

Nurses' Knowledge About, Attitudes Towards, and Perceptions of Emergency Contraceptives

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ABSTRACT

Hormonal methods of contraceptive have been known world-wide for more than 30 years and yet its use in the Republic of South Africa (RSA) is limited. This article focuses on the nurses' knowledge about, attitudes towards and perceptions of providing emergency contraceptives to their clients in the Northern Tshwane (previously known as Pretoria North) area.

A qualitative, exploratory, descriptive and contextual research design was used. A sample of 12 nurses who were providing contraceptive and Choice on Termination of Pregnancy (CTOP) services volunteered to participate in the focus group interview. Results revealed that although the nurses had some knowledge about emergency contraception, they had negative perceptions toward its use and could therefore not recommend its effective use to their clients.

BRIEF OVERVIEW OF EMERGENCY CONTRACEPTIVES AVAILABLE IN NORTHERN TSHWANE

Hormonal methods of contraception have been known world-wide for more than 30 years. In the RSA E-gen-C was introduced in 1998 as an emergency contraceptive which prevents pregnancy if taken within 72 hours after unprotected sexual intercourse or obvious failure of mechanical contraceptive methods, such as a torn condom. It acts as a

contraceptive by delaying the release of a fertilised ovum from the ovaries to the endometrium (Reproductive Rights Alliance 1999:11). Other emergency contraceptive pills include:

- Ovral, dosage of two pills as soon as possible (but within 72 hours) after unprotected sexual intercourse and second dose of two pills 12 hours after the first one.
- Nordette, four pills to be taken within 72 hours after unprotected sexual intercourse as first dose and four pills as second dose 12 hours after the first one.
- Microval, 25 pills to be taken within 72 hours after unprotected sexual intercourse (<http://www.who.int/infs/en/fact244.html>, 24.08.2001).

An alternative form of emergency contraception is the insertion of a copper-containing intra-uterine contraceptive device (IUCD), which can



be inserted up to five days after unprotected sex and even later if intercourse took place early in the menstrual cycle. (An IUCD can be inserted - as an emergency contraceptive - up to five days after the calculated date of ovulation – day 19 of a 28-day cycle). This is possible because the IUCD prevents implantation and it can be left in situ to provide long-term contraception. When using an IUCD, a careful history about the number of sexual partners should be taken and in many health care centres cervical swabs are taken for chlamydia and prophylactic antibiotics might be prescribed to reduce the likelihood of post IUCD insertion pelvic infections. The insertion of IUCDs is an expensive procedure requiring specific skills and should only be offered to clients who would be willing to continue using the IUCD as a contraceptive device, in order to justify the expenses incurred by inserting a copper containing IUCD. Despite the availability of emergency contraceptives, women are still plagued by unintended, unplanned and unwanted pregnancies throughout the RSA. Health care providers including nurses could play a major role in providing accurate information about emergency contraception and encourage its use. Inadequacies in the use of emergency contraception prompted the researcher to investigate the nurses' views regarding this contraceptive method in an attempt to find solutions to the problem. This article reports on the findings of a study aimed to determine the knowledge and perceptions of nurses from three health care centres in the Northern areas of Tshwane, Gauteng Province.

RESEARCH OBJECTIVES

The objectives of the study aimed to:

- assess nurses' knowledge of emergency contraception
- describe nurses' perceptions

of and attitudes towards emergency contraception

- describe the nurses' role in providing services and information regarding emergency contraception to clients

RESEARCH METHODS

A qualitative, exploratory, descriptive and contextual research design was utilised for this study (Burns & Grove 1993:29; Mouton & Marais 1990:43-44). This was deemed to be a holistic research approach, which allowed the researcher to gain a full view of the phenomenon under study.

POPULATION AND SAMPLE

The target population for this study comprised all nurses who provided contraceptive and CTOP services at the three health care centres in Northern Tshwane, Gauteng Province during the data collection phase which occurred during July 2001.

In order to be included in the sample, the respondents:

- could be females or males
- had to be working in units providing contraceptive and/or CTOP services to clients in Northern Tshwane
- had to have at least two years' experience in the specified services
- had to participate voluntarily without being remunerated in any manner whatsoever.

As there were only a few nurses involved with contraceptive and CTOP services at the three selected health care centres in Northern Tshwane, all were recruited to participate in the study. A total of 12 nurses volunteered to participate, but nine managed to attend the focus group interview.

RESEARCH INSTRUMENT

An interview guide was designed for

data collection from nurses who participated in the focus group interview, comprising the following questions:

- (i) Which emergency contraceptives are used by clients coming to your health care centre?
- (ii) What are your perceptions regarding the use of emergency contraceptives?
- (iii) What guidance do you give to clients with regard to emergency contraceptives?
- (iv) Do you think any person who needs emergency contraceptives needs contraceptives?

DATA COLLECTION

A room without distractions was used at one of the health care centres for conducting the focus group interview. A facilitator, with known interviewing skills, conducted the focus group while the researcher took field notes and observed the respondents' interaction to validate data collected. Data was collected until saturation was reached. The interview was tape-recorded with the permission of respondents and later transcribed verbatim (Burns & Grove 2001:305; De Vos 1998:201). Initially 12 nurses volunteered to participate in the focus group interview, but three could not attend because of work commitments. These three nurses provided naive sketches portraying their personal opinions regarding emergency contraception. Cresswell (1994:159) refers to naive sketch questions as a descriptive method in which the respondent is asked for a personal description of the phenomenon in which the researcher is interested. The questions for naive sketches were the same as those posed during the focus group interview. The researcher collected the naive sketches after completion by the nurses and the data was then transcribed with data collected from the focus group interview. Data collected was analysed using Tesch's method (in Cresswell 1994:155). A

protocol for analysis of the data was sent to an external data analyst. Consensus was reached between the researcher and the external data analyst on the results. A literature control was conducted to identify similarities and the uniqueness of the research compared to reports included in the literature review.

A model of Guba (Lincoln & Guba 1985:289-300) was used throughout the study to ensure trustworthiness; by paying attention to the four criteria for trustworthiness, namely truth value, applicability, consistency and neutrality. Credibility was achieved by prolonged engagement with nurses, triangulation, member checking, peer examination and authority of the researcher. Transferability was ensured by providing a full description of the research methodology, dependability by conducting an audit trail whilst confirmability was achieved by replaying the tape and confirming the transcribed and analysed results with nurses who participated in the focus group interview and those who provided the naive sketches.

ETHICAL CONSIDERATIONS

Ethical principles as outlined by DENOSA (1998:2-3) were adhered to throughout. Although participants volunteered to participate in the study, the researcher requested them to read and sign the consent to participate voluntarily prior to the commencement of the focus group interview, or prior to providing naive sketches. The participants were reassured that the researcher would keep the signed consent forms under lock and key and that nobody else would have access to these forms. They would be destroyed as soon as the data analysis and interpretation processes had been completed. All participants were also reassured that no person's name would be mentioned in the research report and that the tape recording of the focus group interview, as well as the written naive sketches, would

also be destroyed by the researcher as soon as the data analysis and interpretation processes were completed. The purpose of the data gathering process was to become familiar with the participants knowledge, attitudes and perceptions towards emergency contraceptives - not to know what each individual participant's ideas were. After some discussions, the group accepted these explanations and reassurances and signed the consent forms.

ANALYSIS AND DISCUSSION OF RESULTS

The four main themes that emerged from the respondents' views of emergency contraception were:

- emergency contraceptives given to clients
- client education regarding emergency contraception
- nurses' perceptions about emergency contraception

These themes were further categorised and subcategorised as depicted in table 1.

Emergency contraceptives given to clients

In response to which emergency contraceptives were available to clients, respondents indicated that they were only aware of the two methods - Ovral and E-gen-C. All respondents argued that most clients were unaware of these emergency contraceptives that could be used within 72 hours after unprotected sex at intervals of 12 hours. Consequently they were reluctant to discuss emergency contraception with clients who might not understand the implications of using emergency contraceptives.

Client education regarding emergency contraception

Very little came out of this as all respondents indicated that most clients were unaware of emergency contraceptives. Respondents had some knowledge about emergency

contraceptives which could be used within 72-hours after unprotected sex. Strikingly, all except two nurses, acknowledged that they were not in favour of informing clients about emergency contraception as they maintained that clients might stop using contraceptives and resort to emergency contraceptives. One respondent stated:

"I personally do not tell clients about emergency contraception. I already have lots of clients who do not comply ... they hardly come on due dates ... giving all sorts of reasons. If I tell them about emergency contraception, will I not be encouraging them to default further knowing that they could use emergency contraception like contraceptives?"

According to these nurses, one of the arguments against sharing information about emergency contraception was that it could be used irresponsibly by women. This appeared to be contrary to Glasier and Bair's (1998:4) research results indicating that making emergency contraceptives more easily obtainable does not harm and may indeed reduce the rate of unwanted pregnancies.

Another respondent said:

"I always feel that if clients do not ask me about emergency contraception, the better for me because I also do not trust this method and cannot advocate something I do not have full details about".

It is imperative that nurses should be fully informed about the developments taking place in medical, technological and education fields so that they are in a better position to inform others. Nurses are well-placed in specific women's health care settings, general settings, occupational and school health services to be informed providers of information concerning emergency contraceptives.

Perceptions about emergency contraception

Nurses expressed various perceptions ranging from positive, nega-

MAIN THEME	CATEGORIES	SUBCATEGORIES
Emergency contraceptives given to clients	Two types of pills given only to clients who knew about emergency contraceptives	Types names: - Ovral - E-gen-C - Other types such as the IUCD, appeared to be important to nurses
Information given to clients regarding emergency contraceptives	- Information only provided to a few clients who knew about emergency contraception - Clients without knowledge of contraceptives were not informed for fear of using emergency contraceptives irresponsibly	Such information included: - Emergency contraception to be given within 72 hours of unprotected sex only in emergencies - Emergency contraception should not be used routinely as contraceptives
Nurses' perceptions about emergency contraceptives	- Positive perceptions - Negative perceptions	- Emergency contraception is better than having unwanted pregnancies - Encourage unprotected sex - Unreliable contraceptive method - It is tantamount to murder
Nurses' perceptions	- Negative perceptions - Ambivalent perceptions	- Uncomfortable feeling about emergency contraception - General hatred of emergency contraception - Providing emergency contraceptives could be effective but clients might be tempted to default - Emergency contraception may prevent unwanted pregnancies, but should not be promoted for regular use

Table 1: Themes, categories and subcategories

tive and ambivalent perceptions.

Positive perceptions

Only two nurses expressed positive perceptions about emergency contraception. They felt that all clients presenting for contraception should be informed about this method to allay fears, anxieties and even risks of choosing to terminate a preg-

nancy. One nurse put it this way: *"Let's give them a chance and see how they will behave after being told about emergency contraception ... I mean not all clients can behave irresponsibly. Why can't we abandon old ideologies and take change as a challenge"*.

Emergency contraception could re-

lieve women from continual stresses and fears of unwanted pregnancies if they are adequately informed about how and under what circumstances it should be used. In the United Kingdom (UK), emergency contraception was introduced in 1984 and a number of studies relevant to its use have reported its effectiveness in preventing unwanted

pregnancies (Belfield 1999:28; Kubba 1997:101; Quinn 1999:39).

Negative perceptions

Eight nurses expressed discomfort and insisted that they would not encourage clients to use emergency contraception even after unprotected sex. They maintained that emergency contraception is tantamount to murder because conception might already have taken place.

"My duty is to teach clients about how to prevent unwanted pregnancies by taking contraceptives correctly. These emergency contraceptives are just like promoting murder. I cannot condone murder ... its against my principles and my church doctrines".

Inaccurate information about emergency contraceptives still persists among nurses. This lack of information creates obstacles in the use of emergency contraceptives. Some nurses indicated that they were not aware that they could use Ovrals for emergency contraception and argued that their health care centres could not afford to get E-gen-C in stock.

Ambivalent perceptions

Two respondents indicated their dilemmas towards emergency contraception. They felt that providing emergency contraceptives depended on the clients' reasons for having been involved in unprotected sex.

"At times you may find that the woman was forced and threatened to engage in unprotected sex ... such as with rape victims. In such cases, I will definitely give emergency contraceptives to the woman".

In such events, tactful questions should be done to elicit whether this episode of unprotected sex took place in a situation where there might be a risk of contracting sexually transmitted infections. If so, screening should be done and the woman should be counselled before giving emergency contraceptives.

Another viewpoint was expressed this way:

"I really feel uncomfortable to give emergency contraceptives to the same clients every day ... I mean an accident can occur once or so, not every day. Why can't people take contraceptives effectively without hassles rather than expect to get emergency contraceptives more often?"

Similar attitudes were identified among pharmacists in the Gauteng Province indicating that 56.25% of participating pharmacists would NOT advocate the use of emergency oral contraceptives and that 12.5% would ONLY supply these pills if the client produced a medical practitioner's prescription (Harris 1999:5). These attitudes and practices of registered nurses and pharmacists might pose barriers for women to access emergency contraceptives, necessitating them to resort to CTOPs or to producing unplanned children. More accessible emergency contraceptives should be available to all women, including adolescents. Another study conducted in the Gauteng Province indicated that 67.56% of the adolescent mothers who participated in this survey, did NOT know about the availability of emergency contraceptives. Even the 13.51% of these adolescent mothers who knew that pills could be taken as emergency contraceptives, could not access such pills in the Gauteng Province (Ehlers, Maja, Sellers & Gololo 2000:48).

If a client reports at the health care centre having had unprotected sex or a contraceptive failure, then nurses should provide the client with the necessary and accurate information about emergency contraception including offering the assistance needed without being judgemental. According to Quinn (1999:39), there is no limit to the number of times hormonal post-coital contraception can be used. Even if hormonal post-coital contraception were to be used three times in one

cycle, it would be no greater than the total dose of one packet of combined pills. The author warns, however, that emergency contraception should not be regarded as an alternative to using effective contraceptives and women need to be advised that the risk of pregnancy when hormonal post-coital contraception is used repeatedly could be much higher than the risk when it is used for emergencies only. When giving emergency contraception, it must be made clear to the woman that further acts of unprotected sex in the current menstrual cycle will carry a risk of conception, and that each request for emergency contraception requires careful assessment.

In response as to whether clients requesting emergency contraception should also be given contraceptives or not, almost all nurses agreed that such clients should be given contraceptives. Nurses urged that such clients should be informed that emergency contraception should only be used in cases of contraceptive. They added that clients should be warned that taking emergency contraception repeatedly could cause health risks and the likelihood of conceptions which might be unwanted or unintended.

CONCLUSIONS AND RECOMMENDATIONS

Most nurses seemed to have some knowledge about emergency contraception as they could give examples of at least two types (Ovral and E-gen-C), when to give it and how much should be given to clients who had unprotected sexual intercourse. Despite having information about emergency contraceptives, all except two of the nurses were not prepared to share this information with their clients because they thought that clients would then use emergency contraception irresponsibly. Most of the nurses had negative perceptions about emergency contraception. These negative perceptions had a direct bearing on how nurses felt about sharing information related to

emergency contraception with their clients. They believed it better to inform clients about contraceptives rather than waiting for emergencies to occur prior to supplying emergency contraceptives.

The following recommendations are made to enhance the use of emergency contraceptives:

- In-service education programmes should be developed for training nurses in aspects relevant to the promotion of sexuality education, self-care and contraceptive services.
- Provision of policy guidelines to health care providers, including nurses providing contraceptive and CTOP services to all clients. These policy guidelines should emphasise the role of nurses in informing clients about emergency contraception as well as clearly stating how and when emergency contraception should be given to clients.
- Access to emergency contraception should be improved by investigating whether private pharmacists and medical practitioners do provide emergency contraception in addition to making it freely available from health care centres and hospitals' emergency rooms.

CONCLUDING REMARKS

All women should have access to effective contraceptives, but if these fail then access to emergency contraceptives should be available. Ideally women should only need to resort to CTOPs when emergency contraceptives failed. Thus it could be concluded that the need for emergency contraceptives indicate a failure of contraceptive services, while a need for CTOPs indicate a failure of contraceptives and/or emergency contraceptives. Research con-

ducted in the United States of America (USA) claimed that use of contraceptives in that country "...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" (Kahn, Brindis and Gleib 1999:39). Although no similar statistics could be found for the RSA, similar tendencies could be expected to occur, emphasising the vital role nurses can play in providing effective contraceptive and emergency contraceptive services in enhancing the quality of South Africa's women's lives, health and well being.

ACKNOWLEDGEMENT

The contributions of all nurses who participated in the focus group interview and who contributed naive sketches are gratefully acknowledged. Without their participation this research would not have been possible.

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