

ADOLESCENT MOTHERS' KNOWLEDGE AND PERCEPTIONS OF CONTRACEPTIVES IN TSHWANE, SOUTH AFRICA

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ABSTRACT

This descriptive quantitative survey attempted to identify reasons why adolescent mothers (aged 19 or younger at the birth of their babies) failed to utilise contraceptive, emergency contraceptive and/or termination of pregnancy (TOP) services. The research population comprised all adolescent mothers in the region, the accessible convenience sample consisted of all adolescent mothers who visited Tshwane's Metropolitan Council clinics from 1 January till 31 March 2000, and who were willing to complete questionnaires, designed and tested during a joint World Health Organization and Commonwealth Reproductive Health Workshop in Harare, Zimbabwe, during 1998. During pretesting, 12 questionnaires were completed by adolescent mothers who were excluded from the actual study. This report refers to data (analysed with the Epi-Info program) obtained from 61 completed questionnaires. Only a minority of these 61 adolescent mothers earned sufficient money to sustain themselves and their babies. In spite of these unfavourable financial circumstances, only 23 (37.7%) had used contraceptives prior to conception. None of them used emergency contraceptives and none accessed termination of pregnancy services. Although all these services are available free of charge in the region, these adolescent mothers did not use them. The adolescent mothers required more knowledge about contraceptives, emergency contraceptives and TOP services, and they need to perceive these services as being accessible and safe before they could utilise them effectively. Clinics providing these services should be open over weekends and during evenings so that adolescents can obtain contraceptive services without fear of meeting their mothers, aunts or teachers at these clinics. Reproductive health clinics should also strive towards providing more adolescent-friendly services.

OPSOMMING

Hierdie beskrywende kwantitatiewe opname het gepoog om redes te bepaal waarom adolessente moeders (wat 19 jaar oud of jonger was tydens die geboorte van hulle babas) nie gebruik gemaak het van kontrasepsie (voorbehoedmiddels) of noodkontrasepsie, en/of terminasie van swangerskap ("termination of pregnancy - TOP") dienste nie. Die navorsingspopulasie het bestaan uit alle adolessente moeders in die streek, die bereikbare gerieflike steekproef het bestaan uit alle adolessente moeders wat die Tshwane Metropolitaanse Raad se klinieke van 1 Januarie tot 31 Maart 2000 besoek het, en wat bereid was om vraelyste te voltooi. Die vraelyste is ontwerp en getoets tydens 'n gesamentlike Wêreld Gesondheids Organisasie en Statebond Voortplantingsgesondheidswerkswinkel in Harare, Zimbabwe, gedurende 1998. Tydens die voortoetsfase is 12 vraelyste voltooi deur adolessente moeders wat nie aan die werklike studie deelgeneem het nie. Hierdie verslag verwys na die data (ontleed met behulp van die Epi-Info program) wat verkry is uit 61 vraelyste wat in die Tshwane-omgewing voltooi is tussen 1 Januarie en 31 Maart 2000. Slegs enkele van hierdie 61 adolessente moeders het inkomstes gehad wat voldoende was om hulleself en hulle babas te onderhou. Ten spyte van die ongunstige

finansiële omstandighede, het slegs 23 (37.7%) enige kontrasepsie gebruik voor hulle swangerskappe. Niemand het noodkontrasepsie gebruik nie en ook nie terminasie van swangerskap dienste nie. Alhoewel hierdie dienste gratis beskikbaar is in die Tshwane-omgewing, kon die respondente nie daarin slaag om die dienste te benut nie. Die adolessente moeders benodig meer kennis oor kontrasepsie, noodkontrasepsie en terminasie van swangerskap dienste, asook persepsies dat die dienste bereikbaar en veilig is, alvorens hulle die dienste kan benut. Klinieke wat sodanige dienste verskaf, behoort naweke en saans oop te wees sodat adolessente die klinieke kan bywoon sonder om te vrees dat hulle moeders, tannies of onderwyseresse ook daar sal wees. Reproductiewe gesondheidsorgklinieke moet ook meer adolessente-vriendelike dienste daarstel.

INTRODUCTION AND BACKGROUND INFORMATION

Tshwane, previously known as Pretoria, has more than 1.6 million inhabitants and encompasses approximately 900 square kilometres or 350 square miles (Diplomatic and Consular Guide to Pretoria, 1999/2000:1-2). Throughout this area, the Tshwane Metropolitan Council's clinics provide reproductive health services free of charge to the clients, including contraceptive, emergency contraceptive and termination of pregnancy (TOP) services, in accordance with the specifications of the National Health Plan for South Africa (ANC, 1994:10). The adolescent mothers thus failed to make effective use of these free services. This survey attempted to identify possible reasons for *not* utilising these services.

The consequences of adolescent pregnancies

Adolescent pregnancies imply adverse health, social and economic implications for the mothers and their children - and usually for the grandmothers as well. Annually approximately 17 000 babies are born to mothers younger than 16 in the RSA (Mwaba, 2000:30). Physical problems experienced by adolescent mothers, younger than 16 years of age in the RSA, include pregnancy induced hypertension, premature labour and anaemia (Lesser & Escoto-Lloyd, 1999:289; Sellers, 1993:1715). These physical problems might remain undetected because they attend prenatal clinics very late during their pregnancies. Many adolescent mothers will need to discontinue their education, limiting their chances of finding jobs with salaries, which can sustain these mothers and their children. Financial hardships can aggravate the adolescent mothers' social adjustment problems, increasing the likelihood of resorting to prostitution to augment their incomes.

Prostitution implies health risks, especially in the RSA with its high HIV/AIDS prevalence, indicated by 22.4% of pregnant women found to be HIV positive during 1998 (Department of Health, 2000:1). Forced early marriages can lead to social problems such as abuse and child battering (De Villiers, 1985:301-302; Rhinehart & Gabel, 1998:62; Sellers, 1993:1719). "The toll of adolescent pregnancy on the adolescent as well as society is immense" (Schaefer & Emerling, 1997:32). Adolescent mothers face failures in many aspects of their lives. This is sometimes referred to as "...the syndrome of failure: failure to fulfill the functions of adolescence, failure to remain in school, failure to limit family size, failure to establish a vocation and become self-supporting, and failure to have children who reach their potential in life" (Blum & Goldhagen *in* Boulton & Cunningham, 1992:160).

The utilisation of contraceptives

The adverse health, social and economic implications of adolescent pregnancies can be averted by the effective utilisation of contraceptives. The potential impact of contraceptives has been estimated as having "averted an estimated 1.65 million pregnancies among the 15-19 year old women in the United States during 1995. If these women had been denied access to both prescription and over-the-counter contraceptive methods, an estimated additional one million pregnancies ... would have occurred. These pregnancies would have led to 480 000 live births, 390 000 abortions, 120 000 miscarriages, 10 000 ectopic pregnancies and 37 maternal deaths" (Khan, Brindis & Gleib, 1999:29). Similar statistics could be applicable to the RSA generally, and to Tshwane specifically, where not only contraceptives, but also emergency contraceptives and TOP services are available free of charge. This survey attempted to identify why adolescent mothers were unable and/or unwilling to use services required to prevent preg

nancies.

Adolescents' knowledge and perceptions of contraceptives, emergency contraceptives and termination of pregnancy services

Adolescents require knowledge before they could consider using contraceptives, emergency contraceptives or TOP services. Makhetha (1996:1) reported that all 211 adolescent mothers who participated in a research project were sexually active by the age of 15, but lacked knowledge about menstruation, conception and contraceptives to the extent that only 11 (5.2%) had used any contraceptives prior to conception. However, knowledge might be coloured by perceptions about these strategies and about the adolescents who use them. Peer pressure, cultural issues and family traditions as well as the accessibility of health services might impact on the actual utilisation or non-utilisation of services enabling adolescents *not* to bear children in spite of being sexually active.

Even in the USA, despite continued health education efforts to reduce the number of adolescent pregnancies, an estimated 800 000 to 850 000 of the one million teenage pregnancies each year are reportedly unintended (Rhinehart & Gabel, 1998:61). In the RSA, Dlamini and McKenzie (1991:28) reported that 92% of all the adolescent mothers who participated in their study were unhappy about their (unplanned) pregnancies. These statistics do not reveal why these adolescent mothers failed to use contraceptives, emergency contraceptives or TOP services.

A review of the literature published about adolescent pregnancies from 1964 to 1994 indicates that variables strongly correlated with pregnancy included identification with the female role, positive beliefs about parenting and sexual activity (Gilliam, 1996:435). This author also indicated that variables strongly associated with the (non-pregnant) control adolescent group included educational expectations, good school grades, future orientations and occupational expectations. In the RSA some researchers also seem to support the possibility that a factor, which might be contributing to adolescent pregnancies, is poor school performance (Mogotlane, 1993:12).

PURPOSE AND OBJECTIVES OF THE RESEARCH

The purpose of the research was to identify reasons why adolescents become mothers in spite of the availability of free contraceptives, emergency contraceptives and TOP services in the Tshwane area. The objectives of the research aimed to gather information about adolescent mothers'

- knowledge and perceptions of contraceptives, emergency contraceptives and TOP services
- perceptions about contraceptive services in the Tshwane area
- suggestions for improving contraceptive services.

This information could be used to

- design a programme of information, education and counseling for schools, parents and health workers enabling adolescents to make informed decisions about their utilisation of contraceptives, emergency contraceptives and TOP services
- enhance the accessibility and user-friendliness of contraceptive services in the Tshwane area.

DEFINITIONS OF TERMS USED IN THIS REPORT

An *adolescent mother* is any mother aged 19 or younger at the time of the birth of her baby irrespective of the pregnancy outcome, and irrespective of her marital status.

Contraceptives are agents used to temporarily prevent the occurrence of conception, including (oral) pills, condoms, intra-uterine devices, diaphragms and injections (Ketting & Visser, 1994:161).

Emergency contraception prevents pregnancy from occurring by preventing implantation of the fertilised ovum in the uterine wall (by using copper-containing intra-uterine devices (IUDs) within five days of unprotected coitus, or altering the woman's hormone levels to inhibit ovulation, ovum transportation and/or endometrial growth by using specific "morning after" pills or by using pre-calculated high doses of oral contraceptives (<http://www.who.int/inffs/en/fact244.html>),

24.08.2001).

Termination of pregnancy (TOP) refers to the act of bringing a pregnancy to a final end, preventing the birth of a live baby (Dickson-Tetteh, 1999:20).

The Choice on Termination of Pregnancy Act (Act 92 of 1996) permits TOP upon the request of the pregnant woman up to and including 12 weeks' gestation. Legal TOPs can be obtained from 13 to 20 weeks' gestation under specific definite conditions, and even after 20 weeks' gestation in rare cases (Dickson-Tetteh, 1999:20).

RESEARCH DESIGN

A non-experimental, quantitative, descriptive survey was used to collect information about adolescent mothers' knowledge, perceptions and utilisation of contraceptives. The research design was non-experimental because only one group of persons, namely adolescent mothers in the Tshwane area provided information for this survey, they were not subjected to any variables and were not compared with adolescents who were not mothers. A quantitative design was adopted because the adolescent mothers preferred to complete questionnaires anonymously, rather than being interviewed by field workers. The open-ended questions were categorised and coded similarly to the closed-ended questions, enabling data to be entered into the Epi-Info computer program. The research design was exploratory and descriptive because it attempted to explore and describe adolescent mothers' knowledge and perceptions of contraceptives, emergency contraceptives and TOP services (Burns & Grove, 2001:38). A special effort was made to identify possible reasons for failing to use contraceptives, emergency contraceptives and TOP services.

Research population and sample

The target population comprised all adolescent mothers, aged 19 or younger when their babies were born, who attended any clinics in the Tshwane Metropolitan Council's area from 1 January till 31 March 2000. Thus all the clinics in this area were included in the survey. Although reports relevant to each clinic were supplied to the health care authorities, this report refers only to the combined results of the 61 questionnaires com-

pleted at all these clinics, comprising the convenience sample of adolescent mothers who voluntarily completed questionnaires. Due to the non-availability of a census of adolescent mothers in the Tshwane region, it was impossible to select a random sample. "Convenience sampling refers to the selection of the most readily available persons (or units) as subjects in a study, also known as accidental sampling" (Polit & Hungler, 1997:392). Sampling bias, referring to the "... systematic over representation or under representation of some segment of the population" (Polit & Hungler, 1997:185) could neither be excluded nor controlled in this survey, using a convenience sample. However, the purpose of this survey (obtaining information about adolescent mothers' knowledge and perceptions concerning contraceptives, emergency contraceptives and TOP services) could be achieved by using a convenience sample.

Data collection instrument

A questionnaire, comprising open and closed ended questions, was constructed based on information available from similar surveys conducted in the RSA (Bodibe, 1994; Boulton & Cunningham, 1992; De Villiers, 1985; Makhetha, 1996; Mogotlane, 1993) and in other countries (Bloom & Hall, 1999; Gilliam, 1996; Lesser & Escoto-Lloyd, 1999; Rhinehart & Gabel, 1998). The questionnaire was critically reviewed by two medical practitioners providing reproductive health services at clinics in the Tshwane region, by nurses working in family planning clinics in this region, and by researchers who participated in the Reproductive Health Workshop organised jointly by the World Health Organization (WHO) and the Commonwealth in Harare, Zimbabwe, during 1998. The questionnaire comprised sections striving to obtain information relevant to the adolescent mothers' knowledge and perceptions of contraceptives, emergency contraceptives and TOPs. The last section of the questionnaire attempted to ascertain adolescent mothers' perceptions about clinics providing contraceptive services in the Tshwane region. In order to contextualise these research results, some biographic questions were asked so that the adolescent mothers' knowledge and perceptions about contraceptives, emergency contraceptives and TOP services could be interpreted against some knowledge about their ages, socio-economic status, education levels, ages at menarche and at becoming mothers.

Reliability and validity

Reliability is a measure denoting "... the consistency of measures obtained in the use of a particular instrument and is an indication of the extent of random error in the measurement method (Burns & Grove, 2001:395). The validity of an instrument "... is a determination of the extent to which the instrument actually reflects the abstract construct being examined"(Burns & Grove, 2001:399). During pretesting the instrument, a number of adolescent mothers refused to answer questions pertaining to HIV/AIDS and the number of sex partners as they perceived these issues to be irrelevant to motherhood. These questions were removed as they apparently impacted negatively on the face validity. The revised questionnaires were provided to the health care authorities of the Tshwane Metropolitan Council. The face validity was evaluated by nurses and doctors working at the clinics where questionnaires were distributed. They perceived the questions to pertain to adolescent mothers' knowledge and perceptions of contraceptives, emergency contraceptives and TOP services. Although some queries were raised about the biographic section of the questionnaire these were retained for contextualising the rest of the data.

Pretesting of the questionnaire

The questionnaire was pretested by 12 adolescent mothers who completed questionnaires during 1999, and who were excluded from participation in the actual survey during 2000. The questionnaire was available in English only, as translating it into all eleven official languages of the RSA would have been too expensive. The adolescent mothers and the field worker understood the questions asked, but suggested that questions about promiscuity, number of sex partners, and HIV/AIDS knowledge should be removed because they regarded these questions as being irrelevant to adolescent motherhood, and as imposing on their privacy. The 12 adolescent mothers who pretested the questionnaire, refused to answer some or even all questions related to these issues. After further consultations, these questions were removed.

Initially the intention was to conduct structured interviews with the adolescent mothers, in an attempt to obtain answers to as many questions as possible, and to ask probing questions about answers to open-ended

questions. During the pretest phase the field worker encountered resistance from adolescent mothers to answer questions pertaining to their personal lives to a stranger. They were willing to complete the questionnaire themselves anonymously, but not to supply answers to a strange interviewer. Therefore the research instrument changed from a structured interview to a self-completion questionnaire. This approach produced few responses to some questions, especially the open-ended questions. Another potential limitation was that only adolescent mothers who could read and understand English could participate in this research. However, during the pretesting phase no adolescent mother was found who was unable to read and write English.

Ethical considerations

Each participating adolescent mother was requested to sign a consent form indicating that she participated voluntarily and without any coercion whatsoever. Accidentally these forms were attached to the questionnaires prior to distribution. As the researcher's telephone numbers were provided on the forms, some participants raised concerns about anonymity. It was decided that the signed consent forms would be placed into individual envelopes and sealed. The anonymously completed questionnaires were individually sealed into different envelopes and placed into a different container. The adolescent mothers accepted this procedure. Each participant could decide whether or not to answer any specific question, explaining why few responses were obtained to some questions, particularly the open-ended questions.

Unforeseen ethical issues arose when some clinic nurses allowed ONLY those adolescent mothers, accompanied by their mothers who signed the consent forms, to complete questionnaires. This was unexpected as the adolescent mothers' knowledge and perceptions were sought, not those of the mothers of these adolescents. However, the decisions of the professional nurses had to be accepted, yielding far fewer completed questionnaires than anticipated.

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

Biographic Information

These questions attempted to obtain general information about the respondents so that the rest of the data could be placed within the context of the realities of the adolescent mothers' lives.

Adolescent mothers' ages

As indicated in Table 1, the majority (49 or 80,3%) of the 61 adolescent mothers (of whom only one was married) fell within the age group of 17-19 years. Only two respondents were 14, one was 15, and six were 16 years of age. This age distribution implies that these research results apply mainly to the older adolescent mothers falling within the 17-19 year age group, and might not necessarily apply to adolescent mothers aged 16 or younger.

Employment status and income

Out of the 61 adolescent mothers, 25 (41.7%) were not working, 34 (55.7%) were students or scholars, whilst one was a gardener and another one was a domestic worker. Fifteen (24.6%) of these mothers indicated that they had no income, whilst another 15 (24.6%) earned less than R500.00 per month. These statistics indicate that 59 (96.7%) of the adolescent mothers were unemployed implying that they lacked the finances to care for themselves and their babies. These dire financial circumstances of the adolescent mothers should have encouraged them to use contraceptives, emergency contraceptives or TOPs at least until they could financially afford to care for their babies.

Number of persons per household

The participants indicated that five or more persons lived in 68.8% (n=42) of their homes. Large numbers of persons per household, and low levels of household incomes, would seem to be factors which should encourage adolescents to utilise the available contraceptive, emergency contraceptive and TOP services, which these 61 adolescent mothers failed to do.

Education level

The age range of the adolescent mothers (as presented in Table 1) correlate with their highest school grades passed. These findings indicate a need to focus family planning information campaigns at secondary school children, especially during grades 11 and 12. Those 23 adolescent mothers who reportedly passed grade 11, might have finished their schooling (grade 12) suc-

cessfully if they had used effective contraceptives for at least one additional year. Completion of their schooling prior to becoming mothers, might have had inestimable value for enhancing the quality of these mothers' lives as well those of their children. These findings did not support those reported by Mogotlane (1993:11), which revealed that the majority of adolescent mothers encountered academic problems and were deemed to be too old for their school grades.

Adolescent mothers' significant ages

Table 1 reflects the ages of the adolescent mothers as well as other significant ages in their lives.

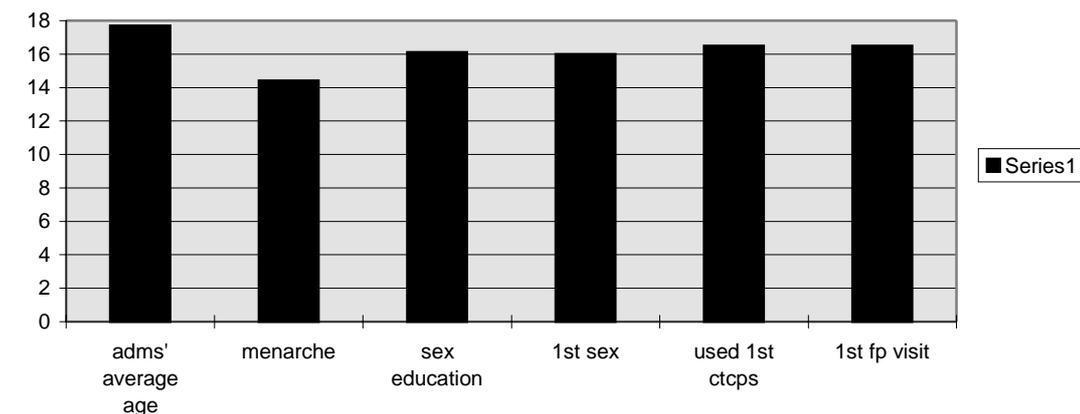
Table 1: Age distribution of adolescent mothers: (n=61)

Age in years	Age of adolescent mothers	Age at menarche	Sex education received	First sexual intercourse	Started using contraceptives	First visit to family planning clinics
up to 11		3		1	1	
12		12	6			
13		10	3		2	2
14	2	7	6	2	1	3
15	1	15	12	11	2	
16	6	9	12	16	8	6
17	17	2	5	12	6	2
18	23		5	2	4	2
19	9				2	2
No response	3	3	12	17	35	44
TOTAL	61	61	61	61	61	61

The onset of menarche ranged from the age of 9 until the age of 17, with a mean age of 14.03 years. The figures in Table 1 indicate that 52.45% (n = 32) of the adolescent mothers started menstruating by the age of 14, whereas only 24.59% (n = 15) had received any sex education by that time. Most participants received sex education at the ages of 15 and 16 - by which time most of them were reportedly sexually active, and some were already pregnant. This age-related finding indicates that some adolescents received sex education only after they were pregnant.

The bar diagram (figure 1) indicates that the majority of these adolescent mothers received sex education after menarche occurred. The first visit to the family planning clinic coincided with their initial use of contraceptives, possibly indicating that many of them obtained

adms' significant ages



*ctps refers to contraceptives

Figure 1: Adolescent mothers' significant ages

contraceptives at their first visit to the family planning clinic. However, these initial visits to family planning clinics, reportedly occurred mostly after initial sexual intercourse, implying that many of them might have been pregnant when they commenced using contraceptives.

Adolescent mothers' reasons for engaging in sex for the first time

The adolescent mothers indicated that they engaged in sex for the first time because they

- did not know or that it just happened (8)
- were requested or coerced by their partners (8)
- loved their partners (6)
- were curious about the experience (5)
- succumbed to peer pressure (4).

KNOWLEDGE AND PERCEPTIONS ABOUT CONTRACEPTIVES, EMERGENCY CONTRACEPTIVES AND TOP SERVICES

Specific sections of the questionnaire attempted to identify whether adolescent mothers knew about contraceptives, emergency contraceptives and TOP services and what their perceptions were concerning these services. Unless adolescents know about and can access these services they cannot use them. In spite of knowledge and accessibility of services, adolescents' perceptions about potentially harmful consequences of these services could prevent their utilisation.

Contraceptives

Although 28 (45.9%) respondents knew about contraceptives, only 23 (37.7%) indicated that they had indeed used injections (16), condoms (16), and pills (5). One adolescent mother indicated that she successfully used contraceptives for seven years (from the age of 11 until 18), starting off with condoms but later changing to injections and pills. She claimed that she conceived when she had forgotten to take one single pill, when the clinic nurse issued her with pills rather than giving her the requested contraceptive injection. Maintaining effective contraception enabled her to complete grade 11 at school despite being sexually active since the age of 11. If only the clinic nurse had enabled her to continue with contraceptive injections she might have been able to complete her schooling (grade 12) successfully despite being sexually active since the age of 11. One respondent managed to maintain effective contraception for three years, four did so for two years, and four for one year. Two respondents claimed to have become pregnant three months after their first injections, presumably Depo Provera. Another respondent claimed that she became pregnant despite the regular use of condoms supplied by a clinic.

Reasons provided for *not* using contraceptives, included that their mothers did not approve, they were ignorant about contraceptives, they were afraid to go to the clinic because their mothers might find out, they feared picking up weight and/or never having children, their boyfriends opposed their use of contraceptives.

Other researchers reported similar findings revealing that only 23% of the sexually active school girls in the RSA had ever used contraceptives, of whom only a minority had ever used condoms (Bugu, Amoko & Ncayiyana, 1996:523). Identified factors which impede condom use among adolescents in South Africa, include the lack of perceived risk, peer norms, condom availability, adult attitudes to condoms and sex, gendered power relations and the economic context of adolescent sexuality (MacPhail & Campbell, 2001:1613). Condoms have been described as a "... nuisance perceived to interfere with passion and performance" (White, 2000:480). Although this survey did not identify factors prohibiting condom use among adolescent mothers, it confirmed that only a minority of Tshwane's adolescents use condoms in spite of the country wide HIV/AIDS drive to abstain, be faithful to one faithful sex partner and to use condoms. This non-utilisation of condoms is of particular significance because the WHO estimates that more than 50% all new HIV infections occur among the 15-24 year olds, approximately 17 million girls younger than 20 give birth each year, and as many as 4.4 million abortions are procured by this age group in developing countries each year (Silberschmidt & Rasch, 2001:1815). The effective and regular use of condoms could prevent or at least significantly reduce all these consequences of adolescents' sexual behaviours.

Out of the 61 respondents, 55 (90.16%) indicated that they used the following contraceptives after the birth of their babies:

- 38 used injections, mainly because they would not need to take daily pills, the family members and boyfriends would not need to know that they used injections, and visits to the family planning clinic every third month were more feasible than more frequent visits
- 10 used condoms, because they would be protected against pregnancies and sexually transmitted diseases
- 7 used contraceptive pills because they were familiar with pills and because they continued to menstruate regularly.

Only six (9.8 per cent) of the adolescent mothers indicated that their pregnancies were planned. Subsequent to the birth of their babies, 55 (90.16%) used contra-

ceptives, but it could not be ascertained why the other 6 (9.8%) did not consider using contraceptives.

Emergency Contraceptives

Surprisingly 40 out of the 61 respondents, amounting to 65.57%, did not know about the availability of emergency contraceptives to be taken within 72 hours after unprotected sex.

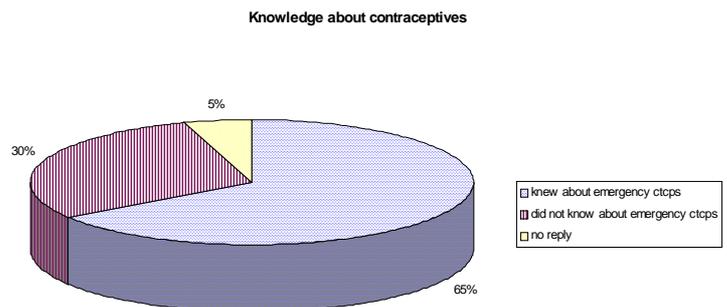


Figure 2: Adolescent mothers' knowledge about emergency contraceptives

Only 18 (29.5%) knew about the existence of emergency contraceptives, but only five (8.19%) knew that pills could be taken to prevent pregnancies after unprotected sex. However, only one respondent could name such a product. In spite of knowing about emergency contraceptives, none of these five respondents attempted to use these because they did not believe that they could become pregnant, did not have sufficient information to obtain these pills, or their boyfriends wanted the babies.

A survey conducted among 93 pregnant student nurses in the Northern Province of the RSA reported that 73.1% of these student nurses had no knowledge about emergency contraceptives. None of these respondents could access emergency contraceptives despite being student nurses (Netshikweta, 1999:96). A survey done among pharmacies and pharmacists in the Gauteng Province found that 56.25% of the pharmacists would not advocate the use of emergency oral contraceptives, and 12.5% would only dispense these pills if the patient had a doctor's prescription (Harris, 1999:5).

Knowledge about and Non-Utilisation of TOP services

Women in South Africa have legalised choices to request the termination of their pregnancies during the first twelve weeks of gestation, in terms of The Choice on Termination of Pregnancy Act, no 92 of 1996. TOP services can also be obtained after twelve weeks' gestation under specific circumstances in terms of this Act.

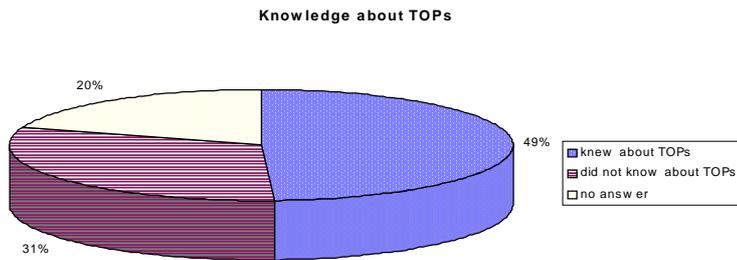


Figure 3: Adolescent mothers' knowledge about termination of pregnancy (TOP) services

Out of the 61 adolescent mothers, 30 (49.18%) knew about legally TOP services, whilst 19 (31.15%) did not know about these services. However, knowledge about TOP services, did not imply that these adolescent mothers necessarily wanted to utilise such services.

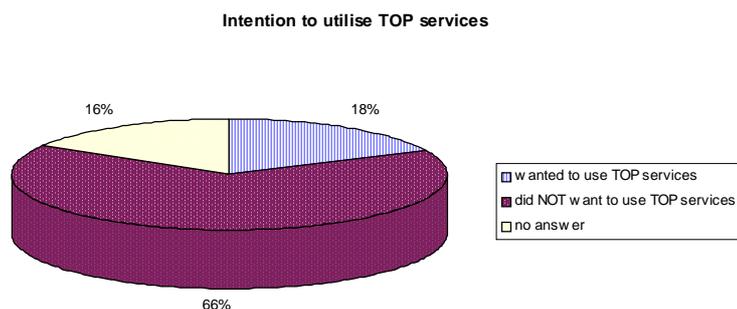


Figure 4: Adolescent mothers' intended utilisation of termination of pregnancy services

Although the majority (40 or 65.57%) did not wish to use TOP services, 11 (18.03%) wanted to do so. Only six (9.8%) of the adolescent mothers asked about TOP services at the clinics they attended, but no one managed to obtain such services. Only two respondents

indicated that they enquired too late (after twelve weeks gestation) about TOP services, the others did not provide any reasons for failing to obtain TOP services.

Varkey (1999:11) reported that the majority of women who obtained TOP services in South Africa were older than 20 years of age, thus excluding adolescent mothers aged 19 or younger at the time of delivery. Reportedly in the RSA requests for TOP services from large numbers of women were rejected because their pregnancies had progressed beyond three months' duration or because there were no hospital/clinic beds to accommodate them (Nursing Update, 2000:16).

PERCEPTIONS OF VISITS TO FAMILY PLANNING CLINICS

Many respondents failed to reply to the questions pertaining to their visits to family planning clinics, probably because they might have regarded these questions as being irrelevant to their pregnancies and babies. Out of the few replies the following aspects emerged:

- 3 respondents indicated that they waited less than 30 minutes
- 3 indicated that they waited very long but did not specify the time
- 2 claimed to have waited two hours or longer.

Although 6 respondents did not perceive the nurses to be helpful at the family planning clinics, 12 experienced the nurses to be very helpful indeed and 18 were satisfied with the services. Only one respondent was dissatisfied because she conceived despite using condoms received at the clinic - she did not complain about the service as such, merely about the quality of the condoms provided.

An open-ended question requested the adolescent mothers to indicate what advice they received at the family planning clinics. Their replies included:

- no advice (3)
- that the clinic should be attended regularly (2)
- information about contraceptive methods and their side effects (2)
- *not to sleep around and get pregnant* (2)
- *never have sex without a condom* (3)
- *you are too young to use contraceptives* (1 respondent who was 18 years old and who

became an adolescent mother because the clinic did not supply her with contraceptives)

- *you do not have to give any man a lot of children to prove your love (1).*

SUGGESTIONS FOR IMPROVING FAMILY PLANNING CLINICS' SERVICES

Only 20 (32.78%) knew during which days and hours their family planning clinics operated, and these respondents indicated that the clinics were within walking distance. Better advertisements of clinic venues and operating hours, would help the adolescent mothers to plan their visits to these clinics more effectively.

Only 13 (21.31%) of the respondents would prefer to attend family planning clinics during evenings whilst 29 (47,54 %) would not do so, probably for reasons of safety. On the other hand 29 (47.54%) would indeed prefer to attend family planning clinics over the weekend, whilst 17 (27.86%) would not prefer weekend clinics. Those who preferred to attend clinics during the evenings and/or over weekends indicated that they experienced problems to reach their family planning clinics during the week without informing their parents or teachers. Another problem was that clinic hours coincided with school hours which made it almost impossible to attend family planning clinics, except during school holidays.

Other general recommendations for improving the family planning clinics' services included that privacy should be ensured during counseling and examination. Heaters in the examination cubicles would be appreciated during winter months.

LIMITATIONS OF RESEARCH RESULTS

Due to problems of compiling a census of adolescent mothers, no random sample could be selected. At the Tshwane Metropolitan Council's clinics, convenience sampling was used by requesting each adolescent mother, who visited one of these clinics during the data collection phase, to complete a questionnaire. Limitations could be imposed on the generalisability of the research findings as no guarantees could be provided that those adolescent mothers who completed questionnaires held the same ideas as those who refused to complete questionnaires, or those who failed to visit

clinics in the region during the data collection phase.

Using only questionnaires as a data collection tool could have imposed further limitations on the generalisability of the research results. However, as the majority of the adolescent mothers did not wish to be interviewed but agreed to complete questionnaires, this state of affairs had to be accepted.

RECOMMENDATIONS BASED ON THE RESEARCH FINDINGS

Despite the limitations of the research, the following recommendations, based on the research findings, could enhance adolescents' knowledge and choices about sex and motherhood:

- school children in the Tshwane region should receive sex education, including information about contraceptives, before reaching the age of 14 when most of the adolescent girls started menstruating
- school children should be taught about contraceptives, emergency contraceptives and TOP services before they reach grade 11 (the second last year at school when the majority of respondents conceived)
- contraceptives, emergency contraceptives and TOP services should be freely accessible to all adolescents - including school children
- clinics providing reproductive health services only for adolescents should be available over weekends and during evenings
- specific policies should guide clinic nurses about issues such as the types of contraceptives to be issued to adolescents, maintaining a non-judgmental attitude towards sexually active adolescents, and facilitating adolescents' access of contraceptives, emergency contraceptives and TOP services - not obstructing these efforts - if the issue of adolescent pregnancies is to be addressed successfully in the Tshwane region.

There appears to be a need to educate adolescents about emergency contraceptives, as almost 66% did *not* know about the existence of any emergency contraceptives, and to make these services accessible to adolescents. Thus emergency contraceptives would need to be advertised in clinics, at schools, and possi

bly also during radio and television broadcasts. Better utilisation of emergency contraceptives could reduce the need for termination of pregnancy services and could enable adolescents to postpone having children until they are emotionally, socially and financially capable of caring for their children. Dickson-Tetteh (1999:22) also advocates the need to introduce, or re-introduce, emergency contraception throughout the RSA by training health care workers and by launching community education campaigns. However, any adolescent who needs emergency contraception, needs contraception and needs to be counseled in this regard.

Another area warranting further research is not only the accessibility of TOP services but also women's knowledge about their legal right to exercise their choice concerning the termination of their pregnancies within the first twelve weeks of gestation, and their right to sole consent for this procedure.

These adolescent mothers' comments about advice received at the family planning clinics could merely reflect their interpretations of actual advice received. However, if an 18-year old sexually active young woman had indeed been told that she was *too young to use contraceptives*, the policy of the family planning clinics and the attitudes of nurses need to be addressed. This 18-year old woman did conceive and had to compromise her education during her final school year. This pregnancy could have been avoided if she had received contraceptive injections, as requested by her. This particular adolescent mother managed to postpone pregnancies from the age of 11 until 18, until a clinic nurse reportedly refused to give her a contraceptive injection, but in stead supplied her with a packet of pills and advised her to abstain from sex because she "*was too young to use contraceptives*". This advice seems to be out of context for this young woman who had been sexually active since the age of 11, but who managed to avoid pregnancies. Nurses who object to providing contraceptives, emergency contraceptives and/or TOP services to adolescents, nullify the potential value of the provision of these free services, because these nurses make it impossible for the adolescents to access these services at clinics. This issue needs to be addressed urgently in the Tshwane region and throughout the RSA. No matter how much adolescents do or do not know about sex and contracep-

tion, the accessibility and actual utilisation of these services are influenced to a great extent by the attitudes and quality of services rendered by nurses at family planning clinics. Nurses who object to providing these services to adolescents should preferably not work in clinics providing family planning services.

CONCLUSION

The majority of the adolescent mothers lacked information about contraceptives, emergency contraceptives and TOP services. None of the participants managed to access the latter two types of services. Although the majority of adolescent mothers were reportedly satisfied with the services received at the clinics in the Tshwane area, these clinics' services and locations need to be better advertised. Specific policies need to be formulated about providing contraceptives, emergency contraceptives and TOP services to adolescents at family planning clinics in the Tshwane area.

The findings of this survey appear to confirm those reported by Bodibe (1994) who found that 157 school children in the RSA had only moderate levels of sexual knowledge, but that no cause and effect relationships could be identified between sexual knowledge, attitudes and behaviors. However, nurses can play a major role in educating South African women, especially adolescents, about their rights so that they can claim these rights for themselves and for their daughters in making informed decisions about their sexuality and productivity. Such knowledge and accessible contraceptive, emergency contraceptive and TOP services, offer many women an escape from the vicious cycle of adolescent motherhood, poverty, lack of education, and possibly prostitution. South African women could use the existing legislation to access contraceptive, emergency contraceptive and TOP services, to enhance the quality of their own and their families' lives - including the lives of their children and grandchildren. All nurses in the RSA should: "... examine their own perspectives regarding clients' concerns about sexuality. Attention to the sexuality needs of women across the life span is an important component of holistic and sensitive care" (Lamp, Alteneider & Lee, 2000:391).

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