems, all the private health care participants responded to this question by pointing out their position of advantage and then sharing negative experiences of other people. For instance, Reeva responded to the question by saying, "eish I am not maybe the right person you know to give you the full picture, the picture that I'll give you is that of a private because everything that I have done in a private hospital." (Reeva) When participants who use public health services were asked the same question, they share their experiences without comparison to private health culture, except Annalise who compared the university clinic to the clinic where she stays. Consequently, participants who use private hospital sexual health services speak of their position as a position of privilege.

> I know the culture in South African Healthcare facilities especially with the medical practitioners when it comes to sexual health stuff, so I know the culture I know the implication of what you're saying. Personally, this is why I'm giving it this way in terms of accessing sexual reproductive health I am much more privileged than the next person I have never had to go to a public hospital to get any of the stuff when I do go to these free clinics it's usually the Wits ones and they have quite open-minded and very well-versed health practitioners who do their job diligently. (Nompumelelo)

Nompumelelo starts by noting her knowledge of the public health culture and then goes on to position herself in a more privileged position. She also notes the spatial differences with public health care facilities, as many in the study did as well. She states that the only public clinic they have been to is the Campus health and wellness center, she points out that they have better services as the health care workers are professional and they do their work diligently. Many other participants agree with her, one states that she is not sure if it's because the clinic is in a more urban area because the public clinic from where she stays is far off compared to the university clinic.

> I've had a better experience at the clinic at uh varsity on-campus way far better experience than going to the public clinic at where I stay and ja I don't know I wouldn't say it's like a private clinic I don't know maybe based on where it's located there are better people I don't know. (Annalise)

Reeva also speaks about the spatial difference of public hospitals. She states that going to the Hillbrow Adolescent clinic was not helpful because of the traffic of patients, had she also stayed she would not have received help, then moved to Parkhurst clinic which was far better, and it is located in the northern suburbs.

> Then I took her to Parkhurst because I used to stay eParkhurst and I know clinic and clinic yase Parkhurst is quite clean. (Reeva)

Charmain is a medical health care student and having practiced in a public hospital I think she is also aware of the stigma around sexual health care and her response was guided by her knowledge of the public health culture. "For me, I haven't had any bad experiences regarding that, and also

the social workers I came across regarding that they were all professional I never felt like I'm being judged or anything". (Charmain)

The private health patients were very confident that they received all the information they required, and they were also offered a variety of options to choose from. Unlike the public health patients who reported that they did not know much about contraceptive methods, they were only offered the available methods. Little or no information was offered to them, only after a couple of visits, and through conducting their own research did they feel they knew better about contraceptives.

> I think from all those experiences going back to refill my contraceptives I've gained bits and bits of information that eventually as time went when I was already far along in my contraceptives journey then I started formulating the idea of what contraceptives are what it will do things like that, so the first nurse that I went to did not give me so much of information it was not really informative it more like okay this is this, that is that which one do you want? (Annalise)

5.1.5 Pros over cons

All participants agree that contraceptives are essential for reducing unwanted pregnancies. They suggest that contraceptive use is protection against pregnancy, especially for young females who are still studying because pregnancy may have consequences like one having to pause with school in order to carry the pregnancy through. Others generally do not want children and contraceptives are essential for them because they do not want a mishap.

> My understanding about contraceptives is that they are measures of preventing unwanted pregnancy. If obviously, you wanted a baby, you wouldn't be taking contraceptives. It's a way of preventing pregnancy and I think that it's very beneficial to people who are not ready to have babies root either financially or emotionally, whatever. (Charmain)

This statement represents a common understanding that all participants have, which is avoiding pregnancy. There are multiple reasons stated, financial stability, emotional maturity, others engaged in contraceptive use after giving birth, while others after pregnancy termination.

> Sometimes you're not even ready to have a baby then engage in sexual activities and you end up getting pregnant and actually failed to raise the child because you don't have the means to raise this child you don't have the partner or your partner doesn't have the means to raise this child because maybe your partner is also studying or they're just not ready to have babies or they don't want to have babies with you or they might leave later on so I think contraceptives really help people to like yes I know what I'm doing is wrong but at the same time can I protect myself from like ruining my life or like ruining whatever I currently have why like entering the sex but at the same time you're protecting your future.(Lebogang)

Contraceptives have their side effects, and these affect people differently, the participants are aware of some of the side effects, and they have experienced some of them, some of which are but not limited to weight gain and mood swings.

> Contraceptives, they bad, if you regard them as bad they also have their own advantages for instance for a person like me who doesn't want a child for 10 years they have worked *kodwa* the unwanted effect is the weight gain, cause now you gain weight and what not for me they doing what I want so I'd rather gain a bit of weight than have a child *kodwa* where or and also they good to regulate cause that is what is happening for me now cause my

> body just changes so now I was using these ones to try and regulate my periods and stuff and it does happen even people with endometriosis where they use them to fix. (Reeva)

Reeva's point about contraceptives shows that they have negative sides to them, others who agree are Lebogang and Annalise. Lebogang said that she does not like the side effects, whilst Annalise said that she has no problem with contraceptives just that at times there are side effects that can be health hazardous but other than that she feels like they are effective. Overall, the participants agree that in their cases the advantages outweigh the disadvantages. The general understanding of contraceptives is that they are useful for avoiding or delaying pregnancy, and that the decision to engage in them lies with the woman as it is her body. 58% of the participants stated that one needs to sit down and think about contraceptives, their advantages, and their disadvantages and if you as an individual feel like you can pros outweigh the cons, the consensus from the participants is that then you can choose them.

5.1.6 Sex and agency

Conversations around contraceptives also speak to sexual intercourse. This theme arose with regards to the objective of the study, which was ensuring that the study does not represent women as victims of their environments without acknowledging their agency. The participants highlighted their agency through narratives about the decisions to engage in sexual activity. As well as in discussions surrounding who has a say when it comes to what happens to their bodies. Many of the Wits female students stated that the decision to engage in sexual intercourse was a decision that they made.

> Nothing influenced me, I just felt like I was ready there was no force I felt like ok I had waited and now even if I whatever that I'm going to do like I have just made up my mind it's not something like or I've been forced into it I'm going to regret it, later on, I was just ready for it. (Lebogang)

As stated in the literature review religion can act as a gatekeeper that polices gender norms. In Christianity, one is not supposed to engage in premarital sex. This was a hurdle for one of the participants but instead of succumbing to the rules and waiting, she and her partner got married.

> I subscribed into the whole Christianity thing…then things changed it was I can only sleep with my husband when after we married right…the marriage, the wedding I mean was rushed because we were like hayi we wanna have sex, yabo. Because if you going to stay, *andithi kukho lanto bana* if you stay for long then you guys might fall into sin you start living together…we were young to get married *kodwa* we wanted to have sex so I'm sorry let's make a plan. (Reeva)

The sense of agency and autonomy, in this case, is that although they followed the rules of religion, they got married at a young age because they wanted to do what they were forbidden from doing and they bypassed it by making themselves and their religious affiliation happy.

However, although the majority spoke about the decision to engage in sexual intercourse others mentioned peer pressure having influenced their decision to engage in sexual activity. Two of the participants mentioned peer pressure but they also stated that they took the decisions, therefore, canceling out peer pressure.

> To be honest for the longest time I must say I thought that my decision was based on the fact that everyone is doing it you know peer pressure You know but then

> later on actually had a conversation about this with one of my friends later on when we spoke about it was more of a me thing more of and I want to do it thing it was a personal choice that I took. (Jasmine)

Annalise also had peer pressure when explaining reasons that influenced her decision to engage in sexual activity, but she goes on to elaborate her concept of peer pressure.

> If I have to be honest looking back at high school and those, during those times when I was making those decisions I can definitely say that peer pressure is something that is real and I did have conversations with my friends, I didn't have conversations with my mom or anyone older whose more family or whatever case may be I started having this conversations around starting to be sexually active with my friends ,friends whom I they knew that at the end of the day the decision is mine so one is pointing a gun at me to say ja ja so peer pressure is real in sense that you do end up making decisions around what you speaking about with your friends but we have to be honest to say that the decision lies with you at the end of the day. (Annalise)

In her explanation of peer pressure, she suggests that conversations influenced her, but the decision lay with her. Whilst Thandiwe also speaks of a similar experience she states that the decision was fully influenced by the urge to fit in with her friends and be able to have things to talk about. She expresses regret for the decision she took of engaging in sex at a young age. As she says

> It was peer pressure, I'm not proud about sexuality active at a young age… all my friends were sexually active, like way before me. They would chat about their weekends and I

wouldn't even comment because I had no clue about what they were talking about. (Thandiwe)

5.1.7 Summary of the findings

There are multiple factors that contribute to decisions that adolescents take regarding birth control. Although there are external factors that contribute to this decision participants have noted that their bodies belong to them therefore, they have the superior say when it comes to what happens with their body. If partners have health concerns relating to the use of contraceptives, then they can share those but the decision lies with the female partner. Much of the discussion around bodily integrity denoted that women are saying that letting a partner know about their contraceptive use is a courtesy. Participants also spoke of growth as an influential factor in decisions they take within intimate relationships. They also spoke about previous relationships as learning experiences.

Using contraceptives as an adolescent can be quite challenging if you are getting the sexual health service from a public health facility. All of the participants spoke of nurse attitudes, and the stigma around being sexually active as an adolescent. Participants who got sexual health services from private care facilities described themselves as privileged compared to their peers, and although they did not directly encounter the ill-treatment by public health care workers, they were aware of the culture, either through accompanying a friend or hearing about the experiences from peers. Although contraceptives have side effects the participants prefer dealing with the side effects rather than getting pregnant.

5.2 Discussion

This study aimed to explore the perceptions of Wits female students on the impact of hegemonic masculinity on their decision-making with regards to birth control. The study aimed to explore the power dynamics within heterosexual relationships and investigate the influence of the South African health care system has on the decisions that students take regarding contraceptive use.

This discussion chapter aims to use the experiences of the students, their perceptions and intersect these with theory and literature to create an understanding of how young females navigate the barriers and dynamics that come with engaging in contraceptive use. In doing this, the study will add to knowledge around contraceptive use in South Africa. The data collected was analyzed and patterns emerged which spoke to the aims of the research, they were then consolidated into themes that have been described in the findings above. The themes will be used in the discussion, together with Judith Butler's theorization of gender and how one can use gender to understand social dynamics.

It became apparent in the interviews that gender roles and norms are understood as being socially constructed, as all participants shared their thoughts on gender roles with reference to society as the guide of how people behave. This was chosen first because it highlights the understanding of gender as a social construct, contextualizing heterosexuality as a hegemony. Heterosexuality is characterized by the subordination of women in relation to men (Hoskin, 2019). It has been established in the literature that South African society is patriarchal and is informed by notions of hegemonic masculinity (Jewkes & Morrell, 2002;Varga , 2003). Gender binaries police and govern gender norms (Butler, 1990). The participants often described gender roles as ‘social rules’ that are there, and society often places various expectations for genders to fulfill. Many of the

participants stated that they do not ascribe to heterosexual gender roles and expectations, but they acknowledged that heterosexual hegemony exists and that it favors men over women.

Heterosexual hegemony requires that women should obey their intimate partners and that the male partners should exert power over women. This expectation is not only limited to public performance but also intimate interactions. Hegemonic masculinity has influenced maintaining the unequal gender relations between men and women (Connell & Messerschmidt, Hegemonic masculnity: Rethinking the Concept, 2005). Hegemonic masculinity informs the actions of social agents, like men, women, healthcare workers, policymakers, religious leaders, and many others. The study uses the theory of hegemonic masculinity as a backcloth that informs how people act, their understanding of their gender identity in relation to their position in society. Hegemonic masculinity as a practice informs not only how men act, but also informs how women act towards other women or men. Connell states that hegemonic masculinity is upheld through repetitive acts (Hoskin, 2019). She also argues that emphasized femininity is essential to preserve male domination within a society. The data set and literature review suggest that health care workers form part of the emphasized femininity because they complement the maintenance of male domination by discriminating against female autonomy. Nurses take on the role of being moral police, judging young females for their engagement in sexual activity, and looking at themselves as adults before they are professionals (Varga, How gender roles influence sexual and reproductive health among South African adolescents, 2003).

Heterosexual Hegemony

In responding to her thoughts about gender roles within heterosexual relationships, Annalise pointed out that these roles are created and maintained by society. In thinking about the roles, she also argues that gender is a social construction. This thought aligns with Judith Butler's theory of

gender performativity, as she argues that gender is delivered through a heteronormative framework in which genuine articulation of femininity and masculinity are engrained within presumed hegemonic heterosexuality (Butler , Gender Trouble : Feminism and subversion of identity , 1990). Heterosexuality then becomes a norm by which social behavior is governed. Annalise contends that society has placed less value on a woman as compared to a man. This speaks to the normative ideal of heterosexuality where men dominate over women. The ascendency of masculinity over femininity legitimizes the discrimination against women, as Annalise stated that "society has made it normal that as a woman in a relationship you are less valuable" (Annalise), the tendency for society to be accepting of women' lives having less value has led to a prominent rise in gender-based violence in South Africa. Butler (2004) states that some bodies are highly protected whilst some do not qualify to be grievable (Butler , 2004). The pattern in the rise of GBV is aligned to the point made by Butler.

Heterosexual norms are used as a tool to maintain heterosexual hegemony, which legitimizes the discrimination against those that are seen as diverging from the norm. This discrimination is also exacerbated by women who also police and discriminate against those that are seen as being outside the spectrum of normative ideals. Hoskin (2019) argues that for male domination to be maintained there should be a complementarity between males and females, women should act according to the social norms (Hoskin, 2019). She defines the femininity that complements heterosexual hegemony as emphasized femininity (Hoskin, 2019). She argues that emphasized femininity contributes to the discrimination against women because it also polices women's behaviors and those that are deemed divergent to normative should be punished to maintain order (Hoskin, 2019). According to this argument then it means that acts like corrective rape which are done against lesbian women are justifiable.

Lebogang' s thought also speaks to how society contributes to the discrimination of individuals that are not 'normal. It speaks to how not only women are policed using gender norms, but men as well. There are certain expectations placed on men in order for them to be recognized as part of the hegemony (Morrell R. , Of Boys and Men : Masculinity and Gender in the Southern African Studies, 1998). Men are expected to be providers, they are expected to be aggressive, they should have sexual prowess, and should exert their masculinity in public and in private (Mathews, Jewkes, & Abrahams, 2014). Lebogang states that when a man does something opposite to what is expected of him, his masculinity is questioned and can be isolated from the rest of the men as he is not 'man enough. The same applies to women when a woman is doing something that is not in place with heterosexual expectations, she is often ridiculed for it (Hoskin, 2019). Some terms are often used to denote discrimination engraved in femininity, such as femmephobia, slut-shaming, slut bashing, misogynoir to name a few. All these terms have been used to refer to women who are not viewed as fitting the category of women within a heterosexual matrix.

It was established from the data set that a large number of the respondents do not ascribe to heterosexual gender norms. Although they made this claim, they also pointed out that there are things that they were socialized into which are now inescapable. Reeva discusses that there are things that she does because they feel natural to her.

According to social expectations, it is a woman's job to cook, and girls are socialized to domestication from a young age. For Reeva, it feels natural to cook because she has had extensive training beyond her husband. After all, when he was growing up, he was socialized differently. How children are socialized is gendered, boys are not raised the same way that girls are raised, and this is also reflected in their adult lives. Annalise also argues that values instilled in children are gendered. The internalization of norms is a result of social expectation, people act according to

social expectations and they repeat these acts so many times that they become so entrenched in one's life they become sort of like second nature. Butler maintains that gender is a continuous repetition of acts (Butler, 1988). She argues that a step to deconstructing gender could be the discontinuation of the acts that maintain male domination (Butler, 1988). The respondents' claims of not ascribing to heterosexual gender norms can be regarded as a step towards displacing gender norms within societies. Various factors contribute to the maintenance of hegemonic masculinity and they cannot all be deconstructed on one. Butler suggests that exploring gender dynamics within a framework that challenges hegemony by acknowledging acts of resistance that can be worked with to develop stronger movements (Butler , 2004).

The heterosexual hegemony is characterized by inequality among men and women (Butler, 1988; Hoskin, 2019). The discourse around gender inequality has been apparent within the data set, respondents speak on the imbalance amongst genders.

The quote by Nompumelelo about an imbalance within genders suggests that women are oppressed by social stratification is they are below men. Feminist theory concluded that women are oppressed by patriarchal norms (Collins, 2000). This quote suggests that men and women are not afforded the same opportunities because of their gender. Women have fewer opportunities than men, and this makes them more prone to violence as they are often economically dependent on men. The economic disparity between men and women also contributes to the maintenance of heterosexual dominance as it ensures that women are subordinate to men. The economic dependency of women on men has led to risky behaviors like transactional sex, for survival (Selikow & Mbulaheni, 2013) . Oftentimes people that engage in transactional sex are young women who get involved with older men. The age gap and the money exchange become a barrier for women as they cannot negotiate

safe sex, the economic advantage is tilted towards men which makes it easier for them to exploit women.

The quote by Nompumelelo captures a lot of the complexities within heterosexual relationships. The power dynamics being tilted towards men and not allowing women autonomy or the capacity to have a voice is very prevalent in hegemonic masculinity. It is imperative for the maintenance of heterosexual hegemony. Hegemonic masculinity is preserved through continuous actions that uphold male power, its preservation has lasted long because for a long time it was not challenged (Morrell, Jewkes , & Lindegger, 2012). Research around hegemonic masculinity suggests that when a man feels like his power is being threatened, he resorts to violence to enforce his power (Mathews, Jewkes, & Abrahams, 2014).

A study by Mathews, Jewkes, and Abrahams (2014) *So now I'm the man: intimate partner femicide and its interconnections with expressions of masculinity in South Africa*, speaks about some of the discourses around hegemonic masculinity and how men conceptualize intimate partner violence against women. This study shows socially women are placed in subordinate positions, and when they challenge the hegemonic masculinity ideals by earning more money than the man or being employed while the male partner is not, they are at risk of being abused (Mathews, Jewkes, & Abrahams, 2014).

Literature on heterosexuality in the South African context has noted the coercive and brutal nature of heterosexual intimate relationships (Shefer & Foster, 2001). GBV is entrenched in gender inequality. The latest statistics showed that there was an increase in calls, an alarming increase of 2,320 national complaints during the first week of the lockdown (Enaifoghe, Dlelana, Abosede, & Dlamini, 2021). This figure was 37% higher than the 87,290 average of cases reported weekly (Enaifoghe, Dlelana, Abosede, & Dlamini, 2021). The increase was exacerbated by the fact that

everyone was at home, so the victims were exposed to the perpetrators more. It has been reported that a high amount of GBV is perpetrated by people close to the victims. GBV is known to be heightened by stressful conditions (Mathews, Jewkes, & Abrahams, 2014) , since it was a lockdown one can conclude that this reason formed part factors that caused the increase. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) construed that GBV incorporates all acts of violence against women including physical, mental, sexual, use of forces or threats and other freedoms they are deprived of (CEDAW, 2017) . Therefore, if men deprive women of their autonomy to fertility regulation it can be regarded as gender-based violence.

5.2.1 My body my rules

Fertility regulation was introduced as a tool to control population growth (Mfono, 2009). Getting approval and consent from a partner for contraceptive use is seen as a key influential factor of whether women will engage in contraceptive use or not (Tuloro, Deressa, Ali, & Davey, 2006). Research around contraceptive use and the factors that contribute to decision-making argue that in many African societies' men have a major influence (Tuloro, Deressa, Ali, & Davey, 2006). This suggests that the right to women's bodily integrity is infringed if the man disapproves of contraceptive use whilst a woman wants to engage. But research also shows that women at times show resistance to this regulation by concealing their contraceptive use to their partner (Margherio, 2019) (Varga, 2002).

The data set shows a shift in the thoughts of women, and their rights relating to contraceptive use. The young women in the study state that the decision of whether one should engage in contraceptive use or not is an individual decision that should be taken by the woman. They state that letting the partner know of their engagement in contraceptive use is courtesy. There were

varying thoughts on whether one should communicate with their partner about contraceptive use, some of the respondents said it is important to let the partner know, but it is not up to the male partner to decide. While others contend that it is an individual decision that females should take alone.

> "Personally, no my body my choice kind of thing but a lot of people in relationships do you have these conversations and also depends on your relationship there's always a risk in taking not disclosing to a man you dating especially in heterosexual relationships cause man immediately to jump to the side effects your body's going to be saggy your body's going to be this blah blah are you cheating on me is this why use a …. But if I mean my stance is it's your body your choice you don't have to discuss it with anyone but if you feel like you want to, I don't know people's relationships that's the thing but my stance, is you decide for yourself about your body". (Nompumelelo)

The participants raised a point of always prioritizing yourself before the male partner. I think this is important to note especially in a country where there is a high prevalence of teenage pregnancy, with many children growing without fathers. Varga (2003) states that principles encompassing male dynamic supremacy give young men and their families autonomy to deny or accept paternity (Varga, 2003). This enforces gender bias, and encourages discrimination against young women who engage in sexual activity, and also allows boys to dismiss fatherhood duties (Varga, 2003). The narratives by respondents from the data suggests that they are aware of the risk of being single parents, and the impact pregnancy may have on them hence they promote the use of contraceptive to protect themselves against pregnancy. This speaks to the common narratives around contraceptive use, where young women frequently express the need to delay pregnancy because

of their age, or because they are not yet financially stable to provide for babies (Abiodun & Balogun, 2009). Another common expression by adolescents is the possibility of being single after pregnancy because young men can escape the responsibility of early childhood bearing but young women cannot as they are the ones who will carry the pregnancy through (Abiodun & Balogun, 2009).

5.2.2 Growth

Within the data set, growth is characterized by knowledge and experience from previous relationships. Research on influence in predicting sexual activity and condom use among adolescents in a South African context suggests that adolescents are more prone to risky sexual behavior with their first boyfriend (Dietrich, et al., 2013). This is because they are inexperienced, and boys may use this as an advantage to coerce their girlfriends into engaging in risky behavior. Varga (2002; 2003) maintains that adolescent relationships are characterized by unequal decision-making between partners, poor dyadic communication about sexual matters, lack of anticipation of intercourse, fear of rejection if behavioral ideals are not met, gender-based differences in the motivation to become sexually involved (Varga, 2003, p. 160). This is consistent with the database although none of the participants reported any sexual coercion it suggests that they may have been prone to be dominated by their partners since they did not assert themselves as much as they do currently. For example, Nompumelelo and Annalise report they are more vocal than in their previous relationships.

Annalise emphasizes her growth by suggesting that she is proud that she is not as naïve as she was before.

5.2.3 Public health versus private health culture

Participants associated public health services with negative treatment in relation to sexual health services for adolescents. The data set had participants who used public health and those that used private health services. They all suggest that public sexual health services are not female adolescent friendly. This aligns with literature around family planning services for adolescents which suggests that the South African public sexual health services are not adolescent-friendly (Coovadia , Jewkes , Barron, Sanders , & McIntyre, 2009; Margherio, 2019;Varga , 2002). There is a stigma associated with adolescent sexual activity (Maharaj & Cleland, 2005). Thandiwe speaks about the treatment at the hospital that led her to stop using contraceptives because of the treatment she got from the nurses at the hospital. When asked if the treatment she received at the clinic influenced her decision regarding contraceptive use she answered, “It definitely has, I stopped using contraceptives last year because my last experience with them was awful.” (Thandiwe)

> She further says, “Last time I went to the clinic I had a very bad experience, mind you I went there because I had lower back pain. And when the nurse did a urine test, she found out I had an infection. First thing she said ja you guys don’t use condoms. That time I didn’t even have a boyfriend, I might have got the infection from the toilet. She didn’t even ask me *ukuthi* why did it come out positive for infection”. (Thandiwe).

Section 7(2) in the South African constitution states that the state should respect, protect, promote, and fulfill the rights in the Bill of rights (Hassim, Heywood &Berger, 2007). According to the public health policy, health care workers should ensure that all individuals are provided with the correct healthcare services in a fair manner (Hassim, Heywood &Berger, 2017). The literature and the narratives of the participants from the data set show the inconsistency between the public health

policy and the public health nurse practices, as they suggest that nurses do not provide services to adolescents because of social beliefs (Abiodun & Balogun, 2009; Coovadia , Jewkes , Barron, Sanders , & McIntyre, 2009; Margherio, 2019; Varga , 2002; 2003).

Maharaj and Cleland (2005) report that in KZN health care workers rejected training on how to administer abortions as they did not want to offer the service (Maharaj & Cleland, 2005). This shows that health care workers carried on the legacy of missionary training which trained them to moralize and save patients (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009). A nurse in (Wood & Jewkes, 2006)'s study shared that in traditional culture it is inappropriate for girls to speak to their mothers about pregnancy or family planning (Wood & Jewkes, 2006). The nurses regard themselves as parents before being professionals (Wood & Jewkes, 2006). Some nurses are relatives of adolescence which means that adolescents cannot go to the hospital because they are publicly engaging in private matters, shaming the family (Wood & Jewkes, 2006). Thandiwe found herself in this position as she could not go for family planning because the person who administers sexual health services at the clinic is her relative.

In contrast to public health services respondents who received sexual health services from private health, facilities reported satisfaction with the service. They pointed out that they received adequate information to make the right decisions relating to contraceptive methods. They also reported that they were offered a variety of options to choose from, unlike public health patients. The culture of the public hospital system and the stigma around providing sexual health services is very common in the South African context, this can be seen with the responses from participants that utilize private services. When asked what their experience with the health care system was,

they responded by first acknowledging the culture of public health and then narrating their own experience.

Nompumelelo goes on to state that she is in a privileged position compared to her peers as she has access to private facilities, Reeva also emphasizes this point in her response about what her experience with the health system has been. “eish I am not maybe the right person you know to give you the full picture, the picture that I’ll give you is that of a Private because everything that I have done.” (Reeva).One other point that was raised by private healthcare users is that contraceptives are expensive, an element that was not part of the public health care users' narratives. This suggests that even if public health patients wanted to change and use private health care they could not unless they can afford it. Coovadia et al. (2009) report that during apartheid more of the health care budget was invested into private health care training, and facilities. Although changes were made post-1994 there are still many loopholes as many hospital facilities are not available in public health facilities (Coovadia, Jewkes, Barron, Sanders, & McIntyre, The health and health system in South Africa :Historical roots of current public health challenges, 2009).

5.2.4 Pros over Cons

This theme was very prevalent among all the participants, where they stated that although contraceptives have side effects like weight gain and mood inconsistencies they would rather have those instead of getting pregnant. Literature around contraceptive use suggests that the most common reason for women to engage in contraceptive use is that young women are trying to delay pregnancy or avoid unwanted pregnancies (Abiodun & Balogun, 2009). The research around contraceptive use and family planning suggests that most of the women who want to avoid

pregnancy are women who are not married and adolescent females (Abiodun & Balogun, 2009). This is consistent with the data set as one out of seven participants is married.

5.2.5 Sex and agency

This theme suggests a shift in literature where women showed their agency in relation to contraceptive use and sexual activity. Margherio (2019) states that literature around contraceptive use views women as victims of their environments, disregarding the fact that there other ways of resistance that are not hegemonic (Margherio, 2019). This aligns with Butler's understanding of oppression, she states that people ought to understand that where there is oppression there is also a possibility for resistance. The participants in my study also agree with this point as they did acknowledge the hegemony of heterosexuality but they also shared their narratives of their agency. For instance, when speaking about the factors that influenced their decision to engage in sexual intercourse, six out of seven reported that engaging in sex was a decision that they made out of their own will. One out of the seven participants reported that their sexual engagement was due to peer pressure from her peers. A common factor that is reported on research around contraceptive use among adolescents (Abiodun & Balogun, 2009; Dietrich, et al., 2013; Jewkes & Morrell, 2002; Maharaj & Cleland, 2005; Margherio, 2019; Varga , 2002). Another narrative that stood out and pointed to an agency is that of Reeva, she stated that after her first boyfriend with whom she had her first sexual interaction, she met her husband. After meeting her husband she subscribed to Christianity which was against premarital sex, so she and her husband decided that they should get married in order to have sex.

> "I subscribed into the whole Christianity thing…then things changed it was I can only sleep with my husband when after we married right…the marriage, the wedding I mean was rushed because we were like hayi we wanna have sex, yabo.

> Because if you going to stay, *andithi kukho lanto bana* if you stay for long then you guys might fall into sin you start living together…we were young to get married *kodwa* we wanted to have sex so I'm sorry let's make a plan". (Reeva)

Research on family planning suggests that religion can act as a gatekeeper or can be used as a tool to police sexual interactions (Dietrich, et al., 2013). Reeva and her husband noticed a barrier between them, and they bypassed it by following the religious way of doing things. All of the participants promote safe sex practices, and through their narratives, they suggest that if their partner is not in agreement with their terms they leave. Annalise states that it is up to the female partner to decide if she wants to engage in risky sexual behavior or not but her as Annalise, she promotes safe sex practices. Her response also suggests that young females are not totally naïve and that they have ways in which they exert their autonomy, like walking away from situations where they feel like they are not heard.

6 Chapter 6

6.1 Conclusion

The study was aimed at exploring how young women navigate the dynamic within intimate heterosexual relationships. It also aimed to explore their navigation with barriers and dynamics related to contraceptive use as young women. The literature showed that the health care system plays a huge role in the impact of decision-making relating to birth control, this study explored how young women from wits navigated with this dynamic.

The study found that there is a sense of awareness relating to gender as a social construct, and the impact of heterosexuality within society. Findings suggest that the public health care system is still one of the biggest challenges that adolescent females face regarding sexual health care. Nurse attitudes are discriminative against sexually active young women.

Although the participants acknowledged the heterosexual matrix and where it places women socially, their narratives suggested resistance. They reported their choice of what happens to their body as a priority, and a decision that solely relied on them, partners can be spoken to but the voice that triumphs when speaking about contraceptive use as they are the ones who are avoiding pregnancy. Sexual engagement and dating currently are different from when they started which is clear in their assertiveness.

Institutions of religion often police gender interactions, Christianity rejects premarital sex and regards it as sin. One of the participants who subscribed to Christianity after having had sex reported that she found a way around this hindrance which was getting married at a young age in order to engage in marital sex. The participants highlighted the importance of contraceptives for

women because men can avoid the responsibility of fatherhood, but women cannot escape pregnancy.

The findings suggest that adolescent females lack information relating to sexual activity and sexual health, and this leads them to getting information from their peers who have little to no experience relating to sexual health and contraceptives. Theory states that adolescent-parental relationship is essential for the promotion of healthy sexual engagements (Abiodun & Balogun, 2009). Annalise reported that she feels she engaged in sexual intercourse impulsively as she had not spoken to her mother or another older family member who is more family oriented compared to her friends. This could have been due to the fact that speaking about sexual activity as a child with your mother is regarded a taboo, therefore speaking to peers is better. These findings suggest that in order to improve sexual health engagement mothers should engage with their daughters from a young age about sexual activity, safe practices, and contraceptive methods. If parents are more welcoming and do not regard sex talk and family planning as a taboo, there may be a decrease in sexually transmitted diseases and teenage pregnancy.

Some participants reported that their first engagement with contraceptive use was after pregnancy. Thandiwe reported that she could not go into family because a relative was providing sexual health services, and since it is regarded a taboo to be discussing sexual health matters, it hindered her from engaging in contraceptive use before pregnancy.

The shift in narrative regarding bodily integrity suggests that with enough knowledge young female can be able to walk away from relationships that do not allow them the platform to express themselves. Knowledge may equip young women to avoid coercive relationships.

The research done with university students where they were reporting on their earlier experiences as adolescents allowed the researcher to see what the changes from when they were adolescent to young adults. The prominent change in growth was experience with previous relationships and more information from health care providers. This shows that there is a need for public health care providers to provide more information to young females about sexual health. Research around contraceptive use suggests that there needs to be more information provided around sexual health from schools and health care facilities (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Dietrich, et al., 2013;Margherio, 2019; Varga , 2002 and Wood & Jewkes, 2006). This study also found that there needs to be more information from schools and health care facilities, which suggests that sexual health should be normalized among adolescents.

Limitations of the research and recommendation for future research

This study was limited with the sample as it involved a small sample of eight participants and seven participants for the data set. The ethnicity of the participants was also limited to black participants. The sample of my study does not fully represent every female at the university of Wits. I would recommend that for future research there needs to be a larger sample, with various other races, ethnic backgrounds, and religion. Another suggestion for future research is that having a sample of both male and female participants may provide a broader understanding of how young females navigate the dynamics and barriers that come with contraceptive use in the South African context.

7

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ANNEXURE A





Demographic information

Please answer the following

Age	
Gender	
Year of study	
Home language	
Religious affiliation	

Interview schedule

1. What do you think about gender roles within heterosexual relationships?
2. Do you believe in the importance for your voice and opinions be heard in a relationship?
3. In your experience do you believe your voice has been heard so far?
4. If so, has that influence how you view relationships?
5. What influenced your decision to be sexually active? How did you know that you were ready to engage in sexual activity?
6. What is your take on contraceptive use? In your own opinion, how do you feel about contraception?
7. Do you feel it is important to have a conversation with your sexual partner about your decision to engage or not engage in contraceptive use?
8. Is your partner's view on the above important? If so please tell me more, if not please explain.
9. What has been your experience with the health care system regarding sexual health services?
10. Do you think your experiences with how the nurses treated you may have an influence on the decision to engage or not to engage in contraceptives?

Annexure B

Dear Madam

My name is Naledi Joyi and I am a master's student in Critical Diversity studies at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project, and I am investigating what the perceptions of the females students of the impact that hegemonic masculinity has on their ability to make decisions about birth control under the supervision Professor Melissa Steyn . The aim of this research project is to find out the personal experiences of young women on birth control, and how they perceive the influence that hegemonic masculinity has on them.

As part of this project, I would like to invite you to take part in an interview This activity will involve you as the responded to answer questions and will take around 60- 90minutes. With your permission, I would also like to record the interview using a digital device.

There will be no personal costs to you if you participate in this project, You will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous as I

will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation in my final research report. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you (optional). The data collected from this research project will be stored in password protected laptop. With your permission the data collected from this research project may be used by other researchers (optional). If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,

Naledi Joyi

Researcher:

Naledi Joyi , 1390351@students.wits.ac.za , 0843528604

Supervisor: Prof Melissa Steyn

Melissa Steyn, Melissa.Steyn@wits.ac.za , 0117174418

Annexure C

TITLE: The role of hegemonic masculinity in the regulation of birth control: understanding Wits female students' perceptions of the impact of hegemonic masculinity in their decision making of birth control

Name of researcher: Naledi Joyi

I, ……., agree to participate in Naledi Joyi's study on what the perceptions of females understanding of the impact of hegemonic masculinity on their ability to make decisions about contraceptives. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
I agree that the researcher may use anonymous quotes in his / her research report	YES	NO

I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO

I understand that my participation is voluntary YES NO

I understand that I have the right to refuse to answer when I am not comfortable YES NO

I have the right to withdraw from the study, and there shall be no penalty for this YES NO

…… (signature of participant)
…… (name of participant)
…… (date)

…… (signature of researcher seeking consent)
…… (name of researcher seeking consent)
…… (date)