

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review undertaken on adolescent mothers' use of contraceptives. According to Polit and Hungler (1997:645), a literature review "involves the systematic identification, location, scrutiny and summary of written material that contains information on a research problem". Polit and Hungler (1997:643) state that a literature review refers to an extensive and systematic examination of books, publications and articles relevant to the research. The purpose is to determine the extent to which theory and research have been developed about the studied topic, identify the definition of concepts and variables already established, examine elements of research used by others, such as designs, methods, instruments and techniques of data analysis that may prove useful in the proposed project.

The purpose of the literature review in this study was to obtain information on adolescent mothers' utilisation of contraceptives. This would familiarise the researcher with the topic and help her to identify gaps and weaknesses in the literature in order to justify the new investigation. The researcher should discover what is known and what remains to be done in the field of study or what could be replicated or which findings might be compared and contrasted with the proposed study. The researcher should see the problem within a broader perspective and evaluate findings and their significance more effectively (Uys & Basson 1991:20). The literature review revealed that considerable research had been done on adolescent mothers and contraceptives but not specifically in the Piet Retief (Mkhondo) area. The literature review will be discussed with reference to the three components of the HBM, namely individual perceptions, modifying factors, and variables affecting the likelihood of initiating action.

2.2 COMPONENTS OF THE HEALTH BELIEF MODEL (HBM)

The literature review will be discussed with reference to the three components of the HBM, namely individual perceptions, modifying factors, and variables affecting the likelihood of initiating action. It should be noted, however, that in this study, the last component of the HBM should concern both the initiation and the maintenance of contraceptive use and not only the initiation of action (Onega 2001:271-275).

2.2.1 Individual perceptions of adolescent mothers that could influence the non-utilisation of contraceptives

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

In a study in South Africa, Mwaba (2000:32) found that 23% of the adolescents indicated that pregnancy was caused by girls seeking to prove their fertility. This perception might encourage adolescents to engage in unprotected sexual intercourse and avoid using contraceptives so as to

prove their fertility. Thus the desire to prove their fertility may have influenced some adolescent mothers' non-utilisation of contraceptives.

Watt (2001:226) found that the belief that condoms are difficult to use and interfere with sexual pleasure was perceived as a barrier to the use of condoms. Adolescents should be educated about contraceptives, including condoms, in a manner that addresses these beliefs. According to Mwaba (2000:33), 50% of the adolescents were ashamed to use contraceptives, 49% feared parental reaction should their contraceptive use be discovered and 43% did not trust contraceptives. Thus adolescents' attitudes of shame for using contraceptives, fear of parental disapproval and distrust in the efficacy of contraceptives all pose possible barriers to adolescent mothers' utilisation of contraceptives to prevent unplanned pregnancies.

Roye and Johnsen (2002:5) found a low level of awareness about ECs. In their study in the Gauteng Province of the RSA, Ehlers et al (2000:48) indicate that 68% of the adolescent mothers did not know about the availability of ECs. This means that in order to improve contraceptive use by adolescents, awareness campaigns, pamphlets and education should be used to inform adolescents about the availability of all methods of contraception, including EC. Although EC cannot replace the effective use of contraceptives, it can help to reduce the number of unplanned pregnancies as well as the demand for TOPs.

In a study in the USA, Paikoff (1990:480) found that although all the participants had heard about contraception, 77% stated that they did not know about contraceptives before their pregnancies, and only 20% were informed about contraceptives at the clinics during their pregnancies. Lack of knowledge was found to be an obstacle to the use of contraceptives. In Uganda, Hulton, Cullen and Khalokho (2000:35) found that adolescents' perceptions of the risks of sexual activity and their consequences indicate a lack of knowledge of contraceptives and in Punjab, Pakistan, Casterline et al (2001:95) report a lack of knowledge as an obstacle to contraceptive use.

Adolescents should be knowledgeable about different methods of contraception before pregnancy in order to feel safe and decide to use them effectively. This knowledge might help to reduce the number of adolescent mothers. Buga, Amoko and Ncayiyana (1996:526) analysed sexual behaviour and contraceptive practices among school adolescents in a rural area of the Transkei region of the RSA and found that only 23,5% of sexually experienced girls had never used any modern method of contraception. According to Ehlers (2003c:7) out of 250 respondents in the RSA, 85 (34%) did not know about contraceptives before their pregnancies. In the Kriel area of the MP, 31,34% and in the Gauteng Province, 34,23% did not know about contraceptives although contraceptives were available free of charge at clinics in all these areas throughout the RSA (Ehlers 2003b:20; Ehlers et al 2000:48).

2.2.2 Modifying factors that could influence adolescent mothers' non-utilisation of contraceptives

The modifying factors that could influence adolescent mothers' non-utilisation of contraceptives include demographic factors, such as age, gender and educational status, and cultural/traditional beliefs and/or practices.

2.2.2.1 Age

The ages of adolescent mothers could be important in identifying the high-risk age groups in order to make concerted efforts to provide such age groups with appropriate health education opportunities. Adolescents might not use contraceptives out of ignorance and the unavailability of contraceptives, for example (Buga et al 1996:523). The adolescents' ages might influence their decisions to engage in sexual intercourse and contraceptive non-utilisation. Belfield (1998:31) maintains that if sexual and relationship education is started at an early age, prior to teenagers' sexual debut, such knowledge could help adolescents to delay their first sexual encounters. Adolescents need knowledge about contraceptives before sexual activities commence in order to prevent unplanned pregnancies and reduce the number of adolescent mothers, or at least

postpone the birth of the first child. While an adolescent mother aged 19 might be able to care for a newborn infant, an adolescent aged 16 or younger might be less able to do so. Thus postponing childbirth could help adolescent women to improve the quality of their own as well as their children's lives.

2.2.2.2 Race

The Concise Oxford Dictionary (1995:1128) defines race as "each of the major divisions of humankind, based on particular physical characteristics; racial origin or the qualities associated with this; a group of people sharing the same culture, language, etc". The literature review revealed no racial factors, specific to race, which could contribute to adolescent mothers' non-utilisation of contraceptives.

2.2.2.3 Gender

There might be gender differences in sexual knowledge, attitudes and behaviour among adolescents. Adolescent males might be willing to participate in reproductive choices but could be at a disadvantage compared to their female peers. Adolescent girls and boys might need interventions that could improve their sexual knowledge and skills, clarify attitudes and beliefs, and enhance discussions and negotiation skills (Watt 2001:227). Adolescent males and females should receive the same information about contraceptives and reproduction. Male adolescents should also be able to control reproductive opportunities by using male condoms to prevent unwanted pregnancies. However, the present study focused only on adolescent mothers.

2.2.2.4 Educational status

Adolescents who lack general education might lack knowledge about contraceptives because they might be unable to understand the relationship between menstruation, coitus, fertility and conception (Mwaba 2000:31). Information about sexual and reproductive issues presented in pamphlets and

posters might be read and understood only by educated adolescents. Poverty, lack of education, and inadequate family support could contribute to a lack of adequate prenatal care, which might account for some of the negative health outcomes for adolescent mothers and their children (Greydanus, Patel & Rimsza 2001:1). Lack of education could impede adolescents' comprehension of important information. Health care providers should help adolescent clients to understand and personalise information about reproductive health issues, including contraception (Hatcher et al 1997:3-2). Persons' levels of education affect their ability to make informed decisions and could impact negatively on their awareness of their rights and choices, affecting not only their own but also their children's future.

2.2.2.5 Social psychological issues

Social values, beliefs and practices influence decision-making about the use of contraception. Some beliefs are beneficial and others are not. Adolescents are influenced by socio-psychological variables in deciding about initiating sexual relations and contraceptive use, possibly allowing their individual perceptions to be greatly influenced by their peers' influence and expectations.

Adolescence is a time of increased need for acceptance and support from others. The qualities that make up an adolescent should be improved through education. According to Meekers and Klein (2002:335), communication programmes should aim to increase adolescents' self-efficacy, particularly in terms of their perceived ability to convince partners to use condoms and use them correctly. According to the Adolescent Sexual and Reproductive Health Rights document (RHRU 2000:44-46), adolescents should be fully informed about their sexual and reproductive health rights. The guidelines (RHRU 2000:44-46) stipulate that adolescents are entitled to the right to

- a full range of accessible and affordable SRH services
- privacy during service delivery

- be treated with dignity and respect during service delivery
- be assured that personal information will remain confidential
- be given an explanation of the processes that they will go through during service delivery
- be treated by people who are trained and knowledgeable about what they do
- continuity of services
- be treated by a named health care provider
- express views on the services provided and complain about unsatisfactory health services
- a healthy and safe environment
- gender equality
- sexual orientation, experience and pleasure, implying the right to
 - * make their own decisions about sex
 - * express him/herself in his/her own way
 - * enjoy sex
 - * abstain from sex
 - * choose to marry or not to marry
 - * choose whether or not to have children
 - * be accepted and respected for whom they are (RHRU 2000:46).

Given these rights, adolescents should have strong personalities and be responsible, take pride in their abilities, and make informed decisions on sexual and reproductive issues, including the decision to use contraceptives effectively to avoid unplanned pregnancies.

2.2.2.6 Cultural/traditional factors

Ethnic background, socio-economic class, educational level, religious affiliation and local community standards are interdependent and interrelated factors in shaping adolescents' sexual ideas and behaviours (Nass & Fisher 1988:86). Adolescents from different cultural backgrounds or traditions might be influenced by different factors, or by the same factors but to different extents, not to use contraceptives.

According to Kaufman, De Wet and Stadler (2001:147), educated girls tend to fetch greater bridal wealth (known as *lobola* in many South African traditional cultures), which may encourage parents to support their daughters' schooling, and perhaps their return to school following childbirth. However, encouraging their daughters to use contraceptives in order to complete their schooling prior to childbearing could be problematic for many parents, especially those living in traditional communities.

Cultural/traditional factors could pose a hindrance to adolescents' utilisation of contraceptives, leading to unplanned pregnancies. The focus of this study was on adolescents, mostly Zulu-speaking adolescents. Culturally, Zulu women are expected to have as many children as possible. Williams and Mavundla (1999:59) state that parents are in a dilemma between upholding the traditional and cultural values at the expense of their daughters' rights to access and utilise contraceptives in order to postpone childbearing. Adolescents might share the same dilemma in many traditional societies regarding cultural/traditional factors, requiring them to have as many children as possible, and their right to use contraceptives in order to postpone childbearing until they have completed their schooling and/or become financially sufficiently independent to care for their children.

Campbell (1997:186) maintains that for many sub-Saharan Africa (SSA) communities, negative attitudes towards condom use is based on cultural factors, including the desire for more children and female sexual compliance to enhance their economic status and/or increase the parents' perceived social security for their old age (by having many children to care for them when they are old).

2.2.2.7 Economic factors

The status of women in African societies varies from culture to culture and even from village to village. Women of inferior status cannot and do not make decisions affecting their own lives.

Therefore, uneducated poor women, dependent on their husbands for their livelihood, cannot oppose their husbands' wishes concerning the number of children, being at risk of losing their only source of financial support for themselves and their children (Ehlers 1999:52). Because adolescent mothers are still dependent on their parents, they are also affected by the same socio-economic considerations as their mothers, possibly contributing to the non-utilisation of contraceptives by adolescent women.

According to Buga et al (1996:526), in many rural settings in the RSA, adolescent pregnancies might be generally accepted, tolerated and even connived at by society. Lack of housing and recreational facilities in villages could cause adolescents to channel time and energy into sexual activities rather than into sports and recreation like adolescents from other socio-economic groups do (Williams & Mavundla 1999:59).

Couples with fewer children are better able to provide them with enough food, clothing, housing and schooling (Hatcher et al 1997:2-21). Adolescents from large families, with low levels of education, engaging in sexual activities without using effective contraceptives, however, perpetuate the cycle of poor families, limited education, overcrowding and adolescent pregnancies. Adolescent women with sufficient knowledge, parental support and access to contraceptives can ensure a better future for themselves and their children.

Adolescents feel comfortable with their peers on whom they can rely and whose judgements are respected. Many adolescents are unable to resist peer pressure because of the need to conform and belong to a group. Adolescents require help to develop skills in deciding whether to follow their own or a group's choices, as well as ways to cope with the consequences of their choices (Nass & Fisher 1988:97). According to Onega (2001:813), teenagers are more likely to be sexually active if their friends are sexually active. Both young men and women might think that being pregnant verifies an adolescent girl's love and commitment to her male partner or boyfriend. Williams and Mavundla (1999:59) state that some teenage mothers were intimidated and told that if they did not engage in sexual intercourse they would become sick or crazy. Olivier, Myburgh and Poggenpoel

(2000:219) state that friends play an important role in adolescents' sexual behaviours. Health education should stress the consequences of adolescent sexuality and childbearing in order to empower them to resist peer pressure encouraging sexual activities and resulting in adolescent pregnancies. Even if adolescents should decide to engage in sexual activities, they should be knowledgeable about and have access to contraceptive services and contraceptives of their choice. Adolescents, like adults, should be enabled to decide if and when they should have children and be empowered to avoid unplanned pregnancies by effectively utilising contraceptives.

2.2.2.8 Structural variables

In terms of the HBM, lack of knowledge is the major structural variable affecting the non-utilisation of contraceptives by adolescent mothers. Adolescents need knowledge about different types of contraceptives and the ways in which different contraceptives prevent unplanned pregnancies in order to be able to make informed decisions and take actions to use contraceptives effectively. For the purposes of this study, contraceptives are divided into modern contraceptives, meaning all contraceptives provided by the formal health care services, and traditional contraceptives, encompassing all methods used traditionally to prevent unplanned pregnancies, including any prescribed medications and/or methods prescribed by traditional healers of any designation.

2.2.2.8.1 Modern contraceptives

The following modern contraceptives will be discussed: barrier methods, oral contraceptives and injections.

◆ Barrier methods

Barrier methods of contraception include methods that physically and/or chemically prevent pregnancy by blocking the passage of sperm into the uterine cavity (Kasner & Tindall 1985:47). All barrier methods are used locally within the male or female genitalia and thus have no related

systemic side effects. Condoms, spermicides, diaphragms and cervical caps are types of barrier methods. Male and female condoms are the only barrier methods available in the MP public health care services (free of charge). A condom is a contraceptive sheath worn by the male or inserted into a woman's vagina to protect both partners against sexually transmitted diseases (STDs) and pregnancy (Hatcher et al 1997:11-13; Kasner & Tindall 1985:94).

Condoms help prevent both pregnancy and STDs, including HIV/AIDS. Ehlers et al (2000:49) found that 24,32% of the adolescent mothers who participated in their study indicated that they would use condoms because they would protect them against pregnancies and STDs, subsequent to the birth of their babies. However, these adolescent mothers failed to use condoms effectively to prevent their previous pregnancies.

◆ **Advantages of condoms**

Hatcher et al (1997:11-15) and Sapire (1995:1081) state that condoms have the following advantages:

- Prevent STDs, including HIV/AIDS, as well as pregnancy, when used correctly with every act of sexual intercourse.
- Protect against conditions caused by STDs – pelvic inflammatory disease, chronic pain, possibly cervical cancer in women, and infertility in both men and women.
- Prevent STDs during pregnancy.
- Are suitable for use after childbirth.
- Are safe because no hormonal side effects are incurred.
- Help prevent ectopic pregnancies.
- Can be discontinued at any time.
- Offer occasional contraception with no daily upkeep.
- Are easy to keep on hand in case sex occurs unexpectedly.
- Can be used by men of any age.

- Can be used without consulting a health care provider.
- Are usually easy to obtain and sold in many places.
- Enable a man to take responsibility for preventing pregnancy and disease.
- Increase sexual enjoyment because there is no need to worry about pregnancy or STDs.
- Help prevent premature ejaculation.
- Female condom is controlled by the woman.
- Condoms can be acquired without prescription and are obtainable from local clinics, hospitals or bought from pharmacies, supermarkets or sex shops (Hatcher et al 1997:11-15; Sapire 1995:1085). Female condoms might not be readily available from health care services and are relatively expensive.

Health care providers should emphasise that it is important to use condoms correctly every time for effectiveness.

In 1997 the female condom became available at public and private sources in the USA and in many European countries (Hatcher et al 1997:11-17). In a survey of condom use among Ethiopian students, Kidan and Azeze (1995:9) found the following reasons given for not using condoms: unavailability of contraceptives (44,3%), partner trust (43%), shortage of condoms (8%) and partner disagreement (5,1%).

The following disadvantages of condoms should be indicated to condom users in order to adhere to correct practice (Hatcher et al 1997:11-16):

- Latex condoms may cause itching for a few people who are allergic to latex. Also, some people may be allergic to the lubricant on some brands of condoms.
- May decrease sensation, making sex less enjoyable for either partner.
- Couple must take the time to put the condom on the erect penis before sex.
- Supply must be ready even if a woman or man is not expecting to have sex.
- There is a slight possibility that condom will slip off or break during sex.

- Condoms can weaken if stored too long or in too much heat, sunlight, or humidity, or if used with oil-based lubricants – and then may break during use.
- A man's cooperation is needed for a woman to protect herself from pregnancy and disease.
- Poor reputation. Many people connect condoms with immoral sex, sex outside marriage, or sex with prostitutes.
- It may embarrass some people to buy, ask partner to use, put on, take off, or throw away condoms.

Health care providers must teach all adolescents about the advantages and disadvantages so that they can use condoms correctly at all times. Leaflets or guidelines on how to open a condom, including the steps of using it effectively, should be included in all condom packs. All health care providers should be willing to demonstrate condom use to every client, including adolescents.

◆ Oral contraceptives

An oral contraceptive is a hormone preparation taken by women to inhibit conception (Kasner & Tindall 1985:278). Women who use oral contraceptives swallow a pill daily to prevent pregnancy. They are very effective in preventing pregnancy when taken regularly every day, and are safe for most clients. There are two types of oral contraceptives: combined oral contraceptives (COCs) and progestogen-only pill (POPs). COCs contains both synthetic progestogen and oestrogen whereas POPs contains only progestogen (Hatcher et al 1997:5-23).

Oral contraceptives have been proved to be effective in controlling pregnancy when taken correctly and consistently, that is, at the same time every day, and do not interfere with sexual intercourse (DOH 1999:78; Hatcher et al 1997:5-54; Theron & Grobler 1998:36). According to Ehlers et al (2000:49), some adolescent mothers preferred using contraceptive pills because they were familiar with pills and they continued to menstruate regularly while using contraceptive pills.

◆ Contraceptive injections

The two types of contraceptive injections are Depo Provera and Nur-Isterate. These are progestogen-only injections, which contain a synthetic progestogen administered by deep intramuscular injection. Depo Provera is given every three months and Nur-Isterate every month (Hatcher et al 1997:7-73). In the RSA, approximately 66% of all family planning clinic clients use contraceptive injections (Theron & Grobler 1998:59). Ehlers et al (2000:49) indicate that 62,16% of the adolescent mothers who participated in a study in the Gauteng Province would use contraceptive injections after the birth of their babies, mainly because they believed that contraceptive injections were effective, they did not need to take pills every day, and neither their partners nor their parents would need to know that they were using contraceptive injections.

◆ Intra-uterine devices

The intra-uterine device (IUCD) is a contraceptive device introduced into the uterine cavity (Kasner & Tindall 1985:212). It is usually a small, flexible plastic frame. It often has copper wire or copper sleeves on it and is inserted into a woman's uterus through her vagina (Hatcher et al 1997:12-13). Most brands of IUCDs have one or two strings, or threads, which hang through the opening of the cervix into the vagina (Hatcher et al 1997:12-13; Theron & Grobler 1998:28). Copper reportedly inhibits fertilisation and/or implantation from occurring.

◆ Emergency contraception

Emergency contraception (EC) is the use of a contraceptive method in the first few days following an episode of unprotected sexual intercourse – before pregnancy begins – in order to prevent, or reduce the risk of an unwanted pregnancy (Hatcher et al 1997:5-20). EC can be used at any time of the menstrual cycle after the occurrence of unprotected sexual intercourse. ECs should not be used in the place of contraceptive methods. Hatcher et al (1997:5-21) emphasise that ECs should be used only in an emergency, for example:

- A woman has had sex against her will or has been forced to have sex (rape).
- A condom has broken.
- An IUD has come out of place.
- A woman has run out of oral contraceptives, has missed two or more POPs, or is more than a few weeks late for a Depo Provera injection and has had sex without using another contraceptive.
- Sex took place without contraception, and the woman wants to avoid a pregnancy.

Knowledge about, access to, and the use of EC can prevent many unwanted pregnancies following unprotected sexual intercourse. It may be an especially useful method for young people, because in this group sexual activity might often be unplanned, sporadic and thus, may be unprotected. Two types of safe and effective EC methods are available:

- Hormonal, emergency contraceptive pills (ECPs) taken within 72 hours of unprotected intercourse.
- Copper containing IUCD, inserted up to 120 hours (5 days) after unprotected sexual intercourse (RHRU 2002:8B.1.1). Emergency contraception is a safe and highly effective method of preventing accidental pregnancy after unprotected intercourse or a contraceptive failure (Kubba 1997:104; Quinn 1999:39).

◆ Termination of pregnancy

In November 1966 the Choice on Termination of Pregnancy (CTOP) Act, 92 of 1996 was introduced, making provision for women to request termination of pregnancy services prior to 12 weeks' gestation. A pregnant adolescent should not be required to give any reasons for wanting to have a pregnancy terminated before 12 weeks' gestation. In terms of the CTOP Act, a termination of pregnancy (TOP) after 12 weeks' gestation can be obtained under specific conditions, provided that at least one of the following conditions be met:

- the continued pregnancy would pose a risk of injury to the woman's physical/mental health

- there is a substantial risk that the foetus would suffer a severe physical/mental abnormality
- the pregnancy resulted from rape or incest
- the continued pregnancy would significantly affect the social or economic well-being of the woman

In terms of the CTOP Act (RSA 1996b), terminations of pregnancies are also available from 20 weeks to term, providing a medical practitioner, after consultation with a registered midwife, is of the opinion that continued pregnancy would:

- endanger the life of the woman
- result in severe malformation of the foetus
- pose a risk of injury to the foetus

In Tshwane, Ehlers and Maja (2003a:21) found that out of 61 adolescent mothers, 19 (31,15%) did not know about TOP services. Ehlers et al (2000:49) indicate that 42,34% of adolescent mothers did not know about legalised TOP services and a further 25,22% felt they would have used these services if they could be accessed. TOP is not a form of contraception but a mechanism for dealing with unwanted pregnancy. The decision to have or not to have children is fundamental to the physical, psychological, and social health of women (Act 92 of 1996).

2.2.2.8.2 Traditional contraceptives

The following traditional contraceptives will be discussed: abstinence, coitus interruptus and other traditional methods.

◆ **Abstinence**

Sexual abstinence is the most effective method of contraception without physiological or psychological effects. According to Theron and Grobler (1998:18), it is unpopular but common among young people, widows, widowers and divorcees.

◆ **Coitus interruptus**

This is the withdrawal of the penis without orgasm and without ejaculation during sexual intercourse. Theron and Grobler (1998:18) estimate that 50% of couples in Western countries occasionally use this method of contraception. Adolescents need thorough education and insight before deciding to use this method. Although this method can be used safely by some couples, the risk of an unplanned pregnancy remains because if a drop of semen leaks into the vagina (which can occur prior to ejaculation), or if the ejaculate is deposited near the introitus, conception can occur.

◆ **Other traditional methods**

Traditional methods for the prevention of pregnancy include herbal mixtures. There has been little research on and documentation of the traditional methods used by the different cultural groups in South Africa. Health care providers should be aware that clients might be using a variety of traditional contraceptives, specific to their areas. Wood and Jewkes (2000:11) describe the following traditional contraceptive methods: tying a rope soaked in traditional medicines around the waist; burying a soiled sanitary pad until conception was desired, and drinking strong coffee or tea or medicines after coitus. Vlok (2000:360) lists the following traditional or folk contraceptive practices: prolonged lactation; vaginal douching after intercourse; drinking 'lewensessens' (a traditional Dutch folk medicine available from pharmacies, supermarkets and general stores), and inserting cotton wool soaked in oil or vinegar into the vagina prior to intercourse.

According to the RHRU (2002: unit 9:16), when clients admit that they use traditional methods of contraception, health care workers should do the following:

- Respect the client's freedom of contraceptive choice.

- Avoid being critical and/or judgmental.
- Determine the client's intentions about future pregnancies.
- Identify whether the pregnancy would be expected to fall into the high risk category.
- Determine whether the client presents as a high-risk for exposure to STI/HIV infection.
- Identify exactly which traditional methods are being used.
- Discuss research findings with the client. While many traditional methods are harmless, they have unproven or doubtful efficacy; for example, the string or band worn around a woman's waist to prevent pregnancies. Traditional methods of contraception should not be dismissed derisively. Clients should be informed about their doubtful efficacy and about suitable, effective contraceptive methods that are available free of charge at the clinics.
- Actively discourage harmful contraceptive practices, such as the use of quinine.
- Discuss the potential risk of mother-to-child transmission of HIV via breastfeeding, and offer alternative appropriate contraceptive choices.
- If the traditional method being used is fairly effective when used correctly, and the client is not a high-risk for STIs/HIV, emphasise how to use the method most effectively. In addition, provide information about modern contraceptive methods and the risk factors for STI/HIV infection. Invite the client to return to the clinic if she wants more information, wishes to use a modern contraceptive and/or her risk status for STI/HIV changes.

The following traditional methods were covered in the questionnaire used to collect data in this study, in order to verify whether or not the adolescent mothers in the Piet Retief (Mkhondo) area used traditional contraceptives:

- tying a rope around the waist
- mixing medicines with menstrual blood
- drinking traditional medicines.

2.3 VARIABLES AFFECTING ADOLESCENT MOTHERS' LIKELIHOOD OF INITIATING AND MAINTAINING ACTIONS TO USE CONTRACEPTIVES

Perceived benefits and barriers have an impact on adolescents' decisions to initiate and maintain the utilisation of contraceptives to avoid unplanned pregnancy.

2.3.1 Perceived benefits of contraceptive utilisation

Adolescent mothers should be informed about the benefits of contraception. Fathalla (1997:64) states that contraception is the woman's power to control her fertility and be able to complete her education, maintain gainful employment and make independent marital decisions. The use of contraceptives saves women's lives and improves their health by allowing them to prevent unplanned pregnancies. Lives are saved from high-risk pregnancies or unsafe abortions. Effective use of condoms can prevent maternal deaths, cancers and STIs, including HIV/AIDS. By delaying childbearing, through the use of effective contraceptives, adolescent mothers would be acting in the interest of their future children because infant mortality rates are reportedly higher for babies born to adolescent mothers than for babies born to women in their twenties or thirties (Greydanus et al 2001:1).

Contraceptive use saves children's lives by allowing individuals and couples to delay and space births thereby providing greater opportunities for emotional support from the parents for each child. In addition, the parents are able to provide for each child's physical needs and so help each child to attain his/her maximum potential in life. Contraceptive use also helps men to provide better lives for their families with less emotional and financial strain than with having to provide for a large family. Contraceptives provide parents with the freedom to choose when to have children and how many children to have at what intervals (Hatcher et al 1997:2-21).

2.3.2 Perceived barriers to the utilisation of contraceptives

Often, the major barriers adolescent mothers encounter that influence their non-utilisation of contraceptives are negative staff attitudes at clinics as well as the accessibility and affordability of contraceptives.

2.3.2.1 Staff attitudes

Health care providers' refusal to give adolescents contraceptives has been reported in the RSA. In a study on adolescents and contraceptive utilisation, Woods, Maepa and Jewkes (1998:26) state that adolescents reported that nurses would not give them contraceptives before asking about their sexual relations and lecturing to them on being too young to have sex.

According to Little (1997:44), intimidation by staff resulted in under-utilisation of clinics by teenagers. Theron (1999:63) emphasises that positive attitudes are an important component of any programme to improve the quality of care rendered. Effective staff attitudes are crucial for improving the quality of care rendered to adolescents. Knowledge about contraceptives and adolescents' reproductive rights constitute the basis on which contraceptive service providers should function effectively (see section 2.2.2.5).

2.3.2.2 Accessibility and affordability of contraceptives

Access to health care services for adolescents also affects the utilisation of contraceptives. Distances from the nearest clinics and payment for transport sometimes prevent adolescents from travelling to health care services for contraceptives and information. Most adolescent girls are financially dependent on their parents who might be unable to pay for transport to clinics. Richter (2000:76) stresses that according to the principles of primary health care, a health service should be accessible to its users (in this case, adolescent women). The service should be within a reasonable geographic distance and be functional in terms of the needs of adolescents. Accessibility could also be improved by rendering services on Saturdays. Contraceptive services could be located at schools, clinics or community centres accessible to adolescents (Richter

2000:81). Reproductive health care services at government institutions are free of charge but to improve access to adolescents, the services should be accessed by everyone, irrespective of sex, age, creed, colour, marital status, disability or any characteristic that puts individuals at a disadvantage. Services should be provided in a respectful, non-judgmental and unbiased way (RHRU 2000:88).

2.4 CONCLUSION

This chapter discussed the literature review undertaken on adolescent contraceptive utilisation with reference to the main components of the HBM. The literature review covered adolescent mothers' individual perceptions about contraceptives, modifying factors which could contribute to adolescent mothers' non-utilisation of contraceptives, and variables affecting the likelihood of adolescent mothers' utilisation of contraceptives to prevent unplanned pregnancies.

Chapter 3 describes the research methodology adopted to study factors contributing to adolescent mothers' non-utilisation of contraceptives.