

**CONTRACEPTIVE PRACTICES  
IN NORTHERN TSHWANE, GAUTENG PROVINCE**

by

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# **CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE, GAUTENG PROVINCE**

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## **Summary**

Unwanted and unintended pregnancies pose major reproductive health challenges to women throughout the world. Despite the availability of modern contraceptives, many women and men fail to use contraceptives effectively. This research focussed on reasons for not using contraceptives effectively in the Northern Tshwane area of the Gauteng Province of the Republic of South Africa (RSA).

Structured interviews were conducted with 83 women and 71 men about their contraceptive practices. Age, religion, educational level and residential areas influenced clients' contraceptive practices. These results were categorised for adult males and females as well as for adolescent males and females. Adolescents encountered problems in accessing contraceptive services. Adult females knew most about traditional contraceptives, although men knew about some of these methods, and adolescents used some of them. All respondents could gain additional knowledge about modern contraceptives. The respondents' knowledge about emergency contraceptives was extremely limited. Although most respondents knew about legalised choice on termination of pregnancy (CTOP) services in the RSA, they did not know when nor how to access these services.

Nurses working in contraceptive health services, revealed during a focus group discussion that a lack of resources (including shortages of male condoms, contraceptive injections and oral contraceptives) hampered the quality of services that could be rendered. Of particular concern was the nonavailability of Norplant implants and female condoms. Nurses expressed a need for specific national policy guidelines about supplying contraception to adolescents. Although most nurses knew about emergency contraceptives, they did not promote its use because they assumed that clients would misuse emergency contraceptives instead of using contraceptives regularly. The nurses indicated that very few facilities offered CTOP services. The nurses regarded women who obtained repeated CTOPs to be misusing these services and suggested that limitations should be placed on the number of times any woman could obtain such services. The negative attitudes of community members and of colleagues towards persons working in CTOP services caused hardships for them. Recommendations address ways in which contraceptive services could be improved.

## **KEY WORDS**

Adolescent health, adolescent's contraceptive use, contraception, emergency contraceptives, modern contraceptives, reproductive health, termination of pregnancy, traditional contraceptives.

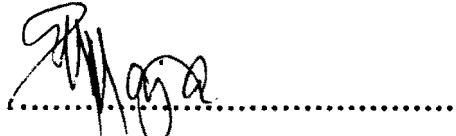
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Student number: 309-021-3

I declare that **CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE, GAUTENG PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. This work has not been submitted before for any other degree at any other university.



**SIGNATURE**  
(TMM MAJA)

20.02.2002

**DATE**

*This study is dedicated to  
my late mother, Mahlako*

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## List of abbreviations

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ANC	African National Congress
CBD	Community-based distribution
CDC	Centre for Disease Control and Prevention
CINAHL	Computerised Index of Nursing and Allied Health Literature
CTOP	Choice on Termination of Pregnancy
D&C	Dilatation and curettage
DENOSA	Democratic Nursing Organisation of South Africa
DOH	Department of Health
HIV/AIDS	Human immuno-deficiency virus/Acquired immuno-deficiency syndrome
IPPF	International Planned Parenthood Federation
IUCD	Intra-uterine contraceptive devices
IUD	Intra-uterine device
LAM	Lactational amenorrhoea method
LRA	Logistic regression analysis
MCWH	Maternal, child and women's health
MVA	Manual vacuum aspiration
NDOH	National Department of Health
PDP	Population Development Programme
PHC	Primary health care
RDP	Reconstruction and Development Programme
RHP	Reproductive Health Programme
RSA	Republic of South Africa

## List of abbreviations

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SPSS	Statistical Package for Social Sciences
SSA	Sub-Sahara Africa
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TFR	Total fertility rate
TOP	Termination of pregnancy
UNPF	United Nations Population Fund
UK	United Kingdom
USA	United States of America
WHO	World Health Organization
ZCC	Zionist Christian Church

## **List of annexures**

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**Annexure 1: Request for permission to conduct research**

**Annexure 2: Letters granting permission to conduct research**

**Annexure 3: Female structured interview schedule**

**Annexure 4: Male structured interview schedule**

**Annexure 5: Introductory letter**

**Annexure 6: Summary of contraceptive methods**

## CHAPTER 1

### Orientation to the study

#### 1.1 INTRODUCTION

Throughout the world, women are trapped in a cycle of unwanted and unintentional pregnancies as a result of inadequacies in contraceptive use. In the second half of the twentieth century, perhaps the most significant and personal change that occurred for women, was the evolution of 'contraceptive technology'. The expanded availability of modern contraceptive methods and the involvement of governments lend support to this notion (Fathalla 1997:68; Hatcher, Rinehart, Blackburn, Greller & Shelton 1997:1-15; Popenoe, Cunningham & Boult 1998:402). Every potentially fertile couple should therefore take cognisance of this giant stride by using contraceptives correctly and consistently to prevent unwanted pregnancies which result in overpopulation or termination of pregnancies (TOP).

On 11 July 1987, a baby was born that sent the world's population over the 5 000 million mark. Since then, this day has been set aside to reflect humankind's growing threat to the planet and ultimately, its own survival (Republic of South Africa 1994:20). On 11 July 1994, World Population Day, Dr Nthato Motlana, then Chairperson of the South African Council for Population Development, said in a media release:

*South Africa will achieve its full potential only if smaller family norms were to be accepted. South Africa has a*

*disconcertingly high birth rate in common with the developing world. The issue has always been politicised in the country and politicians in the past generally steered clear of the controversy.*

These problems therefore affected the activities of the programme until 1994 when a formal process of consultation on a new population policy was initiated by the Department of Welfare and Population Development. Chimere-Dan (1997:2) argues that the reason for the delay in the South African government's policy intervention was the debate about whether or not population activities and family planning programmes were strategies to reduce the numerical strength of Blacks.

The value of population control by using contraceptives effectively is, however, widely acknowledged as a vital requirement for the achievement of optimal health for all. The World Health Organization (WHO) and other intergovernmental, international and bilateral organisations made a commitment to the principles of promoting reproductive health and women's health at the International Conference on Population and Development in Cairo 1994 and the Fourth World Conference on Women in Beijing 1995 (WHO 1995:10). Specific aspects of reproductive health endorsed at the Cairo Conference included the following:

- Abortion should not be promoted as a contraceptive method.
- Recourse to abortion should be reduced through expanded and improved contraceptive services.
- Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion.
- Women who have unwanted pregnancies should have ready access to available information and compassionate counselling. In countries where abortion is legalised, women should have

access to these safe services (Website: <http://web2.../purl.rcl> HRCA 9/22/99).

Similar sentiments were expressed at the International Planned Parenthood Federation (IPPF) Conference, held in Mauritius in 1994, where the Mauritius Declaration called upon participating countries to address the health and social problems of unsafe abortions. Countries were urged to strengthen contraceptive information, education and services, emphasise couples' responsibilities in contraception to prevent unwanted pregnancies and provide quality, prompt humane treatment for women having complications of unsafe abortions, including adolescents (Website: <http://web2/purl.rcl>, HRCA 9/22/99).

In 1995, the Fourth World Conference on Women, held in Beijing, reaffirmed the importance of providing emergency medical care to women's post-abortion complications by indicating the following:

- Recognition and dealing with the health impact of unsafe abortions as a major public health concern.
- Improving medical care of women with complications of unsafe abortions.
- Emphasising the improvement of contraceptive services to prevent unwanted pregnancies (Website: <http://web2/purl.rcl>, HRCA 9/22/99).

Controlled reproduction is necessary to ensure the continued existence of the species. Conversely, uncontrolled, excessive population growth may not only lead to poverty in all its forms, but when all the available natural resources have been exhausted, the very continuation of the species may be threatened (Dreyer, Hattingh & Lock 1997:60; Theron & Grobler 1998:1; Vander Zanden 1996:381). These authors warn that if the present growth rate is maintained and steps are not taken to curb the population increase, the population of

the Republic of South Africa (RSA) may reach 70 million by 2020 and could escalate to 100 million by 2050, with far reaching deleterious effects on the environment.

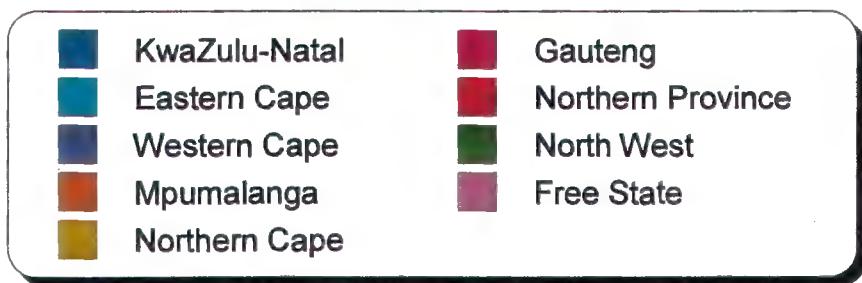
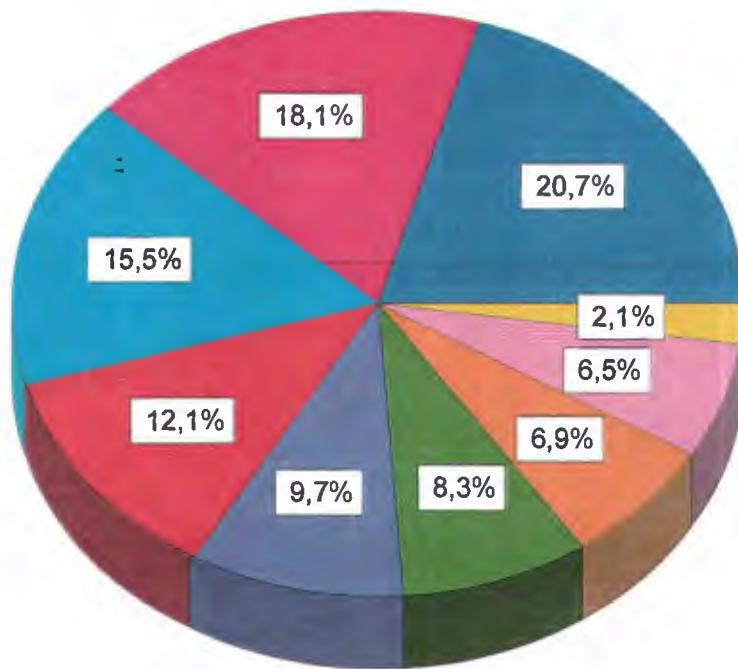
### **1.1.1 The Republic of South Africa's projected population growth until the year 2050**

The RSA's population is one of the fastest growing in the world, with most of the population growth taking place in the impoverished rural areas (Lessing 1994:146; Vlok 2000:335). According to South Africa's 1991 health trends, issued by the then Department of National Health and Population Development, South Africa's population picture was as follows:

- In 1994 mid-year projections of the country were 40,4 million people.
- A baby was born every 26 seconds, resulting in some 33 000 births per day.
- Every five years the population increases by 4,5 million people and at this growth rate the country will have a population of 406 million by the year 2100 (RSA 1994:21). Figure 1.1 portrays the population of South Africa in each province according to the South African census in 1996.

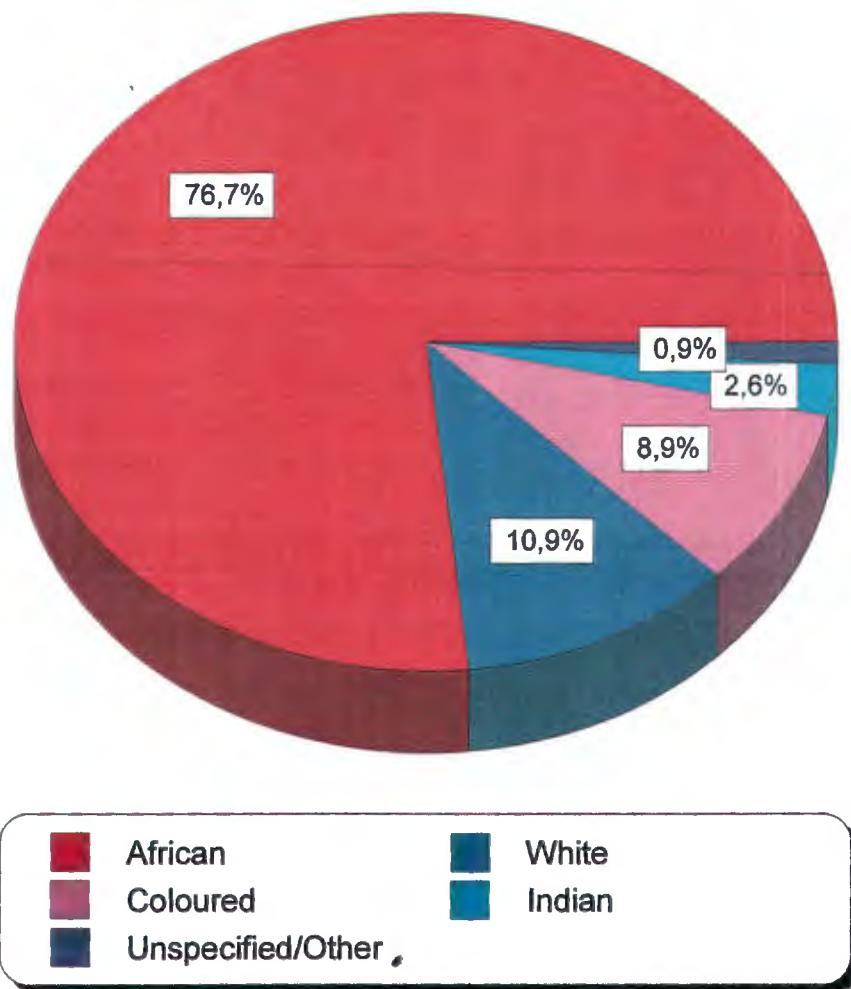
Marais (1988:80) projected the population of South Africa in the future as being 94 million in year 2035 with low fertility assumptions. With high fertility assumptions, the authors have projected fertility assumptions to increase to 119 million by 2035. Implications of these insurmountable projections are discussed in this chapter highlighting the urgent need to address overpopulation by consistent and effective contraceptive use.

It is ironic that in the RSA where contraceptives are freely available, and accessible to most people, these statistics could still prevail.



Total population = 40,6 million

**Figure 1.1: Population of South Africa in each Province → October 1996**  
 (Source: Population Census, South Africa 1996:4)



**Figure 1.2: Population of South Africa by population group → October 1996**  
(Source: Population Census, South Africa (1996:9))

### 1.1.2 Total fertility rate

One of the demographic measures used most commonly is the total fertility rate (TFR), the average number of children a woman will have, assuming the current age-specific birth rate remains constant throughout the childbearing years, ages 15 to 49. The TFR in most of the developed countries was below 2,0, implying that the average woman in these countries will bear less than 2,0 children over the course of her life (Population Reference Bureau in Popenoe, Cunningham & Boult, 1998:402). The lowest TFRs in Italy and Spain, namely 1,3 and these rates are still declining in most of the developed countries.

In the RSA, the TFR has been estimated at 2,1 children per woman by the year 2010 (RSA 1994:24). Popenoe et al (1998:402) state that fertility varies from one segment of a population to the next. In the RSA, for example, because of differing attitudes about reproduction and family size, as well as differing levels of knowledge about, and access to safe and effective methods of birth control, there are significant fertility differences between the four population groups. As in most other countries, there are also differences between rural and urban birth rates of women who are working outside the home and those who are not.

Understanding the factors which have an impact on fertility helps demographers to predict future trends. The estimated TFRs for the four South African population groups are Asians 2,4; Blacks 4,5; Coloureds 2,7; and Whites 1,7 (Popenoe et al 1998:403). Table 1.1 portrays the average number of children per woman by age and racial group. As can be noted from table 1.1, the TFR varies between the different racial groups (Dreyer et al 1997:60).

**Table 1.1: Average number of children per woman of reproductive age in South Africa, by age and racial group in 1993**

Age group	Racial group				
	Blacks	Coloureds	Asians	Whites	South Africa (average for as a whole)
15 – 19	0,2	0,1	0,0	0,0	0,1
20 – 24	0,9	0,5	0,4	0,3	0,8
25 – 29	1,8	1,5	1,2	1,0	1,7
30 – 34	2,8	2,6	2,3	1,7	2,6
35 – 39	3,7	3,1	2,5	2,4	3,4
40 – 44	4,4	3,8	2,8	2,3	3,9
45 – 49	5,0	4,2	3,0	2,5	4,3

(Source: Dreyer et al 1997:60)

In an attempt to restrain high fertility, the Population Development Programme (PDP) highlighted the importance of socioeconomic development programmes aimed at:

- the improvement of the living standards of all people
- economic development and growth
- the acceleration of development in respect of education, primary health care, training of resources, housing and nature conservation
- the vigorous promotion of contraceptive services and the use of contraceptives
- a change in the fertility perceptions of society so that it becomes more receptive to small family norms
- the improvement of the status of women and their integration into the formal economic sector
- a decrease in the infant and child mortality rates (RSA 1994:24)

The Reconstruction and Development Programme (RDP) endorses these aspects as a priority in an effort to curb the population growth by preventing unwanted pregnancies (ANC 1994b:46).

Significant numbers of women exercise their rights in terms of the Choice of Termination of Pregnancy (CTOP) Act to avoid unwanted or unplanned births. CTOP rates are sometimes used as a proxy measure of unintended pregnancies. Estimates are that more than 53 million abortions are performed each year worldwide. One third (17-20 million) of these are performed under unsafe conditions, resulting in 100 000 deaths, the majority of which occur in poor countries (Adanlawo & Moodley 1999:99; Bongaarts 1997:274; De Pinho & Hoffman 1998:790; Nunes 2000:36; WHO 1998:16). According to the WHO (1998a:16), the risk of death in poor countries following unsafe abortions is several hundred times greater than an abortion performed professionally under safe medical conditions.

In most developing countries, TOP has been legalised, including the RSA, in order to address the problem of unsafe illegal abortions and to improve women's health. In the RSA, the Choice on Termination of Pregnancy Act, 92 of 1996 was promulgated and implemented in February 1997. Since its enactment, 150 000 to 155 000 pregnancies have been terminated across the country (Bateman 2000a:11; DOH 2000:12; Varkey 1999:10). Of these, 49% were procured in the Gauteng Province. The health care system has, therefore, been challenged with how best to provide this service. Stevens (2000:22) maintains that preexisting obstacles within the health system were that doctors and midwives did not have TOP techniques incorporated into their training and have been taught rather conservative philosophies about women's right to choose. Increasing access to quality abortion services with dissemination of information regarding the Choice on Termination of Pregnancy Act, 92 of 1996, to all, could assist in addressing the problem of unsafe abortion.

#### **1.1.3 Implications of overpopulation**

An increased population places great demands on the economy, education, social and health care services with concomitant shortages

of qualified personnel to care for the needs of the population in all spheres. Documented literature reveals the ill-effects of over-population:

- shortage of land, water, housing and employment opportunities
- pollution of air, water and the environment will become increasingly worse
- depletion of natural and health services; the infra-structure for public and social services will be lowered and will absorb large sums of money
- increased unemployment, famine and finally, the whole country will become poorer
- increased emphasis on the control of sexually transmitted diseases (STDs) and human immuno-deficiency virus (HIV)/acquired immuno-deficiency syndrome (AIDS), termination of pregnancies, educational programmes and contraceptives for large numbers of adolescents in the community
- the burden and cost of having to deal with increased social pathologies, including alcohol and drug abuse, suicide, child abuse and family disorganisation, in a growing population
- the strain of a bigger older-growing population with its emphasis on the prevention, diagnosis and treatment of chronic diseases and economic consequences for the state and individuals (Dreyer et al 1997:59-61; Popenoe et al 1998:403)

In view of these circumstances, Dreyer et al (1997:59), Goodkind (1995:85) and Popenoe et al (1998:403) state that it has been scientifically proven that South Africa cannot support more than 80 million people and that the zero growth rate, that is, two children per family, must be attained by 2020 in order not to exceed that number.

## 1.2 STATEMENT OF THE PROBLEM

Unwanted and unintentional pregnancies pose problems throughout the RSA. These unwanted pregnancies are mainly terminated either legally or illegally. Research has shown that between 30% and 50% of women presenting for CTOP were not using contraceptives at the time of conception, and that similar numbers of pregnancies were unplanned (Bongaarts 1997:273; Crosier 1996:87). This happens in spite of free contraceptive services, including the availability of a variety of modern contraceptives.

The worldwide estimate of 36 to 53 million induced abortions performed each year resulting in complications leading to death, is a reflection of unwanted pregnancies which imply that women and men failed to use contraceptives. Pregnancies that are too early, too close, too late or too many, lead to health hazards for the mother and child, including the entire family. Such pregnancies are further implications of the failure or non-use of contraceptives. The escalating statistics of HIV/AIDS in the RSA can be attributed to the lack of condom use which protects individuals from being infected as well as from preventing unwanted pregnancies.

The rising incidence of adolescent mothers, repeat CTOPs particularly by adolescents, implies that these adolescents failed to use the available contraceptive services. The increased number of abandoned babies and the number of orphans in the RSA which is expected to exceed 1 million by the year 2000 is a further reflection of the failure to use contraceptives (Department of Child Welfare, SABC TV news: 2 May 1998 at 20:00).

A study to determine contraceptive practices, why men and women fail to use contraceptives consistently and accurately, and what barriers are experienced in contraceptive services and practices, was necessary to address these problems.

### **1.3 ASSUMPTIONS UNDERLYING THE STUDY**

The basic assumptions underlying this study were as follows:

- Contraceptive practices adopted in China, Vietnam, the Netherlands, Bangladesh, Cuba and other countries with effective birth control might provide guidelines to be implemented in Northern Tshwane to achieve similar results.
- Effective contraception through better insight and perceptions would improve the health and wellbeing of individuals and families.
- Improved contraceptive practices should control the growing population with its catastrophic effects and reduce the levels of unwanted pregnancies and CTOPs.
- Various factors might contribute to the use and non-use of contraceptives.
- Nurses would be better equipped to intervene appropriately when presented with clients due for contraceptives and those choosing to terminate a pregnancy (CTOP).

### **1.4 OBJECTIVES OF THE STUDY**

The specific objectives of this study aimed to

- identify contraceptive practices in China, Vietnam, the Netherlands, Bangladesh, Cuba and other countries to provide guidelines to be adopted in Northern Tshwane to achieve similar results
- explore the knowledge, perceptions and contraceptive practices of clients presenting for contraceptives and CTOP services
- describe how clients presenting for contraception and CTOP use contraceptives
- determine the contraceptive methods used by clients presenting for contraceptives
- determine factors influencing the use and non-use of contraceptives

- assess clients' knowledge, perceptions and utilisation of CTOP services
- describe nurses' knowledge, perceptions and their interventions when presented with CTOP clients
- determine the health care needs of women and men presenting for contraceptives and CTOP with regard to what a quality service of this nature should offer in order to improve the services on the basis of their inputs
- describe barriers experienced in offering adequate contraceptive services to clients, and how these could be addressed

### **1.5 SIGNIFICANCE OF THE STUDY**

Fathalla (1994:114) maintains that fertility by choice, not by chance, is a basic requirement for women's health, well-being and quality of life. A woman who does not have the means or the power to regulate and control her fertility, cannot be considered to be in a state of complete mental and social well-being. Effective contraceptive use will, therefore, not only control the population explosion, but a woman would have the joy of a wanted pregnancy, avoid the distress of an unwanted pregnancy, and be able to plan her life, pursue her education as well as plan her children's births to take place at optimal times for childbearing. This would also ensure better chances for her children's survival, health, growth and development.

The pandemic of HIV infection and the sexually transmitted infections (STIs) which are rapidly becoming a threat to women and children in developing countries could be reduced by the effective use of condoms (Haignere, Gold & McDanel 1999:43; Rollins 1996:290).

Unsafe abortions, claiming the lives women worldwide, could be addressed if contraceptives were used consistently, accurately, were accessible, acceptable, affordable and provided in a therapeutic environment. Information on clandestine abortions is difficult to

document but estimates yield a total of 15 to 17 million clandestine abortions worldwide for the period 1997 to 1998 (Adanlawo & Moodley 1999:99; Bongaarts 1997:274; Fathalla 1994:116; WHO 1995:6). Liberal abortion laws on the other hand, do not guarantee that safe services are available to all. This implies that women and couples should make use of other preventative contraceptives to prevent unwanted pregnancies. Following their freedom of choice on CTOPs in Europe, Godfrey (1996:202) recommended implementing initiatives to improve family planning education and contraceptive practice, including the re-education of women to understand that health is their responsibility; increasing the availability of contraceptive advice to improve reproductive health; providing information that would lead to increased use of condoms, afford opportunities for cervical screenings, as well as reduce the rate of CTOPs and maternal mortality.

In the Netherlands, the following factors play a major role in promoting improved contraceptive practices:

- acceptance of family planning movements
- fear of overpopulation with its concomitant implications
- the positive role of health care professionals by their general feeling that abortion should only be used as the final last resort for contraception (Ketting & Visser 1994:164-165).

These factors could guide the contraceptive practices and policy in Northern Tshwane, Gauteng Province. The entire RSA could benefit from adequate, effective and consistent use of contraceptives.

## 1.6 RESEARCH METHODOLOGY

Research methodology refers to the total strategy of the study.

### 1.6.1 Research design

Research design indicates the activities that guide an investigation (Woods & Cantanzaro 1998:117). This study employed a descriptive, quantitative (Burns & Grove 1997:26) as well as a qualitative (Woods & Catanzato 1998:150) research designs.

The research design was guided by the Health Belief Model and is described in chapter 2. Furthermore, it comprised two phases: phase 1 was quantitative and phase 2 was qualitative. In order to broaden the scope of the study and obtain a holistic view. It was decided to combine quantitative and qualitative methods. Hence two populations were selected for the two phases.

### 1.6.2 Phase 1: quantitative design

#### 1.6.2.1 *Population and sampling*

The population comprised all clients presenting for contraceptive and CTOP services at the three selected state health care centres in Northern Tshwane, Gauteng Province, namely:

- Rosslyn Clinic
- Odi Hospital
- Soshanguve Clinic I

Convenience sampling was used to select the sample of 160, 85 women and 75 men presenting for contraceptives and CTOP services at the selected health care centres indicated in section 1.6.2.1 of this chapter.

#### **1.6.2.2 *Data collection***

Data was collected by means of structured interviews with individual respondents presenting for contraceptive and CTOP services at the three selected health care centres.

#### **1.6.2.3 *Research instruments***

Separate questionnaires were developed for male and female respondents and interviews were conducted individually.

#### **1.6.2.4 *Data analysis***

Data analysis was done by means of a computerised Statistical Package for Social Sciences (SPSS). A statistical analyst assisted with data analysis. Logistic Regression Analysis (LRA) was used for further analysis of data to ascertain relationships among variables.

### **1.6.3 Phase 2: qualitative design**

#### **1.6.3.1 *Population and sampling***

The population comprised of all nurses responsible for providing contraceptive and CTOP services to all clients at the three health care centres indicated in section 1.6.2.1 of this chapter.

Twelve nurses responsible for providing contraceptive and CTOP services to clients at these health care centres were selected purposely to participate in the study.

#### **1.6.3.2 Data collection**

Data was collected by means of a focus group interview conducted with nurses providing contraceptive and CTOP services at the selected health care centres in Northern Tshwane, Gauteng Province.

#### **1.6.3.3 Research instrument**

A structured questionnaire was developed with main and subquestions, to address the research questions.

#### **1.6.3.4 Data analysis**

Tesch's model (Cresswell 1994:154-155) was used to analyse the data and encoding used to enhance the trustworthiness and validity of the study.

#### **1.6.3.5 Ethical considerations**

Permission to conduct the study was obtained from the authorities of the selected health care centres. The researcher adhered to Denosa's (1998:1-4) ethical standards for nurse researchers.

#### **1.6.3.6 Pilot study**

A pretest was conducted with 20 clients presenting for contraceptive and CTOP services at a health care centre which not included in the main study. The aim of the pretest was to identify problems related to the research instruments.

### **1.7 OPERATIONAL DEFINITIONS**

The following concepts are used in the context of this study.

### **1.7.1 Birth control**

Birth control refers to limiting the size of families by measures designed to prevent conception. Birth control began in modern times as a humanitarian reform to conserve the health of mothers and the welfare of children, especially among the poor.

### **1.7.2 Contraception**

Contraception means the prevention of conception at impregnation. Contraception may be achieved by using contraceptive methods. This study described contraceptive methods as traditional, modern, emergency and termination of pregnancy (TOP).

### **1.7.3 Traditional contraceptive methods**

Traditional contraceptive methods refer to contraceptives which have been prescribed and may be supplied by traditional healers to prevent unwanted pregnancy.

### **1.7.4 Modern contraceptive methods**

Modern contraceptive methods refer to contraceptives which are frequently used in the modern era. These may be prescribed by medical practitioners, nurses and pharmacists. Such contraceptives may be obtainable from health care centres, pharmacies and doctors' surgeries. Condoms are also obtainable from some public centres.

### **1.7.5 Emergency contraceptive methods**

Emergency contraception is a safe and effective method of preventing accidental pregnancy after unprotected intercourse or a contraceptive accident. Emergency contraception works by inhibiting ovulation, delaying ovulation or by preventing implantation. A person who might

have had unprotected sex should take the emergency contraceptive as soon as possible and then again after 12 hours later.

#### **1.7.6 Termination of pregnancy**

This refers to the abortion of a live foetus of a woman with the intent to kill such foetus (Choice on Termination of Pregnancy Act, 92 of 1996).

Ehlers, Maja, Sellers and Gololo (2000:48) refer to the Act by acknowledging that TOP services should include the counselling of women before and after the CTOP procedures, should be able to manage incomplete abortions, should provide contraceptive services after the TOP and should link TOP services to other related reproductive health services, including contraceptive services.

#### **1.7.7 Contraceptive practices**

For the purpose of this study, contraceptive practices entail contraceptive use, non-use, discontinuation and failure to use any or all contraceptive methods according to a specified set of rules.

#### **1.7.8 Fecundity**

Fecundity refers to the maximum biological capacity of women in the population to produce children (Popenoe et al 1998:401).

#### **1.7.9 Fertility**

Fertility describes the frequency with which births occur in a population and depends on such biological factors as the number and general health of childbearing women in a population (Popenoe et al 1998:414).

#### **1.7.10 Infant mortality rate**

Infant mortality rate refers to the number of deaths in children under one year per 1 000 live births for a defined community during one year. The WHO recommends an infant mortality rate of below 50 per 1000 lives births as acceptable.

#### **1.7.11 Maternity mortality rate**

Maternal mortality rate is defined as the number of deaths registered during one year of women dying from causes due to pregnancy and childbirth per 1 000 registered total births (live and still births) in that year. Maternal mortality rate gives an indication of the risk of mothers during pregnancy and childbirth as well as the socio-economic conditions, the nutritional status and sanitation facilities in a specific community.

#### **1.7.12 Population growth rate**

This refers to the increase or decrease of population numbers expressed as a figure per one thousand of the total population per annum.

#### **1.7.13 Total fertility rate**

According to DOH (1999:glossary), total fertility rate is defined as the number of children a woman will have, assuming the current age-specific birth rate remains constant throughout her child-bearing years ( $\pm 15\text{--}49$  years).

#### **1.7.14 Unwanted pregnancy**

Unwanted pregnancy refers to a pregnancy that may not have been planned, and that may be unintentional and unwelcomed by the

pregnant woman. Such a pregnancy may occur as a result of contraceptive failure or nonuse of contraceptives.

### **1.8 ORGANISATION OF THE REPORT**

This research report comprises of the following chapters:

Chapter 1 give a general orientation to the study and discussed its significance, objectives and underlying assumptions. The research methodology and ethical considerations are also discussed.

Chapter 2 presents the literature review on contraception and contraceptive practices.

Chapter 3 describes the research methodology, data collection and data analysis of the study.

Chapter 4 discusses the data analysis of phase 1.

Chapter 5 discusses the interpretation of the data analysed in chapter 4, validating the findings with reference to relevant literature.

Chapter 6 covers the analysis and discussion of data collected in phase 2.

Chapter 7 discusses the limitations and findings of the study and concludes with recommendations.

### **1.9 CONCLUSION**

This chapter provided an overview of the study. Unwanted and unplanned pregnancies are major reproductive health problems plaguing women throughout developing countries, including the RSA.

Such unwanted and unplanned pregnancies have a negative impact on the country's health, economy and education.

Chapter 2 covers the literature review on contraception.

## CHAPTER 2

### **Contraceptive practices: a literature review**

#### **2.1 INTRODUCTION**

Contraceptive practices entail a wide spectrum of interrelated concepts, namely, contraceptive behaviours, methods, use, discontinuation, nonuse and failure of contraceptive methods. In this chapter, concept analyses of applicable terms will be provided by using relevant literature on the subject in order to substantiate the findings.

An extensive literature study on contraceptive practices was done with relevant literature retrieved from a number of libraries, the Internet, conferences and discussions with experts in reproductive health.

The University of South Africa's library consulted the following databases to obtain reports relevant to contraception and contraceptive practices:

- MEDLINE express .
- CNAHL database
- NISC discover report
- OASIS library catalogue (accessed via the Unisa website:  
<http://www.unisa.ac.za>
- International nursing index
- Social science index

Key concepts used for obtaining relevant literature included:

- contraceptive methods
- modern contraceptives
- traditional contraceptives
- emergency contraception
- termination of pregnancy
- unwanted pregnancy

Literature sources were reviewed, analysed and categorised according to contraceptive methods, contraceptive use, including factors influencing contraceptive practices and the obstacles in contraceptive use.

## 2.2 A HISTORICAL PERSPECTIVE

Throughout history, women have expressed a need to regulate their fertility in order to prevent unplanned and unwanted pregnancies. Until recently, they had neither the means nor the power to do so. Fathalla (1997:4) claims that this did not stop women from doctoring themselves as Hypocrates noted in 400 BC, even at the risk of ill-health, sterility and death.

Traditionally, contraceptive recipes were found in almost every cultural group. Egyptian papyri from 1850 BC, referred to plugs of honey, acacia gum and crocodile dung used by women as contraceptive vaginal paste (Fathalla 1997:8; Theron 1987:16). Whether effective or not, these methods showed women's seriousness about regulating their fertility. In addition, women used prolonged breastfeeding to postpone subsequent pregnancies, and in European countries, relatively late marriages have become increasingly customary.

Men, on the other hand, had the power and the means to prevent unwanted pregnancies very early in history. The book of Genesis 38 refers to withdrawal, which historians considered to be the most ancient contraceptive practice used by men.

These contraceptive methods were classified, according to Theron and Grobler (1998:18), as conventional, which may be natural or traditional. In this study natural methods refer to origins of all contraceptive methods used by women and men. Traditional contraceptive methods are defined as those methods mainly prescribed by traditional healers, including folk contraceptive practices which are used by women and men. Traditional contraceptives also include those practices which are passed on from mothers to daughters, such as wearing contraceptive "bands" or "ropes" around the waist of the woman. In this section, a brief overview of the origins of contraceptives will be presented. Some contraceptive methods will be discussed fully as traditional or modern contraceptives respectively.

### **2.2.1 Natural methods**

Natural methods of contraception are methods of periodic sexual abstention without using artificial means.

#### **2.2.1.1 *Abstinence***

Sexual abstinence is the most effective method of contraception without physiological or psychological effects. It is an old method which is still practised to prevent unwanted pregnancies.

Although abstinence has been an unpopular contraceptive method to practice, it has become common amongst young people, widows, widowers and divorcees (Theron & Grobler 1998:18). These authors point out that there is lack of evidence regarding abstinence as

having harmful physiological or psychological effects, even when practiced for long periods of time. As a result, this method may be used without ill-effects. In an attempt to address and prevent the HIV/AIDS pandemic in most countries, abstinence is advocated as the first option of contraception, particularly amongst the youth, and prior to marriage.

#### ***2.2.1.2 Coitus interruptus***

Coitus interruptus or withdrawal of the penis without orgasm and without ejaculation, is a very ancient contraceptive method which is still widely used. Some couples use it intermittently as an emergency measure whilst for others, it is standard practice. It can be a safe method for experts but the danger is that if a drop of semen leaks into the vagina, or if the ejaculate is deposited on the vulva near the introitus, pregnancy can occur. Theron and Grobler (1998:18) estimate that 50% of couples in some Western countries occasionally use this method of contraception.

Coitus Interruptus can also disturb the sexual relationship of the couple as the need for prompt withdrawal may cause anxiety, tension and non-satisfaction of the woman, with the result that this method might be neither satisfactory nor reliable.

#### ***2.2.1.3 Rhythm method***

This is essentially a method of periodic sexual abstinence. When using the rhythm method, an attempt is made to determine a woman's fertile and infertile periods during the reproductive cycle. If coitus takes place during an infertile period, conception will not occur. During fertile periods, sexual abstinence or contraceptive methods such as coitus interruptus, condoms or diaphragms, must be used to prevent unplanned pregnancies.

Ovulation takes place on the 14<sup>th</sup> day before menstruation, but it is dependent on the regularity of menses and on various psychological influences. Physiologically, conception can take place only during one to three days during the middle of the menstrual cycle while the ovum is alive in the oviduct. Theron and Grobler (1998:19) believe that it is difficult to predict with certainty when ovulation will occur because the follicular phase often varies in duration. The spermatozoa can remain alive in the fallopian tubes for several days, thus prolonging the danger period to nine days. If coitus takes place during this period or shortly before it, conception is likely to take place, therefore it is an unreliable method to use.

Some women use temperature checks for contraception by taking their own rectal temperature at exactly the same time every morning before rising. Ovulation causes a slight drop in temperature, followed a day or two later by a rise of 0,5°C above the normal temperature for the previous 14 days. The temperature remains at this level until menstruation starts, when it drops to the normal once more.

The woman will be safe if she avoids unguarded coitus until three days after the temperature has gone up. This method is not reliable as its efficiency depends on the partner's cooperation and on knowledge of ovulation times which might fluctuate (Miller & Collander 1994:479; Theron & Grobler 1998:19).

#### **2.2.1.4 Calendar method**

A woman using the calendar method of contraception should keep a continuous record of her cycles for a year. A cycle starts on the first day of menstruation and ends the day before the next menstruation. The woman will thus have a retrospective record which can be utilised to calculate the fertile days of the following cycle by considering the cycle lengths of the previous year. The possible fertile period is from 10 to 20 days before commencement of the next

cycle. This method is also unreliable and impractical, because the woman needs to be able to calculate precisely the fertile and unfertile (safe) days, which may fluctuate (Theron & Grobler 1998:17).

#### **2.2.1.5 Lactational amenorrhoea method**

The lactational amenorrhoea method (LAM) is a natural contraceptive method that can be used by breastfeeding women. Breastfeeding-induced child spacing has been practised throughout history and has been found to be an effective method if the following criteria are met:

- the woman is amenorrhoeic
- the woman is breastfeeding fully, implying that she does not give any supplementary food to the infant
- the baby should be younger than six months (DOH 1999:88; Hatcher et al 1997:15-4)

DOH (1999:88) warns that in view of the tendency towards very early weaning in some areas in the RSA, the concern about the high incidence of HIV infection and the risk of transmitting the virus through breast milk, LAM should not be actively promoted. However, health service providers should be well informed about LAM so that they can assist women who choose this method.

LAM is 98-99% effective during the first six months after childbirth in women who are breastfeeding fully. Its effectiveness falls after six months (Hatcher et al 1997:15-4). In most developing countries, people still follow the traditional practice that a woman who is breastfeeding her baby may not have sexual intercourse during the nursing period. In such cases, sexual abstinence becomes the basis of lactation contraception. The advantages of the LAM method have been summarised by Hatcher et al (1997:15-4). These authors maintain that LAM

- effectively prevents pregnancy for at least six months and may be longer, if a woman keeps breastfeeding often, day and night
- encourages the best breastfeeding patterns
- can be used immediately after childbirth
- requires no actions at time of sexual intercourse
- has no direct cost for contraception or for feeding the baby
- needs no supplies or procedures to prevent pregnancy
- has no hormonal side effects
- users should be encouraged to start using a follow-up contraceptive method at the proper time
- breastfeeding practices required by LAM have other health benefits for the baby and the mother, including:
  - providing the healthiest food for the baby
  - protecting the baby from life threatening diarrhoea
  - helping to protect the baby from life threatening diseases such as measles and pneumonia by passing the mother's immunity to the baby
  - enhancing a close relationship between mother and baby
- (Hatcher et al 1997:15-4).

Health care providers should explain the importance of correct and consistent use of the LAM method to clients in order to ensure its effectiveness.

The following disadvantages of the LAM should, however, be indicated to caution clients about the possibilities of falling pregnant if they do not adhere to correct and consistent use of the method:

- effectiveness after six months is not certain
- frequent breastfeeding may be inconvenient or difficult for some women, especially working mothers
- no protection against STDs including HIV/AIDS

- if the mother is HIV positive, there is a chance that the virus can be passed in breast milk to the baby (Hatcher et al 1997:15-5)

Given the advantages and disadvantages of LAM, women who are breastfeeding infants and do not desire another pregnancy at the time, need to use a more reliable form of contraception. Low dose combination oral contraceptives, progestin only, norplant, depo-provera injections and all barrier methods of contraception are recommended for use while breastfeeding (<http://health@yahoo.com/health/contraceptionfamilyplanning> 2001).

#### ***2.2.1.6 Cervical mucous changes (Billings' method)***

Theron (1987:16) explains that the mucous secreted by the cervix changes during the menstrual cycle and becomes noticeably copious for a few days before ovulation. This mucous enables the sperm to swim up through the vagina, uterus and into the fallopian tubes to await the arrival of the ovum. The Billings method teaches women to recognise this change in mucous secretion and abstain from coitus during this time.

Its effectiveness depends on the woman's knowledge of her menstrual cycle in order that she may be able to observe the changes in mucous secretion. This method causes the highest failure rate when the ovum is not present in the fallopian tubes. However, spermatozoa may survive up to seven days and there is no way of predicting ovulation except in the case of Mittelschmerz. If coitus is restricted to the pre- and postovulation period, the risk of pregnancy is decreased.

#### ***2.2.1.7 Diaphragm***

In 1823 the first diaphragm was designed by Dr FA Wilde as a vaginal barrier method. Other similar contraceptive methods such as

a cotton ball in the Talmud, a sponge soaked in vinegar used by Cleopatra and half a lemon hollowed out and placed over the cervix, used by Casanova, are pre-Christian writings describing how women were 'doctoring themselves' to prevent unwanted pregnancies (Theron 1987:16).

#### **2.2.1.8 Condoms**

The condom, another effective method, has been available to men for a long time. According to Theron (1987:17) condoms were first described by Dr Fallopius in 1564. They were made of linen soaked in a secret potion and were meant not only to prevent pregnancy, but also venereal diseases. Condoms are the oldest, cheapest, safest and most widely used contraceptive devices. Condoms are the only contraceptive method which protect the healthy partner against venereal disease, should the other partner be infected. Condoms were therefore issued to soldiers in the Middle East during World War II (Vlok 2000:351).

#### **2.2.1.9 Vaginal douching**

Vaginal douching refers to irrigation of the vagina to cleanse the area, to apply medicated solutions to the vaginal mucosa and the cervix or to apply heat in order to relieve pain, inflammation and congestion.

Vaginal douching with water, soapy water and many other fluids is an ancient method still used by desperate women to prevent unwanted pregnancies. This was prescribed by Lucretius in 99BC and by famous Greek and Roman physicians Soranus and Aricessa (Theron 1987:17).

#### **2.2.1.10 Oral contraception**

In 1200 BC, oral contraception was practised by the Chinese. Documented sources report that the woman had to swallow six live tadpoles before coitus. Women were told to drink a cup full of smithy water after each menstruation. Indian women swallowed preparations of leaves, seeds or roots of certain plants and trees. In 1956, Rock, Garcia and Gregory Piacus demonstrated the ability of a progestogen, norethisterone to prevent ovulation. The pill was finally approved in the United States of America (USA) in 1959 for contraceptive use. In the same year, contraceptive injections, Depo Provera and Nur-Isterate came on the market though they were only used since the late 1960s (Theron 1987:18).

#### **2.2.1.11 Intrauterine devices**

Intrauterine contraception originated with the Egyptian mummies who had semiprecious stones put in their uteri for contraceptive purposes. According to Theron (1987:19) Turks and Arabs also placed stones in the female camels' uteri when undertaking long caravan journeys to prevent them from falling pregnant. In 1909, Dr Richter of Poland described a uterine device that he had made and used on seven hundred patients with no pregnancies occurring from 1929 to 1933. Ernst Grafenberg subsequently designed a silver wire ring without a tail and inserted it wholly into the uterus, resulting in difficulty and pain during insertion and removal. As it was before the advent of antibiotics, fears of infection with intra-uterine device insertions resulted in cessation of its use in 1935. With the discovery and general availability of antibiotics, the fear of infection diminished. It was after the international conference on intrauterine devices and their acceptance in New York in 1962, that the fear of infection decreased. To date, intrauterine devices are used by over eighty million women worldwide (Theron 1987:19).

### **2.2.1.12 *Sterilisation***

Surgical sterilisation in men and women is a procedure that aims at permanently preventing the sterilised persons from producing further children. Sterilisation came with the Greek historian Straba who claimed that in medieval times the royal courtesans underwent ovariectomy to prevent pregnancy and to preserve their good looks. Males working in harems were castrated, but because eunuchs can occasionally still be sexually potent, the penis was sometimes removed in addition to the removal of the testes. Civilised sterilisation techniques were only developed after the discovery of general anaesthesia in the eighteenth century (Theron 1987:6). Civilised procedures are directed at the occlusion of the fallopian tubes in females and the vas deference in males.

### **2.2.1.13 *Termination of pregnancy***

TOP has been used as a form of birth control in many societies, including the RSA. According to Engelbrecht, Pelser, Ngwena and Van Rensburg (2000:5), in the middle of the 19<sup>th</sup> century, British officials in the Eastern Cape reported that abortions were performed on all classes of African women. This was seen as an acceptable way to deal with problematic pregnancies. In the Eastern Cape, some chiefs were expected to force an adulterous wife to induce a miscarriage. A folk-recipe for abortion was included in a 20<sup>th</sup> century Afrikaner home remedy book; indicating that herbs and chemical preparations were widely used. Surgical procedures became available from the 19<sup>th</sup> century, mostly for white women (Engelbrecht et al 2000:5).

Goosen and Klugman (1996:336-338) found that rural Bapedi and Tsonga men believed that if a woman had an abortion, there would be no rain in the area. In addition, African women who had abortions were seen as being deviant or witches. In the most desperate of

circumstances, unwanted offsprings have been subjected to infanticide, and pregnant unmarried women have been disowned and in rare circumstances, put to death (CDC 1999:25).

During the colonisation of South Africa, Roman-Dutch Law was introduced and the general law on abortion was addressed. Abortion was criminalised except where it was performed to save the woman's life. This common law, however, was not able to delineate its boundaries. It was not certain whether the exception was only applicable if an abortion would save the woman's life, or whether it also applied if it would protect her from physical or mental injury (Engelbrecht et al 2000:5). In 1975 the Abortion and Sterilisation Act was passed. The Choice on Termination of Pregnancy Act (Act no 92 of 1996) became operative during 1997. Both the 1975 and 1996 legislation will be addressed under section 2.3.6.3 of this thesis.

## **2.2.2 Traditional contraceptive methods and practices**

### **2.2.2.1 *Introduction***

Traditional methods of contraception have been used worldwide since time immemorial to prevent unwanted pregnancies. Several studies on traditional healers have found that up to 80% of indigenous people in South Africa, consult traditional healers (Barker 1994:2; Freeman & Motsei 1992:1183; Sodi 1996:5). According to Barker (1994:2), there are 200 000 traditional healers in South Africa and adjacent territories who are consulted by people of all ages, both genders with varying levels of education and representing all racial groups. Traditional healers are known to treat the whole person, paying particular attention to family and social relationships as these may influence or be influenced by a person's malady. Traditional healers use various forms of treatment depending on the condition or contraceptive assistance needed by their clients. The creative and occasionally life threatening techniques used to limit childbearing

show how women and men have tried to control reproduction and sexual practices.

#### **2.2.2.2 Traditional healers and contraception**

There are four main types of traditional healers using different forms of treatment and practices for various conditions, including contraceptive services.

➤ **Inyangas (ixhwele in Xhosa; mganga in Swahili)**

About 90% of inyangas are males. They specialise in the use of herbal medicine because they have an extensive knowledge of curative herbs, natural treatments and medicinal mixtures of animal origin. Some treat a particular disease and become experts in areas such as heart, kidney, lung diseases, or rainmaking (Abdool-Karim, Ziqubu-Page & Arendse 1994:11). According to these authors, inyangas may or may not have knowledge of medicinal herbs. Their speciality is divination within a supernatural context through culturally accepted mediumship with ancestral spirits.

➤ **Umthandazi (mu Profiti in Sotho)**

Faith healers are usually professed Christians who belong to one of the missions of the African independent churches. They heal mostly through prayer, by laying hands on patients or providing holy water and ash (Abdool-Karim et al 1994:7). They believe that their healing power comes directly from God. Through ecstatic states and trances they establish contact with spirits or some combination of both ancestral spirit and Christian Holy Spirits. They use a combination of herbs and holy water in their treatment. Training as a faith healer is not necessary. Their healing system is moulded on the sangoma group pattern whereby the afflicted

live for months or years at the prophet's residence. Faith healers are sometimes favoured by clients because they seem to integrate both Christian and African traditional beliefs (Abdool-Karim et al 1994:7).

### ➤ Traditional birth attendants

Traditional birth attendants are usually elderly women who have been midwives for many years and who are highly respected for their obstetric and ritual expertise. Women aspiring to be traditional birth attendants should at least have two children in order to be able to appreciate the joys and agonies of childbirth (Abdool-Karim et al 1994:8). Their training entails 15 to 20 years of apprenticeship before they assume the title. Traditional birth attendants are responsible for duties such as the teaching of behavioural avoidance among pregnant women and ritual bathing of the mothers after delivery. They also give advice on postpartum care and provide important support for breastfeeding, advice on marriage, contraception and fertility. Traditional birth attendants do not charge for their services and that donations in kind or gifts are usually given (Abdool-Karim et al 1994:8). Steyn and Muller (2000:8) report that sexuality education, especially focusing on youth and avoidance of early sexual activity and multiple partners, avoidance of sexually transmitted diseases, abortion, the use of condoms, are aspects addressed by traditional healers in their health education programmes.

#### **2.2.2.3 Traditional contraceptive methods practised in the RSA**

Traditional contraceptive methods are practised by women and men mainly in areas where health care services are lacking in the RSA. In the Northern Province, Wood and Jewkes (2000:11) found that knowledge about traditional methods of contraception was widespread amongst teenagers who perceived that these methods

the medicine had lost its strength. Teenagers in the same study indicated that they had not used these methods because they weren't 'used' to traditional healers. Some of the methods mentioned involved:

- tying a rope containing traditional medicines around the waist
- mixing a cloth covered in the woman's menstrual blood with medicines from the traditional healer and burying it until conception was desired
- putting a woman's menstruation, mixed with medicine from a traditional healer in a bottle and burying the bottle in an inverted position in the woman's home. The interpretation was that the cervix would remain open and no conception would take place till the bottle was removed and contents emptied when conception was desired.
- religious methods mentioned by followers of the Zion Christian Church (ZCC), which discourage the use of biomedical contraceptive methods, included drinking strong coffee or tea and medicines over which church leaders had prayed.

Folk contraceptive practices, reported by Vlok (2000:360) included:

- Prolonged lactation
- Douching after intercourse
- Drinking "lewensesens" after unprotected sex (a Dutch remedy)
- Suppression of emotions by women, believed to be suppressing orgasm during coitus
- Placing cotton wool soaked in oil or vinegar in the vagina during intercourse

Vlok (2000:360) warns, however, that health care providers should emphasise the ineffectiveness of these "folk" contraceptive practices which could lead to unwanted pregnancies.

Silberschmidt and Rasch (2001:1823) found that sexually active girls in their study did not use any type of contraception and had therefore opted for induced abortions. These girls indicated that it was difficult for them to get modern methods of contraception because they were still young and unmarried. Modern contraceptives were given to married women who had children. As a result, young girls resorted to traditional methods of contraception which were cheap to get. These girls admitted to using strings on which they made knots and tied it around the waist. One knot equaled one year, so that if the girl wanted to prevent pregnancy for more than one year, more knots would be tied accordingly.

A number of traditional contraceptive methods have been reported by the Centres for Disease Control and Prevention in the USA (CDC 1999:12-25) and can be summarised as follows:

#### Mechanical barriers

Mechanical barriers used by women as traditional contraceptives are:

- sponge and spongy substances placed in the vagina after sexual intercourse
- lemon halves, shelled out and placed over cervix (similar to cervical caps)
- linen pads in vagina after sexual intercourse to cleanse the vagina
- crocodile or elephant dung applied in the vagina after intercourse to destroy sperms that might result in pregnancy
- condom-like materials: serum and bladder of various animals, linen sheaths, receptacles shaped like condoms that are placed into the vagina before sexual intercourse

### Spermicidal chemicals

Spermicidal materials used by women before and after sexual intercourse include:

- lemon juice and cola drinks taken after unprotected sexual intercourse
- vaginal pills made of tannic acid inserted in the vagina before unprotected sexual intercourse
- sodium bicarbonate, oils and ground betel nut inserted in the vagina before and after sexual intercourse

### Douches

Vaginal douches used for contraception after unprotected sexual intercourse:

- douches of alum
- white oak and hemlock bark
- red rose and raspberry leaves
- roots of specific trees and plants
- sinz sulphate
- sodium bicarbonate and coca cola

### Manual removal of semen

- manual removal of semen with a cloth from the vagina after coitus
- jumping up and down to force the semen out of the vagina after sexual intercourse

### Pessaries or suppositories

Pessaries or suppositories are inserted in the vagina before sexual intercourse. The following are used:

- gold ball at the base of the "temple of love"
- black pessary with four concavities
- beeswax
- opium ball
- stones placed in the uterine cavity

### Systemic preparations

Systemic preparations are taken orally either before or after sexual intercourse. These are:

- Tea made of roots to make a woman sterile, such as warm fern roots
- Sabine (*Juniperus sabina*) to prevent conception
- Marjoram, thyme, parsley and lavender teas
- Willow tea (CDC 1999:23-25)

### Surgical interventions

Traditional surgical intervention methods of contraception refer to female and male circumcision.

#### *Female genital mutilation (circumcision)*

Female genital mutilation varies in degrees from removal of the prepuce of the clitoris to an extensive procedure called excision and infibulation. With the latter, the entire clitoris, all of the labia minora and part of the labia majora are surgically removed and the vaginal opening is almost totally closed to render penile penetration difficult.

Delano (in CDC 1999:21) conducted an investigation in which 1 900 circumcised women were compared with a similar group of uncircumcised women. The findings revealed that 50% of the circumcised women reported having difficulty in permitting penile penetration or suffering pain during intercourse. Of these women, 56% failed to achieve orgasm during intercourse and a further 60% of the circumcised women engaged in sexual intercourse far less often than those who were not circumcised. Female genital mutilation has resulted in pelvic infections and infertility in women because of infectious complications that frequently follow the procedure.

According to the WHO (1998a:3), female genital mutilation continues to be practised in 27 out of the 46 member states in the WHO African Region and that more than 90% of females have undergone genital mutilation in some cultures. The WHO urges that effective interdisciplinary and gender sensitive programmes should be established for the reduction of these harmful practices.

*Male genital mutilation* refers to surgical removal of all or part of the foreskin, or of the prepuce of the penis. The operation is done for hygienic and medical reasons and is also the oldest known religious rite. In the Jewish faith circumcision is a ritual that is performed by a mohel (ordained circumciser) on the eighth day after birth whenever possible. The circumcision is followed by a religious ceremony during which the baby also receives his name (Miller & Keane 1990:220). Male genital mutilation was reported by CDC as a traditional practice that rendered males incapable of impregnating women in most African countries (CDC 1999:21).

#### Plants and other substances

Some plants are used as spermicides, contraceptives or labour-inducing agents. Newman and Nyce (in CDC 1999:21) and Mahran

(in CDC 1999:22) found that women often placed household substances such as aspirin, lemon juice and black pepper, into their vaginas prior to intercourse. In the same study, hot water with salt, vinegar, lemon juice, alum, soap or potassium, were reportedly used by women after intercourse to prevent unwanted pregnancies.

#### **2.2.2.4 Conclusion**

Although modern contraceptive methods are more effective and sometimes safer than most traditional methods, the latter methods continue to be widely used. Many of these methods may be ineffective and/or harmful (CDC 1999:23). It is therefore important that health care providers be informed about these traditional methods as this will assist them in their assessment of clients' contraceptive practices. Replacing the client's traditional practice with modern methods of contraception may not be possible in many instances, particularly in rural areas, where difficulties may be experienced in maintaining a consistent supply of contraceptives. Cultural views may also add to resistance against modern contraceptive practices (CDC 1999:23). The decision about the safety of the traditional method may be difficult to make. If there are any doubts about any of the traditional contraceptive methods, health care providers may recommend modern contraceptive methods.

### **2.3 INTERNATIONAL PERSPECTIVES**

International perspectives of contraceptive uses are included in this thesis to indicate that other countries have had similar problems of unwanted pregnancies and some have successfully encouraged effective contraceptive practices to address their population expansion problems. These countries include China, Vietnam, the Netherlands, Bangladesh and Cuba. In the discussion, ways are identified of how contraception is practised in the various countries referred to. The legal implications of fertility regulations and the

impacts on the respective communities are also addressed, with the view of identifying positive aspects from these countries which could be applied to the RSA, including in the Northern Tswane area.

### **2.3.1 China**

China, the world's most populous country, has a fifth of the world's population and has officially encouraged birth control. China operates the most drastic population control measures found anywhere in the world, the one-child policy (Popenoe et al 1998:412).

#### ***2.3.1.1 Population policy***

In 1979, China adopted antinatal policies (public policies aimed to discourage births) and sought to discourage large families. Antinatal policies aim at limiting population by providing facilities for contraceptives, abortion and sterilisation and encouraging their use; providing penalties for large families and, less frequently, rewards for small families (Popenoe et al 1998:411).

The Chinese government developed a national programme aimed at achieving a stable population by the year 2000. Couples who have only one child, who pledge that they would have no more children and who prove that they are using birth control measures, receive a fixed amount of money each month until their child is 14 years old. The couple receives preferential treatment in obtaining housing, and their child receives priority attention with regard to school admissions and job applications. At retirement, the couple receives a larger pension than they would ordinarily be allocated. In some Chinese provinces, fines are imposed on couples who do not limit the size of their families to two children. The minimum fine is 6% of the couple's income, and the percentage increases with each additional child. Exceptions may be permitted for multiple births or, in some cases, if the first child was a girl (Popenoe et al 1998:412).

### ***2.3.1.2 Contraceptive use***

In China, all contraceptive methods such as the pill, injectables, barrier methods and sterilisation are available, including abortion. The one child family is the official policy, and the recommended minimum age for marriage is 28 years for males and 25 years for females. The seriousness in the desire of the Chinese government to prevent the population from rising to a second billion, is clearly embraced by community pressure and direct coercion. In most Chinese areas, couples must get permission to have a child and according to Butterfield (cited by Goodkind 1995:88), the couple may be ordered to abort an unapproved pregnancy. These restrictive birth control measures have resulted in the reduction of their birth rate from 37 per 1 000 in the mid 1960's to 20 per 1 000 in the late 1970's, with the final aim of reducing births to one child per family and securing an actual reduction in the size of the population.

Vander Zanden (1996:381) maintains that even though Chinese women prefer to have 4.1 children on average, the population policy denies them this opportunity by imposing punishment as described earlier. As a result, compliance to contraceptive use is compulsory, according to Chinese law.

### ***2.3.1.3 Termination of pregnancy***

Singh and Henshaw (1996:6) found that about 32 million induced abortions per year occurred in the developing countries around 1990. China accounted for ten million of these TOPs as TOP had been legalized in China since 1977.

Women have borne the brunt of sterilisations and late abortions in the government's drive to meet rigid birth quotas in China.

According to Vander Zanden (1996:381), couples who have two or more children, are punished and a woman pregnant with a second child is fined 20% of her salary if she refuses to have an abortion. WuDunn and Tien (in Vander Zanden 1996:381) point out that in 1986, there were 53 abortions for every 100 births. The number of reported abortions in China fell markedly from 14.4 million in 1983 to 8.9 million in 1984, rose again to 11.6 million in 1986, then fell to 10.4 million in 1987. Reasons for these changes could not be ascertained.

At a conference held in Beijing in 1995, a commitment to consider renewing laws containing punitive measures against women who have undergone illegal abortions was retained after the addition of a reference that abortion should not be promoted as a contraceptive method (Hartman 1995:3).

### **2.3.2 Vietnam**

Vietnam has a population of more than 72 million people, and has an annual population growth exceeding 2%. According to Le and Rambo (in Goodkind 1995:85) the unemployment and income disparities were growing in the wake of reforms during the 1990's. They believed that unchecked fertility will contribute to the long-term perpetuation of poverty as well as environmental degradation in Vietnam.

#### ***2.3.2.1 Population policy***

In 1988, Vietnam introduced a comprehensive fertility policy encouraging parents to have no more than two children. The Vietnamese policy was formulated to stem the growth in population

which might derail national development plans. In Vietnam the official family size goal of one or two children is advertised on billboards and posters. After almost four decades of continuous social, military and political upheavals that led the country to the brink of mass starvation in the early 1980's, Vietnam has made a phoenix-like discovery. The country began to institute an official programme of agricultural decollectivisation and free market reforms. Vietnam became the third largest exporter of rice next to Thailand and the USA despite being one of the most densely populated countries in the world (Goodkind 1995:85).

The specific guidelines of the one or two children policy included minimum childbearing ages for government cadres, teachers, officials and other state employees. The ages recommended were 22 years for women and 24 years for men; for other members of the community, the policy stated 19 years for women and 21 years for men.

Goodkind (1995:90) adds that the second child, if desired, should be spaced at least 3 to 5 years after the first, except for women above 30 years of age for whom two to three years was considered acceptable. Furthermore, members of ethnic minorities, who constitute about 13% of Vietnam's population and who are concentrated in the more mountainous regions, are allowed to have three children. Provisions for twins and other special situations are allowed.

Television programmes providing information and promoting family planning are shown several times a week on one of Vietnam's two television stations, often at prime times. Cheerful priests, together with other groups that might oppose contraception, make camera appearances on these programmes (Goodkind 1995:90).

### **2.3.2.2 Contraceptive use**

The two or three child norm first promoted in Vietnam in 1963 was not enforced until 1988. The provision of some basic family planning services in certain areas was the only means used to encourage compliance with this ideal. The intrauterine device (IUD) was the main contraceptive method promoted, a strategy similar to that adopted by the Soviet style centralised bureaucratic societies. However, few resources could be devoted to contraception, due to the protracted wars between 1965 and 1975.

In contrast to North Vietnam, the Southern regime in Vietnam disapproved of contraception although attempts were made during the war of reunification to make contraceptive methods available in urban areas, which were less disrupted by military upheavals. After the reunification of the North and South in 1975, small family norms were again advocated during the 1970's and 1980's (Goodkind 1995:89).

### **2.3.2.3 Termination of pregnancy**

TOP has been legalised and made widely available in Vietnam. Early TOPs (those until about 7 weeks) were performed with manual vacuum aspiration (MVA) and TOPs from 7 to 12 weeks were performed by dilatation and curettage (D&C). Since 1994, the international partners in the reproductive health programme (RHP), Ipas and Pathfinder International provided comprehensive support to the Ministry of Health's reproductive health programme at national and provincial levels. Ipas has, in addition, provided technical assistance directly to the Department of Maternal and Child Health including contraceptive services to improve Vietnam's TOP services.

Integration of postabortion contraceptive counselling and services into TOP services has been made a high priority in Vietnam. The support from the RHP, a commitment by the Ministry of Health and the provincial project centres, have increased contraceptive acceptance rates for abortion clients. The provincial centres in the RHP are responsible for the decentralisation of training, service delivery, supplies and supervision to district hospitals and community health centres including abortion-related services (<http://www.ipas.org/region/vietnamEG.htm> 9.5.01).

Regular programme and medical monitoring visits are conducted by RHP partner staff and consultants to ensure that high quality services are being provided. Results of these monitoring visits indicate that infection prevention has improved and counselling of clients has become more frequent, more comprehensive and more interactive. At the beginning of the project, there was an average of 12,5% postabortion contraceptive acceptance rate at the four original sites. At the end of the third year, the four sites had an average acceptance rate of 48,5%, with two sites exceeding 70% (<http://www.ipas.org/region/vietnamEG.htm> 9.5.01).

### **2.3.3 The Netherlands**

The population of the Netherlands has been numbered at 16 million in 2000 (<http://www.nidi.nl/data/nidi7300html>, 10.12.01). Unplanned pregnancy and its prevention was considered a huge problem that was dealt with seriously in the Netherlands. Van Delft and Ketting (in Ketting & Visser 1994:162) reported that joint efforts of a constant stream of reports, documents and discussions, debates, proposals and activities on the problem of unplanned pregnancies and how to prevent them, contributed to the success in addressing the problem of unplanned pregnancies in the Netherlands.

### **2.3.3.1 Population policy**

Before 1960, contraception was a taboo subject in Dutch society. Contraceptive sale displays were legally restricted, the medical community hardly played any role in contraceptive services, and there was almost no discussion in society about these topics (Ketting & Visser 1994:162). In spite of these restrictions, people were doctoring themselves by all means to prevent unwanted pregnancies. As a result of these restrictions on spreading contraceptive knowledge, the birth rate remained high at 20/1000, rated as one of the highest in Western Europe during the 1960's. Sexuality was not mentioned in families, schools or in the media.

During the period 1965-1975, changes took place, including

- a shift from a predominantly agricultural to an industrial society,
- rapid economic growth of a welfare state with an extending system of social security
- a decline of the influence of the church in public and personal life
- introduction of modern mass media
- rapid increase in the general education level of an entire population

Ketting and Visser (1994:163) contend that these changes caused a breakthrough in the field of contraceptive use, marked by the introduction of modern contraception.

The Dutch Association for Sexual Reform fought for the legalisation of contraception, and finally 100 people were employed to pressurise the government to develop programmes for sexual education, influencing the media to support a network of centres for contraceptive services throughout the country. In the mid 1960s, these plans were implemented.

After lifting the legal ban on contraceptives in 1969, the government included contraception in the national public health insurance system. The pill, intrauterine device (IUD) and diaphragm were obtainable free of charge. Contraceptive sterilisation was introduced two years later. The government further subsidised clinics for contraceptive services run by the Dutch Family Planning Association for those people who could not consult their family doctor for contraception (Ketting & Visser 1994:164).

#### **2.3.3.2 Contraceptive use**

Contraception is strongly accepted and well developed in the Netherlands. The pill was introduced in 1961 and officially registered in 1963. Contraception was suddenly felt to be a necessity practised effectively by most sexually active people.

Contraceptive services are an integrated part of primary health care in the Netherlands for which the family doctors are responsible. They accept it as their duty to prevent unwanted pregnancies. For consumers, contraception was accepted as it became available from known and trusted family doctors. Voluntary family planning movements, fear of overpopulation and the active role of medical practitioners contributed to the acceptance and effective use of contraception. Added to these successes, sterilisations enhanced the overall success of contraception in the Netherlands (Ketting & Visser 1994:167).

Another indicator of effective contraceptive use in the Netherlands is the low rate of teenage pregnancy. Ketting and Visser (1994:167) reported teenagers' needs for sexual and contraceptive education and specialised services which were addressed by sexual education in schools, including the Protestant and Roman Catholic schools. Mass media such as television, radio and popular youth magazines

address issues of sexuality openly and frankly, including teenagers' interests. Public information campaigns addressing adolescents in their own language and popular images are non-moralistic and positive towards teenage sexual behaviour. These seem to be successful in promoting and sustaining effective contraceptive practices in the Netherlands.

Ketting and Visser (1994:168) attribute the declining teenage pregnancy to improvements in contraceptive use. They feel that modern, reliable methods of contraception, particularly the pill, were rapidly accepted and used effectively. The authors add that the reasons for improvements in contraceptive use among adults in the Netherlands are the same as for teenagers, although sexual education, sexuality in the mass media, public education campaigns and low use of barrier methods of contraception were specific factors regarding teenagers. Contraceptive services delivered by family doctors for teenagers, are kept confidential if teenagers prefer such confidentiality. For lower income groups contraceptives are available free of charge. Teenagers who prefer health services for contraceptives, have easy and confidential access to these services that are heavily subsidised by the Ministry of Health in the Netherlands (Ketting & Visser 1994:169).

#### Contraceptive non-use

Ketting and Visser (1994:167) declared that during the 1970s, research data demonstrated that contraceptive use by immigrants was far less effective. However, special programmes have been developed to address the contraceptive practices of such groups in the Netherlands.

### **2.3.3.3 Termination of pregnancy**

TOP was liberalised in the Netherlands between 1967 and 1972, and services were offered by a network of free standing clinics throughout the country, as well as by several hospitals. After 1973, the abortion rate started to drop. In 1980, the TOP rate increased following a wave of messages in the press on the adverse health effects of the pill (Singh & Henshaw 1996:8). There was a sudden drop in oral contraceptive use, but during the 1980s, pill use gradually increased and surpassed its original level of the 1970s (Ketting & Visser 1994:162). Refer to table 1.4 for these statistics.

**Table 2.1: Induced abortion in the Netherlands**

Year	Number	Abortion rate /1000	
		Total population	Women 15-44 yr
1971	16 500	1,3	6,1
1975	15 000	1,1	5,2
1980	21 300	1,5	6,7
1985	17 300	1,2	5,1
1990	18 400	1,2	5,2
1991	19 600	1,3	5,6

Source: Rademakers (in Ketting & Visser 1994:162)

### **2.3.4 Bangladesh**

Bangladesh is the most densely populated country in the world and among the poorest. Available statistics indicate that this population exceeds 100 million (Phillips, Simmons, Koenig & Chakraborty 1988:313). Bangladesh has been included in this study as a result of

projects which have been implemented to address birth control – the Matlab project, the CBD programmes, involvement of government, nongovernmental organisations and commitment in the fight against overpopulation. A striking feature of improvements in contraceptive use was the commitment of men who assist women in using contraceptive services.

#### **2.3.4.1 *Matlab project***

The Matlab project was launched in 1977 with project field staff recruited, trained and assigned specific tasks. All married men and women within reproductive ages were visited fortnightly to assess their contraceptive behaviour and any health related issues arising from contraception. The principal aim of the Matlab project was to address the issue of whether service programmes could succeed in rural traditional settings where social and economic conditions remained underdeveloped.

The findings of the first research conducted as part of the Matlab Project revealed that one third of eligible women expressed a desire for no additional children, by 1984 this percentage had increased to more than 50%. It must be noted that in rural Bangladesh, women had ten to twelve children on average. To these families, children represented insurance against risks in the face of social and environmental uncertainties and hardships. The desire for many children was not only a household decision, but a systemic necessity (Phillips et al 1988:315; Vander Zanden 1996:380).

Another qualitative research project conducted by Simmons (1996:265) revealed that women felt their lives were in transition in Bangladesh. They perceived significant changes in the cost of living and rearing families; in the value of education; in the way family members related to each other; in women's positions; in financial transactions involved in marriages; in the growing influence of

commercialised economies and in new employment opportunities and new ideas. Central to these changes, women were committed to having smaller families and the contraceptive practices as well as strong programmes incorporating community-based workers and the media were major sources of information. Large scale community-based distribution (CBD) programmes were launched throughout the region with the aim of reaching women who were not free to travel to clinics or other locations where services were provided (Phillips, Hossain & Keunning 1996:204).

#### **2.3.4.2 Community-based distribution programme**

The outreach programme of contraception has been assigned high priority by programme strategic planners and from 1978 to 1980, nearly 12 000 village women were recruited, hired and trained for visiting women in their homes to discuss contraception and health related issues. During 1985 to 1990, the family welfare assistant programme improved outreach coverage and intensified the frequency of exchanges between workers and clients in their homes. Phillips et al (1996:205) acknowledged that 16 000 male health assistants were orientated to outreach work, and to visiting households where they could provide contraceptive services.

Although this programme raised considerable debate in terms of its monetary costs, government planners continued to commit major resources to household service delivery programmes and nongovernmental organisations continued to expand outreach services. According to Phillips et al (1996:205), supply depots, satellite clinics and social marketing at outlets were developed and subsequently functioned well. The outreach programme was complemented for introducing contraception. When supply points were located in clinics and other fixed sites, the programme became ineffective. The CBD programme was therefore instituted to mitigate costs by delivering services to couples in their homes, leading to

crystallisation of demands for contraception such as fertility regulation and the acceptability of small families. Concomitant social change led to ideational change and mobilising demands for contraception.

#### **2.3.4.3 Termination of pregnancy**

Prior to 1970, TOP was illegal in Bangladesh except when a woman's life was considered to be endangered by the pregnancy. In 1974, the government of Bangladesh allowed a clinic in Dhaka to offer menstrual regulation (early termination without pregnancy testing), and in 1978 the government initiated the training of doctors and paramedics to provide such services (Caldwell, Barkat-e-Khuda, Ahmed, Nessa & Haque 1999:35).

Menstrual regulation services are available at all major government hospitals, including health facilities, and are legal for pregnancies of 6 to 10 weeks. At a health complex in Thana, the services are provided by physicians, and at union health and family welfare centres these services are performed by female paramedics, referred to as family welfare visitors. Nurses and family welfare visitors can provide menstrual regulation services if the period of gestation has not exceeded 8 weeks. If the period of gestation is 10 weeks, the procedure is done by the doctor (Caldwell et al 1999:35).

According to Islam (in Caldwell et al 1999:35), women who do not use menstrual regulation services may resort to abortion, which is sometimes induced by inserting a foreign object into the uterus or by indigenous oral medicine. Abortifacient tablets or potions for oral consumption, obtainable from local pharmacies or untrained village doctors, may be used.

Mitra et al (in Caldwell et al 1999:35), were of the opinion that although menstrual regulation had been legalised in Bangladesh, and

were provided in government facilities, many procedures were not recorded. As a result of this failure to record, no precise menstrual regulations and abortion statistics could be found. According to the Bangladesh Demographic and Health Survey conducted in 1993 to 1994, 2% of a sample of 9,640 married women had terminated unwanted pregnancies and 65% of these terminations involved menstrual regulation. The authors believed that the real figures might be much higher (Mitra et al in Caldwell et al 1999:35).

A study of 212 menstrual regulation clients in Matlab found that the majority were motivated to space births, with a minority wishing to limit overall family size. Women in this study reported economic problems and contraceptive failure as their main problems. Studies on menstrual regulation have found the procedure to be safe, although concerns were raised over the technical training and skills of service providers (Bhatia & Ruzicka in Caldwell et al 1999:37).

### 2.3.5 Cuba

Cuba is located 144 km from the tip of Florida in the Caribbean Islands, with a population of 10.8 million (Swanson, Swanson, Gill & Walter 1995:300). Before the 1959 revolution, like most developing countries, Cuba lacked comprehensive PHC. About 25% of the adult population was unable to read or write, and only half the children of primary school age were at school. Malnutrition was common in both urban and rural areas (Swanson et al 1995:301).

Danielson (in Swanson et al 1995:301) allege that those who were unsupportive of the revolution, including half of the country's physicians and nurses, fled the country. A redistribution of income among those remaining occurred with education and health care afforded highest priorities. Swanson et al (1995:301) stated that literacy was the key to development and fundamental to the population's ability to bring about change, including change in the

areas of health beliefs, practices and services. As a result of the massive literacy campaign, the adult illiteracy rate dropped to less than 4% compared to a Latin American median in 1960 of 32,5%, an accomplishment believed to be unique to Cuba. In 1974, over half a million previously illiterate persons finished the sixth grade. All children aged 6 to 12 years were at school, and 84% of children between the ages 13 to 16 years attended secondary school.

### **2.3.5.1 Cuba's health care system**

Cuba has been included in this study in reference to its achievements in health outcomes. Cuba has successfully instituted services based on PHC principles to attain the WHO goal of Health for all by 2000 (Demers, Kemble, Orris & Orris 1993:164; Swanson 1988:11; Swanson et al 1995:303). According to these authors, the achievements include mortality rates that rival, and in some instances even exceed, those of Western countries. Halebsky and Kirk (in Swanson et al 1995:303) agree with the statement by reporting that in 1957, Cuba's infant mortality rate was 57 per 1 000 live births, which dropped to 9,4 per 1000 live births in 1993, a level modestly above that of the overall African American population.

Dr Sefularo, member of the executive council (MEC) for health in the North West Province of the RSA, referred to the benefits of the Cuban health system after visiting Cuba in 2000. He pointed out the following important statistics:

- Maternal death rates of the North West Province was 78,5 against Cuba's 9,2 per 100 000, and added that the North West Province figures may be an underestimate because reporting of maternal deaths only started in 1997.
- Infant mortality rate was 36,3 whilst Cuba had 6,4 per 1 000.

Most Cubans, including women and children, live better lives than citizens of many richer countries who spend more on health care. This, Dr Sefularo added, included the RSA and the USA.

Cuba's health care system guarantees accessibility for the entire population. The service is free of charge, including all aspects from vaccinations to advanced levels of care. Every individual, family and community is covered by all levels of the health service. Every citizen is assured of finding a clinic, nurse, a doctor or any health worker when he/she needs one and every child and pregnant woman is guaranteed the best possible care (Sefularo 2000:22; Swanson 1988:16; Veeken 1995:935).

Veeken (1995:935) states that Cuba experienced difficulties after the collapse and subsequent loss of support from the Soviet Union. The trade embargo of more than 30 years, as well as a gradual change from a centrally planned economy towards a free market system, added to the difficulties. Contraceptive and AIDS services are given specific attention in Cuba.

Each year around 4 000 students start their medical training at 23 different universities in Cuba. By 1994 Cuba had 60 000 doctors, one for every 200 inhabitants. Their main work is prevention, health promotion and the offering of basic curative care. In addition, Cuba has 400 polyclinics and 263 hospitals where specialists offer their services to about 30 000 people (Veeken 1995:939).

#### Cuba's neighbourhood/home clinics

In 1984, the family medicine or neighbourhood/home clinic model was created to respond to President Fidel Castro's, plea that parents and sick children should not leave their homes for consultation, especially not at awkward hours or on rainy days and nights. He

urged that the doctor, as a well person, should rather go to the residence of the patient (De la Osa in Swanson et al 1994:302).

Cardelle (1994:421) suggested the need for physicians who should practice at the general level and who should understand, integrate, coordinate and administer treatment not only to meet the health needs of the individual, but also to meet the health needs of the family and the community. Cardelle (1994:421) added that the foundation of premedical education that is provided to meet PHC needs, should be considered.

In terms of the Cuban model, the family physician and the nurse live in the community in which they practise, in a combination of providing both home and clinic services. After the revolution, the education of physicians was revised to highlight the social, psychological and epidemiological needs and profiles of the community. This move aligned medical education more closely with nursing education (Swanson in Swanson et al 1995:302).

Clinic hours are held in the mornings by both the nurse and physician, who make home visits during the afternoons. Chronically ill persons are visited monthly, and those at high risk are seen weekly, whilst the well elderly are seen every three months. Every member of the community is visited in her or his home at least once per year for an assessment of her or his physical and social health. Evening hours and emergency calls are kept to a minimum. Health education focuses on health promotion programmes for groups in the community. Such programmes include grand parents' circles which provide health promotion activities for elders on a group basis and adolescent circles to provide health education about sexual health, contraception and STDs (Swanson et al 1995:302).

In a personal communication with a Cuban, Dr Varona, who was stationed in the RSA at the time of this survey, the researcher

established that although contraceptives were in short supply, unwanted pregnancies were not a problem in Cuba. Dr Varona added further that condoms were in equally short supply, although he felt that it was not required, as Cubans were responsible for their own health, including their sexual health.

#### **2.3.5.2 *Termination of pregnancy***

Veeken (1995:936) reported TOP rates to be low in Cuba, stating that it was less than one per 100 deliveries. All women whose expected menstruation was delayed by two weeks, menstrual regulation, were offered a micro-aspiration in the polyclinic. In Cuba, 700 menstrual regulations are performed without complications for every 5 000 fertile women. No pregnancy test equipment is available, and as a result, such tests cannot be performed.

#### **2.3.6 The Republic of South Africa**

The Republic of South Africa (RSA) occupies the southernmost tip of the African continent, with a total surface area of 1 219 090 km<sup>2</sup>. According to Census (1996:4) the total population was numbered at 40 583 573 million people comprising 76,3% Africans, 12,7% Whites, 8,5% Coloureds, and 2,5% Indians. The Gauteng population comprises 7 048 300. In terms of the new restructuring of metropolitan areas, Northern Tshwane incorporates various townships, suburbs and intermediate cities, which embrace Soshanguve, Ga-Rankuwa, Mabopane, Odi Region and Akasia. The population composition is multi-cultural with all socioeconomic strata from high, middle and low socioeconomic groups (Northern Pretoria Metropolitan Substructure 2000:1). There are a total of two state hospitals and sixteen health care centres in Northern Tshwane. All provide contraceptive services integrated with PHC services. These services are offered free of charge.

### **2.3.6.1 Population policy**

In the RSA, birth control officially started in 1932, when a family planning association was established in Cape Town. There was much concern about the high fertility rate in the Cape Peninsula, with the result that several privately owned clinics were opened to promote contraceptive services, and to advise women who wanted to curb their fertility. Popenoe et al (1998:412) state that associations, similar to the one in Cape Town were established in Johannesburg in the 1940s, in Durban in the 1950s and in East London in the 1950s. At that stage contraception was still a sensitive issue and there was no financial support from local town councils, nor from the central government. During the 1960s, the local authorities and central government became interested in these associations and their activities.

In 1963, the watershed was reached when the central government gave formal support to the initiatives taken by family planning associations, and provided substantial funding for private family planning clinics, hospitals, and clinics run by local authorities and the central government. This support included the supply of contraceptives free of charge to those in need (Popenoe et al 1998:413; Vlok 2000:349).

The major turning point in the RSA occurred during 1974 when the National Family Planning Programme was established. This programme aimed at making every adult in the country aware of contraceptive issues. Other objectives of this programme were to

- strengthen the provision of contraceptives by making contraception an integral part of all health services
- establish a major organisational and information unit within the DOH

- recruit educators for contraceptive services for carrying out individual motivation beyond that being done by the media for family planning associations
- employing media for the dissemination of messages regarding contraception
- finding relevant social and medical research (Caldwell in Popenoe et al 1996:413).

Since 1983, the National Family Planning Programme was incorporated into the Population Development Programme, and subsequently became part of the Reconstruction and Development Programme (RDP). The RDP became concerned with the social and economic needs of the population in addition to contraception. The Science Committee of the President's Council drew up a report on demographic trends in the RSA, which were approved by the government in 1993. This was another breakthrough which ushered in the third phase of the government's contraceptive policy. Addressing the recommendations of the Science Committee, a new directorate, the Chief Directorate Population Development, was established within the new department – the National Department of Health and the nine Provincial Departments of Health. The main objectives of the Population and Development Programme aim to establish a stable population of eighty (80) million at the end of the 21<sup>st</sup> century; accelerate the social and economic development of all population groups; achieve an average of two children per woman by 2010; promote a minimum level of health among all population groups; effect an orderly geographic distribution of the population of the country and develop rural areas (Popenoe et al 1998:413; Vlok 1996:340).

The DOH carries the financial responsibility of this nationwide service which is provided free of charge at government clinics. The full time services of experts in health administration, fertility control, demography, sociology, communication, nursing, training and

evaluation are available. The Directors of Hospital Services and Regional Directors of National Health are responsible for the local administration of the programme. Local authorities, primary health care services and nurses play important roles in contraceptive programmes. Community health nurses doing 'first visits' after confinements, are important carriers of information about contraception and refer patients to clinics. In rural areas, nurses are appointed on a part-time basis to carry out contraceptive duties to serve farming communities, while occupational health nurses serve occupational health settings. Private organisations such as the Planned Parenthood Association of South Africa, also render contraceptive services (Vlok 2000:349).

#### ***2.3.6.2 Contraceptive use***

Documented literature provides evidence of contraceptive prevalence in the RSA. Most hospitals, health services and clinics offer contraceptive services incorporated within their services. There is widespread information about contraceptives at institutions, community centres and widening attempts to reach rural areas (DOH 2000:12-18). The greatest concern, however, is the effective, consistent and accurate use of contraceptives. This study therefore, aims at identifying reasons for not using contraceptive services effectively, and will attempt to suggest how the use of contraceptive practices can be improved.

#### ***2.3.6.3 Termination of pregnancy***

Terminating a pregnancy whether legal or illegal, is the most commonly practised method of population control worldwide. Between 40 and 60 million TOPs are performed throughout the world each year, most of which are performed in poor countries, under unsanitary conditions and by unqualified persons. Complications of illegal abortions have been reported to be the leading cause of death

for women between ages 15 and 35 years in these countries (Adanlawo & Moodley 1999:99; Fathalla 1994:116; RRA 1998:1; WHO 1995:15).

In 1975, the Abortions and Sterilisations Act (Act No 2 of 1975) was promulgated. In accordance with this Act, abortions were legalised, provided certain conditions were met. Conditions for such a legal abortion included: where the continuation of pregnancy posed a threat to the physical and/or mental health of the mother; where there was evidence to the effect that the unborn child was afflicted by an incurable congenital abnormality; in cases of incest and rape and where there was evidence of unlawful carnal intercourse with a mentally retarded female (Abortions and Sterilisation Act No 2 of 1975). This stringent law did not address the problem of illegal abortions, as most women who did not meet the conditions for legal abortions, risked their lives and consulted backstreet abortionists. Those who could afford to do so, went to countries such as England or Wales for legal abortions (Fathalla 1993:247; Vlok 2000:356).

In November 1996, the Choice on Termination of Pregnancy (CTOP) Act No 92 of 1996 was promulgated and became operative in 1997 at designated health facilities across the RSA. This Act ushered in a new era in which all women, rich or poor, young or old, urban or rural, black or white, could access safe, legal abortions.

The Choice on Termination of Pregnancy Act (No 92 of 1996) was given specific attention in this study as a controversial contraceptive method aimed at addressing the mounting problem of unsafe, illegal abortions. Legalising termination of pregnancy does not guarantee that safe services are available and accessible to all, and that the community and health care professionals are fully informed of what the Act entails. Another important issue is that legalising CTOP does not infer that contraceptive methods should be ignored or not be used. CTOP should be regarded as a last resort in preventing

unwanted pregnancies. There is a need for regular information regarding the Choice on Termination of Pregnancy Act and CTOP services, if communities are to utilise these services effectively.

One of the objectives of this study was to assess the clients' and nurses' knowledge of the Act, its main contents, their expectations and barriers in the provision of CTOP services. It is generally hypothesised that if contraceptives are used effectively, and CTOP services are provided and utilised appropriately, then unwanted pregnancies and unsafe illegal CTOPs will be minimised, as happened in the Netherlands (Ketting & Visser 1994:161-171).

## **2.4 THE HEALTH BELIEF MODEL**

The Health Belief Model (HBM) will be used for this study to explain why people use or fail to use contraceptives effectively. Figure 2.1 illustrates the HBM.

The model was first developed in 1950 by Hochbaum (1958), Kegeles (1965) and Rosenstock (1966) to determine causes of nonparticipation in preventive measures such as Pap smears and tuberculosis screening later in 1974 and 1977. Becker et al modified the model to include the influence of health motivation. In 1988 Becker modified the HBM which comprised of three primary components including individual perceptions, modifying factors and factors affecting the likelihood of initiating or engaging in an action. These are briefly portrayed according to Becker et al's description (in Kozier, Erb, Berman & Burke 2000:195-198).

### **2.4.1 Individual perceptions**

- Perceived susceptibility which refers to an individual's estimated probability of encountering a specific health problem. In this study, this can be explained by the following example: nonuse,

failure to use contraceptives effectively and defaults in using contraceptives may result in unwanted pregnancies and complications thereof.

- Perceived seriousness implying the degree of concern one experiences created by the thought of disease or problems associated with a given health condition. Health problems of unwanted pregnancies and complications of which may include terminating such pregnancies, having unwanted babies and adding to overpopulation.
- Perceived threat: the combined impact of perceived susceptibility and perceived seriousness. Implications of unwanted pregnancies on the health of individuals should be perceived as serious threats to individuals and their respective families.

#### **2.4.2 Modifying factors**

Modifying factors include a variety of demographic, sociopsychological and structural factors that predispose one to take preventive action and cues to action are factors that purport to trigger preventive action depending on one's level of readiness to engage in such activities.

##### **♦ Demographic variables**

Demographic variables include age, sex, race and ethnicity. Adolescents, for example, do not perceive the importance of using contraceptives effectively, as compared with adults who might find contraceptive use to be desirable. Similarly, sex, race and ethnicity might impact differently on people regarding their contraceptive practices.

- ◆ **Socio-psychological variables**

An individual may be influenced positively through social pressure such as applying preventive health measures despite low individual motivational levels. Expectations of others may motivate people, such as preventing unwanted pregnancy by effective contraceptive use or by abstaining from sex.

- ◆ **Perceived threat**

Structural variables presumed to influence preventive behaviour regarding contraceptive practices are knowledge about contraceptives which might influence individuals' effective use of contraceptives.

- ◆ **Cues to action**

Cues to action are described as either internal or external. Internal cues include feelings of fatigue, uncomfortable symptoms or thoughts about the condition of a specific person with an unwanted pregnancy. External cues could be mass media campaigns, advice from others and reminder postcards from the nurse or doctor.

#### **2.4.3 Likelihood of action**

Variables likely to affect initiating action. The likelihood of the action component of the model is driven by the positive difference between perceived benefits and perceived barriers to action (Becker et al in Kozier et al 2000:196).

- ◆ **Perceived benefits of the action**

Perceived benefits are beliefs about the effectiveness of recommended preventive health actions, such as the ability of

contraceptives to prevent pregnancy and its complications. In addition, the benefits of using contraceptives should be acknowledged.

◆ **Perceived barriers to preventive action**

Perceived barriers are possible blocks or hindrances to engage in preventive behaviours which include such factors as cost, inconvenience and unpleasantness. Pender (in Rogers 1994:295) adds two further considerations, namely, the importance of health as perceived by the individual and perceived control.

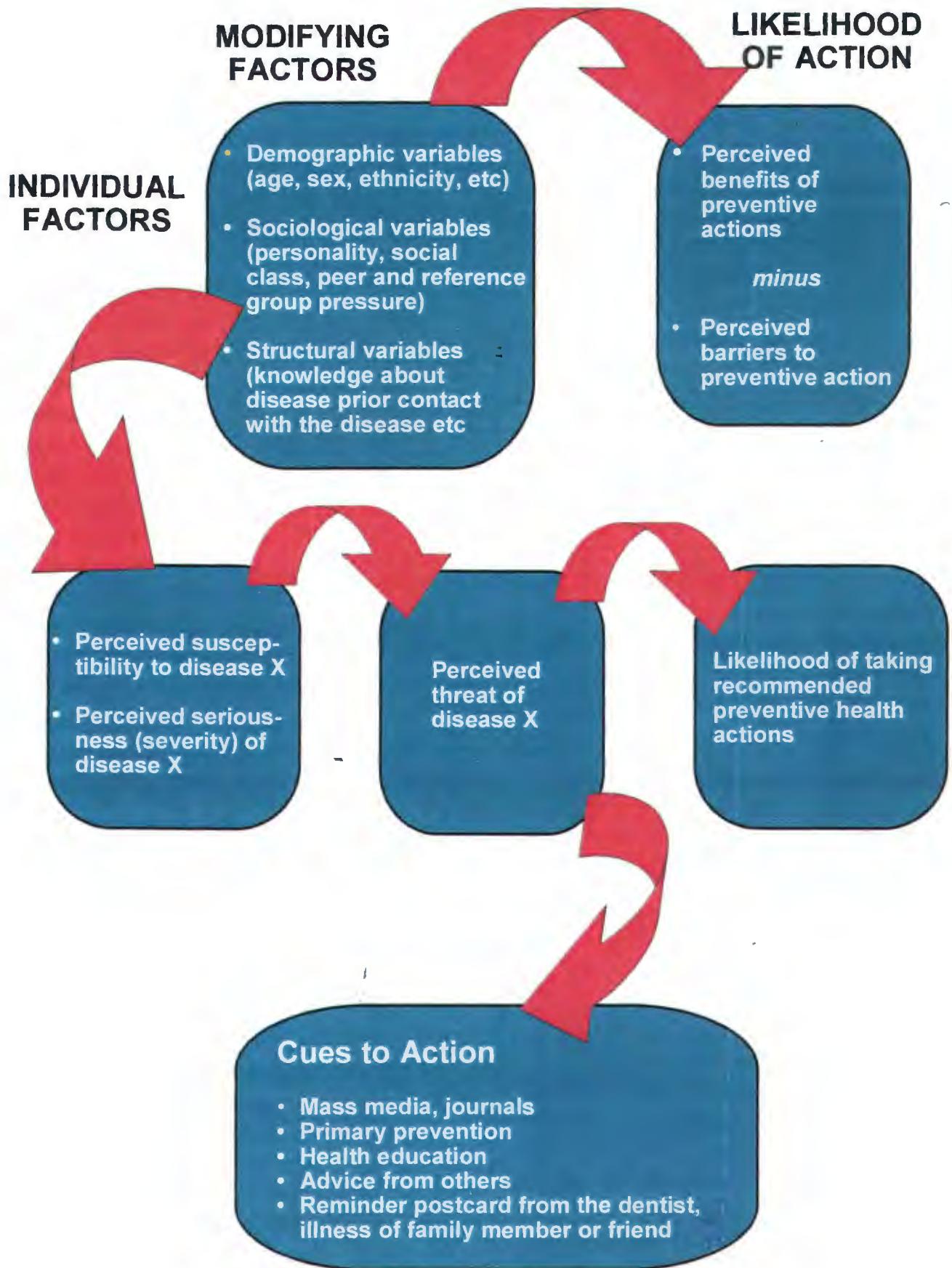
◆ **Importance of health to the person**

This is observed when a person's behaviour shows that health is perceived as something valuable by using contraceptives effectively and consistently to prevent unwanted pregnancies.

◆ **Perceived control**

People who have control over their health are more likely to use preventative services than people who feel powerless. Control over health can relate to behaviours such as consistent use of reliable contraceptive methods and avoidance of unprotected sexual intercourse.

Nurses may play a significant role in helping clients implement healthy behaviours. They may show clients how to monitor their health, supply anticipatory guidance and empower clients with knowledge regarding effective contraceptive practices. They can assist clients to break down perceived barriers to action such as reducing discomfort, inconvenience and supporting clients positively (Becker et al in Kozier et al 2000:195-198).



**Figure 2.1: The Health Belief Model**  
(Becker et al in Kozier et al 2000:174)

## **2.5 POLICIES AND LEGISLATION IMPACTING ON CONTRACEPTION IN THE REPUBLIC OF SOUTH AFRICA**

Legislation and policies are meant to regulate, guide and prescribe peoples' behaviours and actions at specific times and under specific circumstances. Contraceptive legislation and policies are concerned with contraception, contraceptive use in terms of when, how, why and who should use certain contraceptive methods. A number of Acts and Policies have been identified and will be discussed as follows:

- The Constitution of the Republic of South Africa (RSA) 1996
- Population Policy 1998
- The Reconstruction and Development Programme (RDP) 1994
- The National Health Bill 2000 (although the National Health Bill 2001 will be tabled in Parliament during 2002, the DOH functioned on the basis of the National Health Bill 2000 during this investigation. Consequently this research refers to the National Health Bill 2000).
- Draft Youth Adolescent Health Policy Guidelines 1999
- Essential Drug list for Primary Health Care 1998
- Sterilisation Act No 44 of 1998
- Medicines and Related Substances Act No 90 of 1997
- The Child Care Amendment Act No 13 of 1999
- Choice on Termination of Pregnancy Act No 92 of 1996

### **2.5.1 Constitution of the Republic of South Africa, 1996**

Reproductive rights and the right of access to reproductive health care are included in the Constitution's Bill of Rights.

- The rights pertaining to the freedom and security of the person state that, "everyone has the right to bodily and psychological

integrity, which includes the right to make decisions concerning reproduction".

- Included in the section on "health care, food, water and social security" is the decree that "everyone has the right to have access to health services, including reproductive health care, and that the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights" (Constitution of the Republic of South Africa, Act No 108 of 1996) 1996).

### **2.5.2 Population Policy, 1998**

The population policy outlines 24 strategies, three of which are particularly pertinent to the National Contraception Policy. The DOH (2000:10) summarised these policy outlines by emphasising:

- Improving the quality, accessibility, availability and affordability of primary health care services, including reproductive health and health promotion services such as contraceptive services to the entire population in order to reduce mortality and unwanted pregnancies, with a special focus on disadvantaged groups, currently underserved areas and adolescents; eliminating disparities in the provision of such services.
- Promoting responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high risk teenage pregnancies, abortion and STDs, including HIV/AIDS, through the provision of life skills, sexuality and gender sensitivity education, user friendly health services for engaging in social and community life.
- Promoting the equal participation of men and women in all areas of family and household responsibilities, including responsible parenthood, reproductive health, childrearing and household work.

### **2.5.3 Reconstruction and Development Programme, 1994**

In terms of this programme, one aspect of people being able to control their lives is their capacity to control their lives and their own fertility. The Government must ensure that appropriate information and services are available to all people. Reproductive rights must be guaranteed and reproductive health services must promote peoples' rights to privacy and dignity. Every woman must choose whether or not to have an early TOP according to her own individual beliefs. Reproductive rights must include education, counseling and confidentiality (ANC 1994b:46-47).

### **2.5.4 National Health Bill, 2000**

(Although the National Health Bill 2001 will be tabled in Parliament during 2002, the DOH functioned on the basis of the National Health Bill 2000 during this investigation. Consequently this research refers to the National Health Bill 2000.)

Prioritising maternal, child and women's health (MCWH) is emphasised by the following policy intentions:

- MCWH services should be accessible to mothers, children, adolescents and women of all ages, with the focus on the rural and urban poor.
- MCWH should be comprehensive and integrated.
- Women and men should be provided with services that will enable them to achieve optimal reproductive and sexual health.
- Individuals, households and communities should have adequate knowledge and skills to promote positive behaviour related to maternal, child and reproductive health (DOH 2000:11) (although the National Health Bill 2001 will be tabled in Parliament during 2002, the DOH functioned on the basis of the National Health Bill

2000 during this investigation. Consequently this research refers to the National Health Bill 2000).

### **2.5.5 Draft Youth Adolescent Health Policy Guidelines, 1999**

The specific identified policy aims for contraceptive services include

- the provision of education on sexual and reproductive health to youth, parents and key community structures; and the provision of contraceptives to all sexually active youth and adolescents
- that TOP is not a form of contraception or population control
- that the state has the responsibility to provide safe conditions under which the right choice can be exercised without fear or harm (DOH 1999:40)

### **2.5.6 Essential Drug List for Primary Health Care, 1998**

When treating clients, the final responsibility for the well-being of these clients remains with the health care providers. It therefore becomes necessary that health care providers should be conversant with drugs and treatments used for contraceptive purposes, to be able to prescribe appropriately. These have been summarised as follows:

#### **2.5.6.1 Hormonal contraceptives**

##### **2.5.6.1.1**

##### **Injectables**

- Medroxyprogesterone Acetate 150 mg long-acting
- Norethisterone Enanthate 200 mg

##### **2.5.6.1.2**

##### **Oral contraceptives**

Health care providers may recommend the use of any of the following drugs for clients using oral contraceptives:

- monophasic preparations progestogen only tablets  
→ Levonorgestrel 0,03 mg
- monophasic preparations – combination formula containing in each tablet  
→ formula 1 – Levonorgestrel (as progestogen) 0,15 mg and Ethinyl Oestradiol (as oestrogen) 0,03 mg  
→ formula 2 – Norgestrel (as progestogen) 0,5 mg and Ethinyl Oestradiol (as oestrogen) 0,05 mg
- Biphasic preparations – combination formula  
→ Levonorgestrel (as progestogen) and Ethinyl Oestradiol (as oestrogen) and Ethinyl Oestradiol (as oestrogen)  
> 11 tablets Levonorgestrel 0,05 mg and Ethinyl Oestradiol 0,05 mg  
> 10 tablets Levonorgestrel 0,125 mg and Ethinyl Oestradiol 0,05 mg
- Triphasic preparations – combination formula  
→ Levonorgestrel (as progestogen) and Ethinyl Oestradiol (as oestrogen)  
> 6 tablets Levonorgestrel 0,05 mg and Ethinyl Oestradiol 0,03 mg  
> 5 tablets Levonorgestrel 0,075 mg and Ethinyl Oestradiol 0,04 mg  
> 10 tablets Levonorgestrel 0,125 mg and Ethinyl Oestradiol 0,03 mg (National Department of Health 1998:52)
- Postcoital contraception  
Post-coital contraception must be used within 72 hours of unprotected sex and should not be used regularly in the place of other contraceptive methods. NDOH (1998:53) refers to the following monophasic preparations stated in oral contraceptives formula 2 which may be used.

→ Norgestrel (as progestogen) 0,5 mg and Ethinyl Oestradiol (as oestrogen) 0,05 mg, 2 tablets should be taken after unprotected intercourse and 2 tablets 12 hours later.

#### **2.5.6.2 Vaginal contraceptives**

Spermicides are inserted in the vagina prior to intercourse. They contain an ingredient which either kills spermatozoa or weakens them to prevent fertilisation. The following types of spermicides are available:

- spermicidal jelly 0,1 g active ingredient/5 mg in 81 g tube with applicator (NDOH 1998:52)
- foam preparations
- vaginal pessaries
- film strips (Theron & Grobler 1998:23)

#### **2.5.7 Sterilisation Act No 44 of 1998**

The Act provides the right to sterilisation, to determine the circumstances under which sterilisation may be performed and, in particular, the circumstances under which sterilisation may be performed on persons incapable of consenting or incompetent to consent due to mental disability and to provide for matters connected therewith.

##### **➤ Persons capable of consenting**

1. In terms of this Act, no person is prohibited from having sterilisation performed on him or her if he or she is capable of consenting and is 18 years or older.
2. A person capable of consenting may not be sterilised without his or her consent.

3(a) Sterilisation may not be performed on a person who is under the age of 18 years, except where failure to do so would jeopardise the person's life or seriously impair his or her physical health.

➤ **Persons incapable of consenting or incompetent to consent due to severe disability**

1. Sterilisation may be performed on any person who is incapable of consenting or incompetent to consent
  - (a) upon a request to the person in charge of a hospital and with the consent of a
    - (i) parent
    - (ii) spouse
    - (iii) guardian or
    - (iv) curator
  - (b) if a panel contemplated in subsection (2) after considering all relevant information, including the fact that:
    - (i) the person is 18 years of age, unless the physical health of the person is threatened; and
    - (ii) there is no other safe and effective method of contraception except sterilisationconcurs that sterilisation may be performed; and
  - (c) if the person is mentally disabled to such an extent that such a person is incapable of:
    - (i) making his or her own decision about contraception or sterilisation
    - (ii) fulfilling the parental responsibility associated with giving birth

- (2) The person in charge of a hospital contemplated in subsection (1) must upon request, as prescribed for sterilisation, convene a panel which will consist of a psychiatrist; or a medical practitioner if no psychiatrist is available; a psychologist or a social worker and a nurse.
- (3) Where a person to be sterilised is in custodial care, no member of the panel may be an employee of the custodial institution.
- (4) If sterilisation is to be performed in a private health care facility, the members of the panel may not be employees of or have a financial interest in the facility.
- (5) The person performing the sterilisation must ensure that the method of sterilisation used holds the lowest health risk to the person on whom the sterilisation is performed.
- (6) Sterilisation may not be performed in terms of subsection (1) unless the person suffers from a severe mental disability (Sterilisation Act No 44 of 1998).

#### **2.5.8 Medicines and Related Substances Control Act No 90 of 1997**

This Act allows for the sale of oral contraceptives in accordance with the Act's Schedules, progestogen-only pills fall under Schedule 2 (they may be supplied by a pharmacist to a person over the age of 16 years or to a person under 16 years with a medical prescription) and other oral contraceptives under Schedule 3 (may be supplied by a pharmacist upon a medical prescription only).

#### **2.5.9 Child Care Amendment Act 13 of 1999**

This Act stipulates that any person over the age of 14 years could consent to an operation being performed on himself/herself without a parent or guardian's assistance; and any person over the age of 14 years could consent to medical treatment on him/herself or his/her child without assistance of a parent or guardian. This means that the

nurse or doctor is now authorised to provide teenagers of 14 years or older with contraceptives within a very definite context of counselling and support, the importance of which should never be disregarded or underestimated. Although parental consent was not legally required, in practice it was recommended that girls under 18 years inform their parents of their wish to use contraception. However, this did not allow for service providers to inform parents without the patient's (child's) consent (Child Care and Amendment Act No 13 of 1999).

#### **2.5.10 Choice on Termination of Pregnancy Act No 92 of 1996**

In terms of the Act, the following are stipulated:

1. Circumstances in which and conditions under which pregnancy may be terminated.
  - Pregnancy may be terminated:
    - (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy
    - (b) from the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that:
      - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health
      - (ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality
      - (iii) the pregnancy resulted from rape or incest or
      - (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman
    - (c) after the 20<sup>th</sup> week of the gestation period if a medical practitioner, after consultation with another medical

practitioner or a registered midwife, is of the opinion that the continued pregnancy:

- (i) would endanger the woman's life
- (ii) would result in a severe malformation of the foetus
- (iii) would pose a risk of injury to the foetus

2. Termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.

- Place where surgical termination of pregnancy may take place:

- (a) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the Government Gazette for that purpose under subsection (2).
- (b) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.
- (c) The Minister may withdraw any designation under this section after giving 14 days prior notice of such withdrawal in the Gazette.
- (d) Counselling

The State shall promote the provision of nonmandatory and nondirective counseling, before and after the termination of a pregnancy.

## (e) Consent

- (1) Subject to the provisions of subsections 4 and 5, the termination of a pregnancy may only take place with the informed consent of the pregnant woman.
- (2) Subject to the provisions of subsections 4 and 5, no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.
- (3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. Provided that the termination of the pregnancy shall not be desired because such minor chooses not to consult them.
- (4) Subject to the provisions of subsection 5, in the case where a woman is –
  - (a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy or
  - (b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2
  - (i) her pregnancy may be terminated during the first 12 weeks of the gestation period, or from

the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period on the grounds set out in section 2(1)(b)(i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be or

- (ii) if such persons cannot be found, upon the request and with the consent of her 'curator personae'. Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, consent thereto.

- (5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that

- (a) during the period up to and including the 20<sup>th</sup> week of a pregnant woman referred to in subsection 4(a) or (b)

- (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health or

- (ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality or

- (b) after the 20<sup>th</sup> week of the gestation period of a pregnant woman referred to in subsection 4(a) or (b) the continued pregnancy –

- (i) would endanger the woman's life

- (ii) would result in a severe malformation of the foetus or

- (iii) would pose a risk of injury to the foetus they may consent to the termination of the pregnancy of such a woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be.

Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

(6) Information concerning termination of pregnancy

A woman who in terms of section 2(1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under the Act by the person concerned.

(7) Notification and keeping of records

- (i) Any medical practitioner or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2(1)(a) or (b), shall record the prescribed information in the prescribed manner and give notice thereof to one person referred to in subsection (2).
- (ii) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.
- (iii) The person in charge of a facility referred to in section 3 shall, within one month of the

termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director General: Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.

- (iv) The Director General shall keep record of the prescribed information which he or she receives in terms of subsection (3).
- (v) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she chooses to disclose that information.

(8) Delegation

- (i) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director General or any other State office, any power conferred upon the Minister by or under this Act, except the panel referred to in section 9.
- (ii) The Director General may, on such conditions as he or she may determine, in writing delegate to a State officer, any power conferred upon the Director General by or under this Act or delegated to him or her under subsection (1).
- (iii) The Minister or Director General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

## (9) Regulations

The Minister may make regulations relating to any matter which he or she may consider necessary, or expedient to prescribe for achieving the objects of this Act.

## (10) Offences and penalties

## (1) Any person who:

- (a) is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2(1)(a)
- (b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c) or
- (c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy
  - shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years

- (2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on

conviction to a fine or to imprisonment for a period not exceeding six months.

(11) Application of the Act

(1) The Act shall apply to the whole of the national territory of the Republic of South Africa.

(2) This Act shall repeal:

(a) the Act mentioned in columns one and two of the Schedule to the extent set out in the third column of the schedule and

(b) any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa (Act No 108 of 1996), possessed legislative authority with regard to the termination of pregnancy.

(12) The title of the Act shall be called the Choice on Termination of Pregnancy Act 1996 and shall come into operation on a date fixed by the President by proclamation in the Gazette (Choice on Termination of Pregnancy Act No 92 of 1996).

The CTOP Act recognises that the decision to have children is fundamental to the physical, psychological and social health of women, and that universal access to appropriate health care services includes contraception, CTOP, sexuality education and counseling services (Act No 92 of 1996). In addition, the Act emphasises that

CTOP should not be seen as a form of contraception or birth control, but as a mechanism of addressing the problem of backstreet abortions (Bateman 2000a:11; Botes 2000:27; Poggenpoel et al 1998:27).

Within the first three years of the enactment of the Choice on Termination of Pregnancy Act No 92 of 1996, public health facilities conducted 150 000 CTOPs in the RSA, with 49% of these TCOPs conducted in the Gauteng Province (Bateman 2000a:11; Varkey 1999:11). At the same time, Bateman (2000a:11) added that backstreet abortion figures were also increasing with a reported number of 300 000 abortions across the RSA. Lack of knowledge about CTOP and the designated facilities to conduct the procedure could contribute to the increasing statistics in backstreet abortions and adolescent pregnancies. Ehlers et al (2000:49) support this statement by indicating that 42,34% adolescent mothers in their study did not know about legalised TOP services and a further 25,22% felt they would have used these services. Facilities designated for TOP were overburdened. The overloading of these services has further been compounded by the health centres which are not performing TOPs even though they have been designated to do so. Of the 289 services designated for TOP, only 59 were reportedly involved in the procedure (Bateman 2000a:11; Varkey 1999:11).

Health care providers opposed to CTOP, who regard the Act as unacceptably permissive, constitute some of the impediments that have the potential of impacting negatively on the implementation of the Act. Research conducted by Maforah, Jewkes and Wood (1997:82); Poggenpoel, Myburgh and Gmeiner (1998:5) and Rorke (1997:54) revealed that nurses were uncaring, unsympathetic and treated CTOP clients unkindly. Some nurses reportedly refused to participate in caring for CTOP clients (Poggenpoel et al 1998:5). Nurses who are involved with CTOP clients have been victimised by

colleagues and community members (Bateman 2000b:750; Maja 2000:20; RSA TV Special assignment 20:30, 02.10.01).

Doctors working in a community hospital in Kwa-Zulu Natal objected to the Act before it was passed. They felt that abortion on demand was a violation of not only the sanctity of human life, but also of their moral and professional responsibility to preserve life (Hardy, Gilpin, Stead, Van Andel & Semasumeran 1996:1433). De Pinho and Hoffman (1998:788) point out that the South African Medical and Dental Council had indicated that no doctor may refuse to provide treatment for a woman presenting with an incomplete abortion, whether the abortion was induced or spontaneous as these are regarded as emergencies. This sentiment was supported by Dr Mhlanga, Chief Director of Maternal and Child Health services, who urged that health workers should not deny clients access to health services on moralistic and religious grounds. He highlighted the urgent need for programmes to help health workers re-examine their roles and for overworked nurses to get psychological support (Bateman 2000b:750). More values clarification workshops have also been recommended by researchers to assist health care providers to come to terms with their feelings regarding CTOP (De Pinho & Hoffman 1998:790; Gmeiner, Van Wyk, Poggenpoel & Myburgh 2000:70; Varkey 1999:11).

Implementation of the Act should be viewed in the context of strengthening the reproductive health services available to women in the RSA. Improvements in the organisation of services and health care provider attitudes, awareness among women and men of the available TOP services could contribute in reducing backstreet abortions and maternal deaths resulting from complications of these abortions. During post-abortion and counseling, health care providers should reinforce the consistent and correct use of contraceptives to prevent unwanted pregnancies.

## 2.6 BENEFITS OF EFFECTIVE CONTRACEPTIVE USE

Of the essential elements comprising reproductive health, prevention of unwanted pregnancies by consistently and accurately using contraceptives, has the potential to make a significant contribution towards improving the health and status of women. Women have the freedom to determine the number and timing of their children, they are empowered to control their fertility, manage their reproductive lives and they can maintain a basis for self respect and social dignity.

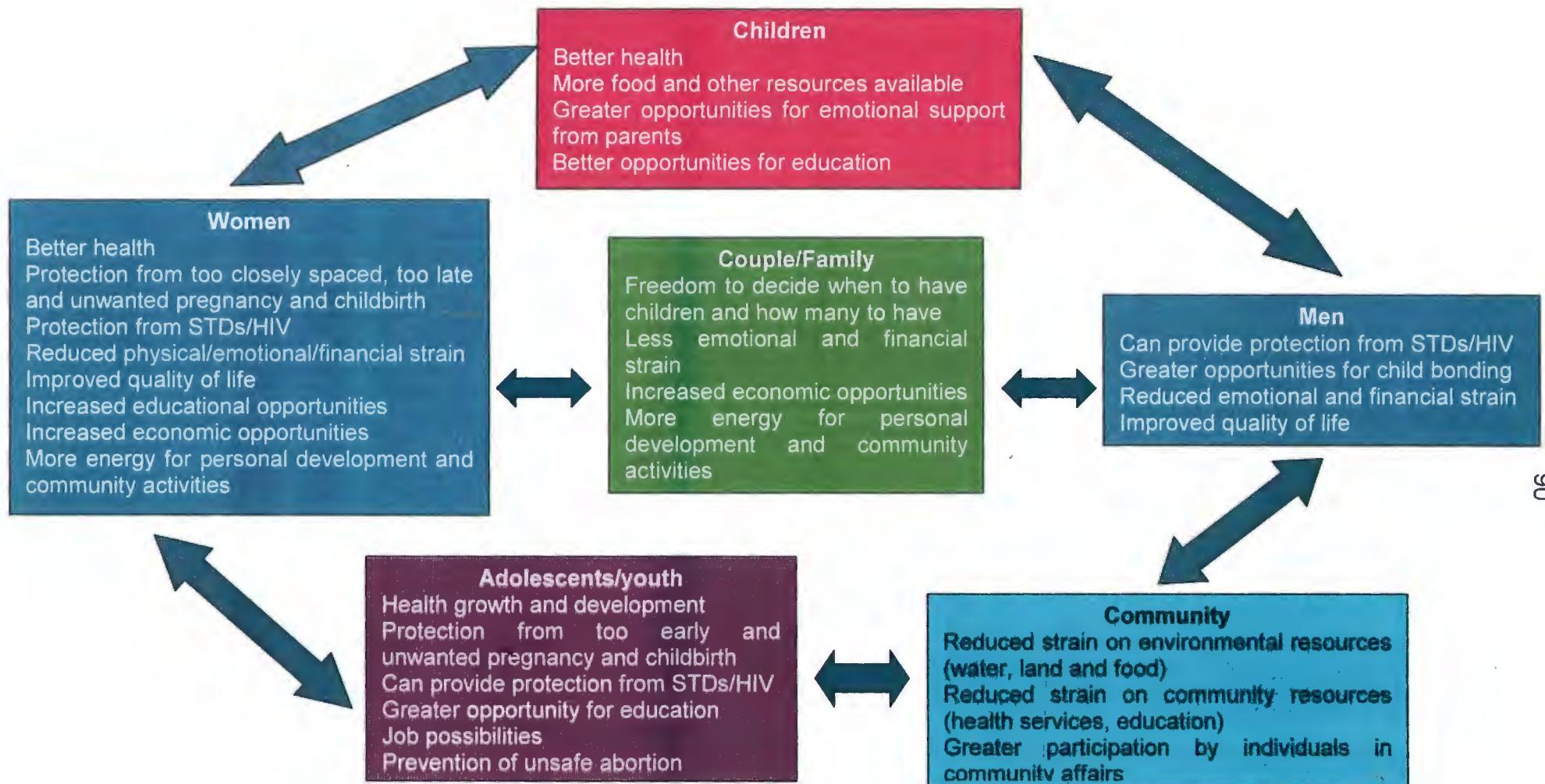
Fathalla (1997:64) envisioned contraception as being the woman's power to control her fertility which is consequently the freedom from which other freedoms flow. Such a woman will be able to complete her education, maintain gainful employment, make independent marital decisions and will have more choices open to her. In the RSA, similar to developed countries, women are assuming high positions in politics, academic, economic, technological and social spheres. These achievements require that a woman should be in a good state of mind and health to cope with demands associated with various responsibilities. A woman with an unwanted pregnancy cannot be considered to be in good health, even if the pregnancy would not impair her physical position. Limiting the size of the family by consistent contraceptive use would ensure that a young couple can postpone having children until they are financially stable. This means that it will not be necessary for the mother to go out to work soon after the birth of the baby, leaving it in the care of someone who might not be suitable. Parents will ensure that all their children are adequately planned for, receive material things which are necessary for their health and welfare such as food, housing and medical care (DOH 1999:vi; Hatcher et al 1997:2-1). The authors state further that between 13 and 15 million children younger than age five die each year, and that if all children were born at least two years apart, by effective use of contraceptives, three to four million of these deaths could be avoided.

The WHO estimates that throughout the world, of the more than 150 million women who become pregnant every year, an estimated one million die during pregnancy and childbirth, and another 13 million develop long-term disabilities, such as severe anaemia, pelvic inflammatory disease, infertility and obstetric fistulae (WHO 1994:10). With effective contraception, these could be averted, or at least reduced. Some hormonal methods reduce the risk of both endometrial and ovarian cancers. Grimes and Economy (1995:227) maintain that the risk of endometrial cancer can be reduced by 50% by the use of combination oral contraceptives. They further state that oral contraceptives also reduce the risk of ovarian cancer by 30% to 60% and that the longer duration of use increases the protective effect. Effective contraception not only has benefits for the woman, but the entire family and the community derive economic, social, psychological and health benefits as depicted in figure 2.2.

## **2.7 MODERN AND FREQUENTLY USED CONTRACEPTIVE METHODS**

It is evident that no single contraceptive method can meet the needs of all women, or of an individual woman at all different stages of her life. According to Fathalla (1995:1180) and Popis (1998:58), no contraceptive method is absolutely effective. The authors urge that clients must be helped to choose the most effective, medically safe method by excluding contraindications, considering the efficiency, advantages and disadvantages of available methods.

When clients do not get the contraceptive that meets their needs, they may not use what is chosen for them, they may discontinue the method or use the method inconsistently.



**Figure 2.2: Benefits of contraception**

Source: Adapted from Health Benefits of Family Planning, World Health Organization 1995

### **2.7.1.1 Male condoms**

The male condom is a thin rubber or synthetic rubber (latex) sheath worn over the penis by men during sexual intercourse. It is one of the oldest, cheapest, safest and most widely used contraceptive methods.

If properly used, condoms protect the wearer against infection by preventing direct contact between the penis and cervical, vaginal or rectal secretions or lesions. They also protect the partner from exposure to infected semen, discharge or penile lesions. A number of studies have found that, in addition to preventing unplanned pregnancies, condoms provide an impervious barrier to most sexually transmitted pathogens which include the herpes simplex virus Chlamydia Trachomatis, cytomegalavirus and HIV (Arts, Macalauso, Brill, Kelaghan, Austin, Eleanor, Robey & Hood 2000:237; Haigene et al 1999:44; WHO 1997:18).

### **2.7.1.2 Female condoms**

The female condom is a strong, soft, transparent sheath made of poly urethane and intended for preventing pregnancy and for preventing sexually transmitted diseases (STDs) including HIV/AIDS infection. The sheath has a flexible ring at either end. The smaller ring at the closed end is used for insertion and helps to keep the device at the upper end of the vagina. The larger and thinner outer ring remains outside the vagina when the condom is inserted, and anchors the condom so that the sheath covers the external genitalia and the base of the penis during intercourse. It is prelubricated with an inert, nonspermicidal, silicone-based fluid.

The condom is inserted manually into the vagina before intercourse. It can be placed in the vagina up to several hours before sexual activity or immediately before intercourse. It thus provides an

advantage over a diaphragm which requires the woman to insert the method shortly before intercourse. Each condom has been labeled for single use (DOH 1999:71; Haignere et al 1999:237).

Use of condoms correctly and consistently has advantages which can be outlined as follows:

- Condoms can be acquired without prescription and are obtainable from local clinics, hospitals or bought from pharmacies, truck stops, supermarkets and sex shops.
- Prevent STDs, including HIV/AIDS, as well as pregnancy when used correctly with every act of sexual intercourse.
- Help protect against conditions caused by STDs, pelvic inflammatory disease, chronic pain and possibly cervical cancer in women, infertility in both men and women.
- Can be used to prevent STD infection during pregnancy.
- Can be used soon after childbirth.
- Safe, no hormonal side effects.
- Help prevent ectopic pregnancies.
- Can be stopped at any time.
- Offer occasional contraception with no daily upkeep.
- Easy to keep on hand in case sex occurs unexpectedly.
- Can be used by men of any age.
- Can be used without seeing a health care provider first.
- Usually easy to obtain and sold in many places.
- Enable a man to take responsibility for preventing pregnancy and disease.
- There is increased sexual enjoyment because there is no need to worry about pregnancy or STDs.
- Often help prevent premature ejaculation (Hatcher et al 1997:11-15; RRA 1998:24; Sapire 1995:1081).

Clients need to be informed about the disadvantages of condoms so that precautionary measures could be taken to address these in order to avoid unwanted pregnancies.

Disadvantages of condoms include the following:

- Latex condoms may cause itching for a few people who are allergic to latex or some may be allergic to the lubricant on some brands of condoms.
- May decrease sensation, making sex less enjoyable for either partner.
- Couple must take time to put the condom on the erect penis before sex.
- Supply must be ready even if the woman or man is not expecting to have sex.
- Small possibility that the 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 as many people associate condoms with immoral sex, sex outside marriage or sex with prostitutes.
- Some people may be embarrassed to buy, ask the partner to use, put on, take off or throw away condoms (Hatcher et al 1997:11-15).

Added to the already mentioned advantages of condoms, the female condom has the following which could encourage women to use the condom:

- It is controlled by the woman.
- Designed to prevent both STDs and pregnancy.

- No medical conditions appear to limit use.
- No apparent side effects and no reported allergic reactions (CDC 1999:10-12; Hatcher et al 1997:11-7; WHO 1995:12).

### **2.7.1.3 Condom use**

According to Dr Gro Harlem Brundtland, Director General of the WHO, the promotion of condoms should be ensured in all contraceptive services to prevent unwanted pregnancies and protect against sexually transmitted diseases. She supports the effectiveness of condom use by stating the following:

*"Male and female condoms are the only contraceptive methods available that provide dual protection when used consistently and correctly". Dual protection may be particularly important for:*

- Sexually active young people.
- Men and women (and their partners) who have high risk sexual behaviour.
- Sexually active people in settings with high prevalence of HIV and STDs.
- Those who already have HIV or STDs and their partners.
- Sex workers and their clients (WHO 1995:8).

Service providers and counselors must be knowledgeable about the dual protection of condoms to be able to inform clients during counseling. They should emphasise the importance of using condoms consistently and appropriately. CDC (1999:10-12) refers to consistent and correct use of condoms by stating the following clarifications:

### Consistent use

Consistent use implies using a condom with every act of sexual intercourse, from beginning to the end of sexual intercourse, including penile vaginal intercourse, oral and anal intercourse.

Appropriate use of condoms seems to be a problem as evidenced by research conducted regarding condom use. Abdool-Karim, Abdool-Karim, Preston-White and Sankar (1992:108) did an explorative, qualitative study to find out the reasons for lack of condom use among high school students in Kwa-Zulu Natal, South Africa. The findings revealed that condom use was not sufficiently well understood and that condoms were not accessible or available when needed.

Peltzer (2001:54) feels that there is a paucity of data concerning male condom use, particularly about the correct use of male condoms by the target group of youth in South Africa, and adds that such data remains crucial for prevention programmes. He investigated knowledge and sexual practices with reference to the correct use of male condoms. The results suggested that the commonest mistakes with respect to condom use were ignorance about the correct moment to put on a condom (56%) and not knowing when to take off a condom (55%), and whether a condom should be unrolled before being put on a penis (28%).

Sharma, Dave, Sharma and Chauhan (1997:707) found that the most common mistakes related to the incorrect use of condoms were use of oil-based lubricants with condoms, ignorance about the technique of putting on a condom, reuse of condoms and how to remove a condom properly. CDC (1999:13-14) and Hatcher et al (1997:11-9) suggest the following to ensure effective use of condoms:

- Storing of condoms in a cool place out of direct sunlight, not in wallets or glove compartments. Latex will become brittle from changes in temperature, rough handling or age. Damaged, discoloured, brittle or sticky condoms should not be used.
- Expiry date should be checked and condom package should be opened carefully, avoid using teeth or fingernails to open the packet.
- Put on the condom after the penis is erect and before it touches any part of partner's body. If the penis is uncircumcised, the person must pull back the foreskin before putting on the condom.
- Put on the condom by pinching the reservoir tip and unrolling it all the way down the shaft of the penis from head to base. If the condom does not have a reservoir tip, pinch it to leave a half-inch space at the head of the penis for semen to collect after ejaculation.
- Withdraw the penis immediately if the condom breaks during sexual intercourse and put on a new condom before resuming intercourse. When a condom breaks, use spermicidal foam or jelly and consult the health care provider about emergency contraception.
- Use only water-based lubrication. No oil-based lubricants such as cooking/vegetable oil, baby oil, hand lotion or petroleum jelly should be used as they cause the condom to deteriorate and break.
- After sexual intercourse, the penis should be withdrawn immediately after ejaculation while it is still erect, grasp the rim of the condom between the fingers and withdraw the penis so that semen does not spill (CDC 1999:12-14; Hatcher et al 1997:11-9).

It is noteworthy to mention that most clients may not understand step by step the theory presented about correct use of condoms. As a result, health care providers should have models to demonstrate the technique of putting on a condom correctly to

ensure that clients understand and see the entire process while it is described and demonstrated.

#### **2.7.1.4 Condom failure**

Condom failure may be caused by nonuse, incorrect use, breakage, slippage or leakage. The risk of condoms breaking was reported by Lindberg, Sonenstein Ku and Levine (1997:131) among males aged 17 to 22 years, a group at particular risk for STDs/HIV infections and unintended pregnancies. The risk of condom breaking was low, as only 2,5 of condoms used in the previous year had broken. This low breakage rate was attributed to knowledge and experience about condoms, which resulted in improved skills in using condoms, the education and training received regarding the use of condoms.

Incorrect use (not placing the condom on the erect penis at the initiation of sexual activity) was documented in a prospective study of men who acquired gonorrhoea despite condom use (Cates & Stone 1992:79). Condom effectiveness increases with duration of use and contra-ceptive failure rates as low as 0,6% have been documented among experienced users among women aged 40 to 44 years (Cates & Stone 1992:80).

Rosenberg and Waugh (1997:20) conducted a survey to determine latex condom breakage and slippage in a controlled clinical trial among males aged 18 to 50 years and females aged 18 to 40 years who had sex at least six times a month and did not have a history of fertility-impairing conditions including STDs. Ninety-two couples participated with 70-75% of participants having experience in condom use. The rate of complete slippage was 0,63% and total failure (clinical breaks plus complete slips) was 1,04%. The results suggest that condoms can, in experienced, motivated populations provide satisfactory performance and suggest that their efficacy at preventing pregnancy may equal that of other reliable contraceptives.

Sharma et al (1997:707) highlight the need of informing and teaching clients about the importance of knowing the correct use of condoms by stating that distribution of condoms should be coupled with education about correct and consistent use, including information about the dual protective nature of condoms.

In addition, leaflets or guidelines on how to open a condom, including the steps of how to use it, should be included in condom packs for users. These guidelines could be written in either of the eleven languages for clients who may understand any of these languages. Perhaps this may ease the problem of condom use as already explained.

### **2.7.2 Emergency contraception**

Emergency contraception is a safe and highly effective method of preventing accidental pregnancy after unprotected intercourse or a contraceptive accident (Kubba 1997:104; Quinn 1999:39). There are two types of emergency or postcoital contraception: hormonal methods and the insertion of a copper-based intrauterine contraceptive device (IUCD).

In the RSA, E-gen-C was introduced in 1998 as an emergency post-coital contraceptive, which prevents pregnancy if taken within 72 hours of unprotected sexual intercourse or the obvious failure of mechanical contraceptive methods. It acts as a contraceptive by delaying the release of a fertilised ovum from the ovaries, or by stopping the ovum attaching itself to the endometrium (RRA 1999:11).

E-gen-C comprises four tablets, each containing 0,25 mg levonorgestrel and 0,05 mg ethinylestradiol. The first two tablets are taken as soon as possible after unprotected sex – up to 72 hours at

the latest, and the second two tablets are taken 12 hours later. The earlier E-gen-C is used, the more effective it is. Unprotected sex must be avoided until the next menstrual period and until then only local mechanical or chemical methods of contraception may be used.

E-gen-C is contra-indicated in cases where pregnancy already exists, or in thrombo-embolic processes in arteries and veins and states which predispose to such diseases. E-gen-C is intended for emergencies only and is completely unsuitable for regular contraception. Its reliability is not as high as that of the common birth control pill.

Possible side effects which may occur are nausea, vomiting and congestion in the breasts.

Other emergency contraceptive pills include:

- Ovral, recommended dosage of two pills first dose within 72 hours and two pills second dose 12 hours later.
- Nordette, four pills are recommended within 72 hours as first dose and four pills as second dose within 12 hours.
- Microval, twenty five pills within 72 hours and another twenty five pills as second dose within 12 hours (<http://www.who.int/inffs/en/fact244.html> 24.08.2001).

#### ***2.7.2.1 Hormonal methods of postcoital contraception or the Yuzpe regime***

The Yuzpe regime has been known for more than thirty years and licensed for use in the United Kingdom in 1984. The most widely used preparation consists of two divided doses. Each tablet contains 50 $\mu$ g Ethinyl-Oestradiol plus 500 $\mu$ g Norgestrel equivalent to 250 $\mu$ g of Levonorgestrel (Kubba 1997:104).

Two tablets are taken as soon as possible and not later than 72 hours after intercourse, followed by the other two tablets 12 hours later. The authors refer to the importance of stressing that the tablets should be taken 12 hours apart to maintain an adequate hormonal level for 24 hours. The first dose can preferably be taken during consultation to aid compliance. Pregnancy rates increase from 0,5% when treatment is given within twelve hours of unprotected sex, to 4,1% when given between 61 and 72 hours. The earlier treatment commences after unprotected sex, the more effective it is (Webb 1997:243).

#### ***2.7.2.2 Progestogen only emergency contraception***

This method involves the use of Levenorgestrel alone. Two doses each of 750 $\mu$ g are given twelve hours apart, the first within 72 hours of the episode of unprotected sex. Postinor-2 (Levenorgestrel 750 $\mu$ g) is mainly used for emergency contraception and mainly used in Eastern Europe and the UK.

The WHO conducted a randomised study involving 1 998 women in 21 centres worldwide. Among the women who took Levenorgestrel tablets alone within 72 hours of unprotected sex, the crude pregnancy rate was 1,1% compared with 3,2% in the group that used the Yuzpe method (WHO 1998c:428). In a similar study, nausea and vomiting were also significantly less common with the Levonorgestrel method compared with the Yuzpe regime.

#### Common problems and management

When informing women about the use of emergency contraception, health care providers should explain the possibility of common problems such as nausea and vomiting. Hatcher et al (1997:5-23) and Quinn (1999:39) suggest that the woman should eat something soon after taking the pills to reduce any nausea. Hatcher et al

(1997:5-23) add that nonprescription antinausea medicines such as Dramamine and Marazine can reduce the risk of nausea when taken half an hour before taking emergency contraceptive pills and every four to six hours thereafter.

If a woman vomits within two hours after taking the pills, she may take another dose, but should not take any extra pills as they will not make the method more effective but may aggravate nausea. Quinn (1999:41) suggests that health care providers should obtain information from clients presenting for emergency contraception and the following areas should be addressed:

- Date of the last menstrual period (LMP) and whether it was normal or abnormal (the woman might already be pregnant, for example if the last period was not normal). If there is any doubt, a pregnancy test should be discussed so that she is referred appropriately.
- Usual length of the woman's menstrual cycle.
- When the episode of unprotected or inadequately protected sex occurred in relation to the day in the menstrual cycle. Day one of the menstrual cycle is the first day of the LMP.
- Number of hours since the first episode of unprotected sex.
- Use of enzyme-inducing drugs.
- Detailed medical history related to: history of thrombo-embolism, focal migraine, recent STDs, past history of ectopic pregnancy or any specific contra-indications to any type of post-coital treatment. Pelvic examination (by doctor) if pregnancy is suspected or to assess the suitability for an IUCD, or for cervical screening, if appropriate (Quinn 1999:41).

In addition to this information, the woman should be counseled before she can give verbal consent to emergency contraceptive treatment.

### **2.7.2.3 Intrauterine contraceptive devices**

An alternative form of emergency contraception is the insertion of a copper-containing IUCD. According to Curtis (1993:211) and Kubba (1997:104), there were only four documented failures when the IUCD has been used postcoitally, inferring a 99.9% effectiveness.

IUCDs can be inserted up to five days after unprotected sex, and often longer if intercourse has taken place early in the cycle. It can be inserted up to five days after the calculated date of ovulation – day 19 of a 28-day cycle. This is possible because the IUCD works by preventing 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 centres cervical swabs are taken for chlamydia routinely, and prophylactic antibiotic use may be considered to reduce the likelihood of postinsertion infections.

### **2.7.2.4 Antiprogestins (*Mifepristone*)**

Mifepristone is a synthetic steroid with potent antiprogestational properties. The hormone progesterone is essential for implantation. This drug is licensed only as a method of inducing abortion in pregnancy and not as a form of emergency contraception.

A study conducted by Glasier (1992:1041) randomly assigned women to either the Yuzpe method (n=398) or Mifepristone (n=402) revealed that there were four pregnancies in the Yuzpe group and none in the Mifepristone group. Less nausea and vomiting were also reported in the Mifepristone group, although this method is likely to cause delay in menstruation compared with the Yuzpe method.

Estimates suggest that nearly half of all women who become pregnant do not plan to do so and many women presenting for CTOP could have used emergency contraception had they known about its availability and if they could access it (Crosier 1996:87; Ehlers et al 2000:48; Glasier 1992:611).

Duncan, Harper, Ashwell, Mant, Buchan and Jones (1990:112) in a study of women requesting CTOP in Oxford UK, found that 70% of respondents said they would have used emergency contraception, but did not know how to obtain it and a further 30% were not aware of emergency contraceptives as an option for preventing unplanned pregnancies. In the Oxford study, 528 pregnancies might have been predicted as either no contraceptive method was used or a recognisable contraceptive failure occurred. As many as 80% of these pregnancies might have been prevented by the use of emergency contraceptives, only 18% admitted to using it (Glasier 1992:611). Similarly, Bromham and Cartmill (1993:180) revealed that 93% of women requesting CTOP, would have preferred to use emergency contraception to prevent unplanned pregnancies if they knew about its use.

Adolescent mothers in the study by Ehlers et al (2000:48) in the Gauteng Province of the RSA, indicated that 68% of these mothers did not know about the availability of emergency contraceptives. Only 38% knew about the existence of emergency contraceptives, but 13% of these knew that "pills" could be taken to prevent pregnancies after unprotected sex, and only one respondent could name such a product. None of these adolescent mothers succeeded in obtaining these services, in spite of knowing about emergency contraceptives. Reasons given for not attempting to use emergency contraceptives included: they feared that the baby might be malformed if they took pills; did not have sufficient information to obtain these pills; their boyfriends wanted the babies; did not believe that pills would be effective; mother discouraged the use of

emergency contraceptives and that not wanting the clinic sister to know about sexual activities.

Knowledge about emergency contraception is deficient in the RSA and the need exists for more and accurate information regarding emergency contraception to men and women of all ages. Accessibility, affordability, availability and acceptability of emergency contraceptives cannot be overemphasised. Better utilisation of emergency contraceptives could reduce high rates of unwanted pregnancies and possibly reduce the number of unwanted pregnancies, abandoned babies and requests for CTOPs in the RSA.

### **2.7.3 Hormonal methods**

Hormonal methods include combined oral and progestogen only oral contraceptives

#### ***2.7.3.1 Combined oral contraceptives***

Modern combined oral contraceptives contain very low doses of synthetic oestrogen and progestogen. These are commonly known as combined pills, the pill and birth control pills. They 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).

When motivating clients to use combined oral contraceptives, health care providers should emphasise the following advantages:

#### **Advantages**

- There is no need to do any preparations at the time of sexual intercourse

- The couple has increased sexual enjoyment because there is no need to worry about pregnancy.
- Monthly periods are regular, there is lighter monthly bleeding and fewer days of bleeding, milder and fewer menstrual cramps.
- Oral contraceptives can be used as long as the woman wants to prevent pregnancy, there is no rest period needed.
- They can be used at any age from adolescence to menopause, including women who have children and those who do not have children.
- The woman can stop using pills at any time and fertility will return soon after stopping.
- Oral contraceptives can be used as an emergency contraceptive, for example, two ovral tablets taken immediately after unprotected intercourse, then two tablets after 12 hours.
- They can prevent or decrease iron deficiency
  - > anaemia
  - > ectopic pregnancy
  - > endometrial cancer
  - > ovarian cancer
  - > ovarian cysts
  - > pelvic inflammatory disease
  - > benign breast disease (Hatcher et al 1997:5-4; <http://www/plannedparenthood.org/birth-control/depoforyou.htm>, 9.20.01).

Clients should also be informed of the possible disadvantages of combined oral contraceptives so that these may be expected and probably accepted, as common occurrences.

- Common side effects are inter alia:
  - > Nausea (during the first three months).

- > Spotting or bleeding between menstrual periods, especially if a woman forgets to take her pills or takes them late (most common in the first three months).
- > Mild headaches.
- > Breast tenderness.
- > Slight weight gain, although some may appreciate it.
- > Amenorrhoea, some women may see it as an advantage.
- Not highly effective unless taken every day, some women have difficulty in remembering to take a pill daily.
- Not recommended for breastfeeding women because they affect quality and quantity of milk.
- May cause mood changes including depression, less interest in sex in some women.
- Very rarely causes stroke, blood clots in deep veins of the legs or heart attack. Women who are 35 years or older and at the same time smoke more than 20 cigarettes per day, are at highest risk.
- Oral contraceptives can not protect against sexually transmitted diseases (STDs) including AIDS.
- A new packet of pills must be at hand every 28 days.

These disadvantages may discourage clients to use oral contraceptives or lead to discontinuation of the method. In an effort to encourage consistent use, specific instructions should be emphasised when giving contraceptives to clients. Hatcher et al (1997:5-12) recommend the following procedure for giving oral contraceptives to clients:

- Hand client at least one packet of the same pills she will use, even if she will be getting her pills elsewhere later.
- Show her the kind of pill packet you are giving her, 21 pills or 28 pills. In addition, with the 28-pill packets, health care providers should explain that the last seven pills do not contain hormones as they are reminder pills. It should be added that if the woman

forgets to take the reminder pills, she is still protected from pregnancy and that the risk of unwanted pregnancy will occur if she forgets to take active hormonal pills.

- Clients should be shown how to take the first pill out of the packet, how to follow the packet's instructions to take the rest of the pills, one each day starting with the hormonal pills, then the reminder pills.
- Give clients instructions on starting the first packet, starting the next packet, and what to do after missing a pill.

Additional information about side effects that might occur and how to manage such problems could ease clients' anxieties related to the use of oral combined pills. Hatcher et al (1997:5-5) summarise common problems and their management as follows:

**➤ Nausea, mild headaches, moodiness, tender breasts, spotting between periods, irregular bleeding**

The clients should keep taking their pills and not skip pills as they will thereby risk falling pregnant. For spotting, the woman should try taking each pill at the same time of the day, for example, every evening when they brush their teeth before going to bed.

**➤ Vomiting within an hour of taking a hormonal pill**

The woman should take another hormonal pill from a separate packet, so as not to get confused with the current packet of pills.

**➤ Severe diarrhoea or vomiting for more than 24 hours**

Severe diarrhoea or prolonged vomiting may manifest in clients using high-dose oral contraceptives. If the client experiences these complications, she should keep taking her pills, if she can, despite her discomfort. In addition, she should either use

condoms, spermicides or avoid sex until she has taken a pill each day for seven days in a row after diarrhoea or vomiting has stopped. The client might be advised to use another method.

➤ **Nausea**

Suggest taking the pill at night or with food.

➤ **Minor headaches**

Clients experiencing minor headaches when taking oral contraceptives should be advised to take aspirins, ibuprofen, paracetamol or other nonsteroidal anti-inflammatory drugs. They should also try to reduce their salt intake, as water retention (aggravated by salt intake) can make headaches worse.

➤ **Amenorrhoea**

It should be established if the woman has vaginal bleeding at all or just a small stain. It is also important to enquire if the woman was taking the pill every day and if she has, it should be explained that she is not likely to be pregnant. If she might have missed the 7-day break between 21-day packets, which may cause a missed period, she should be reassured that she may probably not be pregnant. If the client might have missed two or more active, hormonal pills in a row, a pregnancy test should be done to assess whether the woman is pregnant. If she is pregnant, then she should be informed and asked to stop taking oral contraceptives and advised to use condoms and/or spermicides until the pregnancy has been confirmed by means of a laboratory test. Health care providers should establish if the woman had irregular periods before she took combined oral contraceptives. If so, her periods may be irregular again after she stops taking the pill.

➤ **Spotting or bleeding between monthly periods**

The woman should be asked if she has missed any pills and if so, it should then be explained that missing pills can cause bleeding between periods, although bleeding can occur even when taking pills every day. The woman should be asked if she took rifampicin or medicines for seizures (excluding valproic acid). These medications make oral contraceptives less effective, as a result, the woman should be encouraged to use condoms and/or spermicides together with the oral contraceptives.

➤ **Unexplained abnormal vaginal bleeding**

This could suggest pregnancy or an underlying medical condition. The woman should be advised to take combined oral contraceptives while her condition will be evaluated and pregnancy excluded (Hatcher et al 1997:5-5,6).

#### **2.7.3.2 Progestogen-only oral contraceptives**

These are often referred to as progestogen-only pills and minipills, are oestrogen-free oral contraceptives containing very low doses of synthetic progestogen. To be effective, progestogen-only contraceptive pills should be taken daily at the same time.

Use of progestogen-only contraceptive pills reduces menstrual cramps and pain, prevents iron deficiency anaemia and decreases the risk of endometrial and ovarian cancers, pelvic infections and breast tumours.

Progestogen-only contraceptive pills are effective in preventing pregnancy, when taken correctly and consistently with a failure rate

of 0,5% to 10% during the first year of typical use. Their effectiveness is slightly less than that of combined oral contraceptives, especially in younger women. This method can be used by breastfeeding as there will be no oestrogen side effects (DOH 1999:79; Hatcher et al 1997:6-5).

Mehta (1994:168) asserts that, of the 92 million users of the method worldwide, 55 million live in developing countries, including the RSA. However, this author states that in spite of the safer low-dose pills in use, some concerns and controversies continue to persist regarding adverse effects which have been documented such as intermenstrual bleeding, amenorrhoea, weight gain, loss of libido, depression, dyspareunia and hypertension (Mehta 1994:170; Theron & Grobler 1998:37-39). DOH (1999:78-80) and WHO (1996:8) recommend that doctors and other trained clinic personnel (nurses, midwives, pharmacists) and community-based health workers should play a major role in encouraging clients to return after three months, or earlier in the event of any ill-effects to discuss their concerns and to implement alternative interventions if so desired by the client.

#### **2.7.4 Injectable contraceptives**

Two types of injectables commonly used are Depot-medroxyprogesterone acetate, Depo Provera and Norithisterone enanthane, Nur-Isterate.

##### **2.7.4.1 Depo Provera (Depot-medroxyprogesterone acetate)**

Depo Provera is an aqueous suspension of medroxyprogesterone acetate administered by injection every three months. The method is licensed as a contraceptive in more than 90 countries including the RSA (Mehta 1994:170-171; Theron & Grobler 1998:59). In the RSA approximately 66% of all family planning clinic patients make use of injectables (Theron & Grobler 1998:59).

Depo Provera acts by inhibition of hypothalamo-pituitary-ovarian functions; implantation of the ovum is prevented by maintenance of the endometrium in a state unsuitable for embedding and passage of the spermatozoa is prevented by the formation of a cervical mucus barrier. Its user effectiveness is 0,24 pregnancies per 100 women years. However, it might be unsuitable for young women who have not yet completed their families and who wish to space their children. Mehta (1994:170) urges that while the method is highly effective in providing pregnancy protection, its amenorrhoeic nature should be duly emphasised during counseling of potential users.

#### **2.7.4.2 Nur-Isterate (*norithisterone enanthate*)**

Nur-Isterate is a long-acting contraceptive which is given intramuscularly every two months, in addition, monthly injectables are available in some countries (Hatcher et al 1997:7-3). The indications for use are the same as for Depo Provera, but recovery of fertility takes place within six months. For this reason, it can be used by women who have not completed their families. Correctly used, it is an extremely reliable protection method against pregnancy. Its effectiveness is 0,3 pregnancies per 100 women in the first year of use (three per 1 000 or one in every 333) when injections are regularly spaced three months apart. Pregnancy rates may be higher for women who may be late for an injection if providers run out of supplies.

Hatcher et al (1997:7-14) suggest the following advantages of injectable contraceptives which could guide health care providers in motivating clients to use the method consistently and effectively.

- It is an effective method if used consistently.
- It can be used privately without others knowing.

- No interference with sex, no daily pill-taking as one injection provides three months' protection against pregnancy.
- Client can return to clinic as early as two to four weeks before scheduled date or two weeks to four weeks later than the due date for next injection as it allows some flexibility (although this may not be ideal).
- Quantity and quality of breast milk do not seem harmed. Breastfeeding mothers can use the method as soon as six weeks after childbirth.
- There are no oestrogen side effects and no increased risk of oestrogen-related complications.
- Helps prevent ectopic pregnancies, endometrial cancer, uterine fibroids and ovarian cancer.
- Added advantages include prevention of irondeficiency anaemia, may contribute to less frequent seizures in women with epilepsy and less frequent and painless.

Every method has its disadvantages which need to be explained to clients. If clients are also informed about how to manage and cope with side effects, they may not necessarily abandon the method.

Common side effects of injectable contraceptives may be:

- Light spotting or heavy bleeding.
- Amenorrhoea, especially after the first year's use. To some women, this can be an advantage.
- May cause weight gain although changes in diet can help control or prevent weight gain.
- There may be delayed return of fertility (until DMPA levels in the body drop). Women may have to wait longer prior to falling pregnant than women who used combined oral contraceptives, IUCDs, condoms or vaginal method.
- Requires another injection every three months.

- May cause headaches, breast tenderness, moodiness, nausea, hair loss, less sex drive or acne.
- Does not protect against HIV/AIDS (Hatcher et al 1997:7-5).

Mehta (1994:170) urged that during counseling, the amenorrhoeic nature of injectable contraceptives should be emphasised to allay anxiety. Research by Ehlers et al (2000:49) and Wood and Jewkes (2000:18) reported that 62,16% adolescent mothers used injections mainly because they would not need to take pills, family members and boyfriends would not need to know that they used injections and visits to the family planning clinic every three months would be more feasible than monthly visits.

#### **2.7.5 Intrauterine contraceptive devices**

An intrauterine device is a small, flexible plastic frame. It often has a copper wire or copper sleeves and is inserted into a woman's uterus through her vagina. Most brands of intrauterine contraceptive devices (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). The nurse may check if the IUCD is still in place by touching the strings and can remove the IUCD by pulling on the strings with forceps. Types of IUCDs include copper T, TCu-380A, MLCu-375 (Multiload), Nova T, Progestasert, Gynae T380 and LNG-20 (Hatcher et al 1997:12-13; Theron & Grobler 1998:28; Vlok 2000:359).

IUCDs exert their effect by reason of being irritant foreign bodies which elicit an inflammatory reaction with the outpouring of many polymorph leucocytes which phagocytose spermatozoa and any fertilised ovum which may be present (Vlok 2000:359). Suitably trained health care providers may insert or remove IUCDs. A woman who chooses an IUCD should be informed about what to expect and

how to overcome common problems related to IUCDs. Such problems include that:

- She can expect some cramping pain for the first day or two after insertion. The woman should take either aspirin, paracetamol or ibuprofen.
- Some vaginal discharge for a few weeks after insertion which should be considered normal.
- Heavier menstrual periods. Possible bleeding between menstrual periods during the first few months after IUCD insertion.
- IUCD may come out without the woman feeling it. She should therefore check her IUCD once a week during the first month after insertion and after each menstrual period.

#### Advantages of IUCDs

The advantages of using IUCD should be part of the information sharing process between health care providers and IUCD clients. These may be discussed in view of the following advantages:

- Effective long-term prevention of pregnancy.
- Long-lasting, the most widely used IUCD, the TCu-380A, lasts for 10 years.
- Very effective, little to remember.
- No interference with sex.
- Increased sexual enjoyment as there is no need to worry about pregnancy.
- No hormonal side effects with copper-bearing or inert IUCDs.
- Copper-bearing and inert IUCDs have no effect on the amount or the quality of breast milk.
- Immediately reversible. Women can become pregnant soon after the removal of the IUCD.

- It can be inserted immediately after childbirth (except hormone-releasing IUCDs) or after induced abortion, if there is no evidence of infection.
- IUCDs can be used throughout menopause, preferably for 1 year or more after the last menstrual period.
- No interactions with any medications.
- Helps to reduce the incidence of ectopic pregnancies (reduced risk of ectopic pregnancy than in women not using any contraceptive method at all (Hatcher et al 1997:12-5; <http://www.health.yahoo.com/health/diseasesandcondi/contraception>, 24.08.2001).

### Disadvantages of IUCDs

Common side effects may include any of the following:

- Menstrual changes during the first three months, but likely to lessen after three months:
  - longer and heavier menstrual periods
  - bleeding or spotting between periods
  - more cramps or pain during periods
  - heavy menstrual bleeding or bleeding between periods, possibly contributing to anaemia
- Other uncommon side effects include:
  - severe cramps and pain beyond the first 3 to 5 days after insertion
  - perforation of the wall of the uterus, very rare
- Does not protect against STDs including HIV/AIDS, therefore may not be recommended for women with multiple sex partners.
- Pelvic inflammatory disease, likely to follow STD infection and can lead to infertility.
- Client cannot stop IUCD on her own, a trained health care provider must remove the IUCD for her.

- IUCD may dislodge from the uterus without the woman being aware of such dislodging.
- Does not prevent ectopic pregnancies, although the incidence is reduced compared to women who do not use contraceptives at all (Hatcher et al 1997:12-6; <http://contraception/intra-uterinedevice, 2.20.01>).

About two or three pregnancies occur per year out of 100 women using IUCDs (<http://health.yahoo.com/health/diseasesandcondition/contraception, 24.08.2001>).

### **2.7.6 Norplant implants**

Norplant is a hormonal contraceptive which consists of a time-released implant of synthetic progestin which lasts up to five years. The implant consists of six matchstick-sized silicone capsules which are inserted into the upper arm by a physician or trained health care provider (Belfield 1998:26; Federl 1997:18). According to Federl (1997:18), Norplant was approved by the Food Development Administration in the USA. By 1991, 1,6 million women were using it in 51 countries all over the world.

Belfield (1997:26) refers to the following types of Norplant:

- Norplant-2, a two-rod progestogen-releasing system that lasts two years.
- Implanon is a single-rod progestogen-releasing system that lasts two years.
- Biodegradable implants are still being researched, including Caprano, which releases levonorgestrel and Annuelle, which releases norethindrone.

The advantages of Norplant as outlined by Federl (1997:18) and Hatcher et al (1997:8-4) can be summarised as follows:

- Long-term pregnancy protection, is reversible and it can lead to effective contraception for up to five years.
- Woman has no need to do anything at time of sexual intercourse.
- Increased sexual enjoyment because there is no need to worry about pregnancy.
- There's nothing to remember, no daily pill-taking or repeated injections and there is no repeated clinic visits required.
- Norplant is effective within 24 hours after insertion and fertility returns almost immediately after capsules are removed.
- Quantity and quality of breast milk do not seem to be harmed, nursing mothers can use norplant six weeks after childbirth.
- No oestrogen side effects.
- It helps prevents ectopic pregnancies and endometrial cancer.
- Insertion involves only minor pain of anaesthesia needle, not painful if local anaesthetic is given properly.

Common side effects which may be experienced by women using Norplant can be outlined in the following:

- Changes in menstrual bleeding, such as light spotting, prolonged bleeding or amenorrhoea.
- Headaches, dizziness, breast tenderness, nervousness, nausea, acne, change in appetite, weight gain or hair loss.
- Client cannot start or stop using norplant on her own, capsules must be inserted and removed by a specially trained health care provider.
- Minor surgical procedures are required to insert and remove capsules. Some women may feel uncomfortable with implants seen or felt under the skin.

- Women may experience discomfort for several hours to one day after insertion and removal may be painful or difficult.
- Norplant does not protect against STDs including HIV/AIDS (Federl 1997:18; Hatcher et al 1997:8-15).
- Federl (1997:19) suggests that the woman should be seen a month after implant and thereafter once every year. It is also important to keep track of women after the five year period as the implant will not be effective after this time.

### **2.7.7 Sterilisation**

Sterilisation is a procedure that aims at permanently ending the reproductive functions. Conception is prevented by sperm-oocyte contact. Sterilisation is performed by ligating partially, destroying or removing or occluding fallopian tubes in females and the vas deferens in the males (Hatcher et al 1997:93 & Theron & Grobler 1998:95). Estimates are that in 1950, 3 to 4 million people worldwide used sterilisation for contraceptive purposes. Hatcher et al (1997:93) add that these numbers increased to 20 million people in 1975, and that an estimated 100 million people have been sterilised worldwide. In the RSA approximately 45 000 sterilisations are performed annually as compared to 750 000 sterilisations in the USA (Theron & Grobler 1998:95).

Hatcher et al (1997:10-4) have summarised the following advantages of sterilisation:

- It is a permanent and effective contraceptive method.
- There is no interference with sex and it does not affect a person's ability to have sex.
- The client does not have to get supplies or go to the health service repeatedly.
- There are no apparent long-term health risks.

- With females, sterilisation has no effect on breast milk.

Both male and female sterilisations have disadvantages which should be explained to clients so as to allay anxieties and misconceptions about the procedure. The following disadvantages may be outlined:

- Sterilisation is usually painful at first, but pain disappears after one or two days.
- Uncommon complications of surgery may include:
  - infection or bleeding at the incision
  - internal infection or bleeding
  - injury to internal organs
  - anaesthesia risk such as allergic reaction or
  - overdose, delayed recovery and side effects
- In rare cases when pregnancy occurs, it is more likely to be ectopic than in a woman who used no contraception.
- It requires physical examination and minor surgery by a specially trained provider.
- Female sterilisation is slightly more risky as compared to a vasectomy, and often more expensive.
- Reversal surgery is difficult, expensive and not available in most countries. Women who may want to become pregnant in future should choose a different method as successful reversal may not be guaranteed.
- Sterilisation does not provide protection against STDs (Hatcher et al 1997:9-5).

Sterilisation is a permanent contraceptive method and clients need to think carefully before consenting to the procedure so as to avoid regrets after the procedure is done. Health care providers can assist clients to make informed choices by counseling, listening and responding to clients' questions and concerns.

Special care must be taken to assure a voluntary informed choice of the method by the client, considering the irreversibility or the permanence of sterilisation procedures. Particular attention must also be given in the case of young people, nulliparous women and men who have not yet been parents and in clients with mental health problems, including depressive conditions.

## **2.8 BARRIERS TO CONTRACEPTIVE USE**

There are various factors that could adversely affect the utilisation of contraceptive services as well as the use of contraceptives. These barriers should be avoided, or overcome, if contraceptives are to be used consistently and effectively to the ultimate benefit of individuals, communities and countries. These have been classified into personal and situational factors.

### **2.8.1 Personal factors**

Various demographic aspects such as age, level of education, partner support; parity; cultural beliefs; values and norms; and religion have been considered as personal factors which may influence whether men and women seek and use contraceptives consistently, or not.

#### **2.8.1.1 Age**

Age has been identified as an important factor in influencing contraceptive practices. Women and men, at each end of the childbearing continuum, may have age-related reasons for not seeking contraception, and using contraceptives consistently. For the elderly, multiparous women who may not seek and use contraceptives, this might be that she has enough children. Piccinino and Mosher (1998:6) found that women above 35 years did not use

contraceptives irrespective of whether they had sexual intercourse or not, as they believed that fertility rates decline as age increases.

At the other end of the age continuum, is the adolescent, who is particularly vulnerable to complications of unwanted pregnancies. Ignorance and nonavailability of contraceptive advice have been reported to be possible reasons for low usage of contraceptives by adolescents (Buga, Amoko & Ncayiyana 1996:523; Koyana 1995:3).

In some cultures, it is generally accepted by society that sexual matters should not be discussed with adolescents as it is feared that such knowledge might encourage them to become promiscuous. Mayekiso and Twaise (1992:23) found that there's minimal involvement of parents in sex education in the RSA. Parents were reportedly reluctant to discuss sexual matters with their adolescent children, although the latter indicated their need to communicate openly with their parents about sex-related issues.

According to Wood and Jewkes (2000:5), most mothers had not even told their daughters about menstruation, or had simply informed them that it was 'growing up', 'normal' or that the blood signified that 'at any time you can have a baby'. As a result, many adolescents had been secretive about their first menstruation, partly because of fear. Many adolescents in the same study admitted that they had not understood during their first few months of sexual activity that sex could lead to pregnancy.

Adolescents are likely to be ridiculed by society if seen to be using contraceptives. In the RSA, studies have shown that most adolescent mothers did not use contraceptives before falling pregnant because their mothers considered the use of contraceptives to be causing infertility and promiscuity (Mogotlane 1993:13; Williams & Mavundla 1999:59).

Lack of accessibility, confidentiality and privacy with regard to adolescent contraceptive services have been cited as reasons for inadequate use of these services by adolescents (Jagananen 1999:75; Richter 2000:76). The authors maintain that adolescents are more likely to seek the necessary care if the environment is youth-friendly. Adolescents are not strong enough to resist peer pressure. Adolescent girls have reportedly engaged in sex, even though they were not ready, because they feared to be ridiculed and sometimes ostracised by other girls. Williams and Mavundla (1999:59) found that girls were intimidated, called nuns and told by other girls that they will become sick and crazy if they did not engage in sexual intercourse. As a result, these girls yielded to having sex and ended up being pregnant, implying that they failed to use contraceptives.

Poor contraceptive seeking behaviours of adolescents have been reported to be due to some health care providers' refusal to give adolescents contraceptives. Kunene (1995:49) reported that some health workers refused adolescents contraceptives fearing that this could encourage premarital sexual relationship. Adolescents in Wood et al (1998:26) reported that nurses would not give them condoms before asking about their sexual relations and lecturing to them on being too young to have sex.

#### **2.8.1.2 Level of education**

Level of education has been cited by researchers as having an influence on contraceptive utilisation. Women who lack education have fewer chances of being employed. As a result, they end up staying at home aimlessly with no other sources of information. Willis and Fullerton (1991:345) argue that women with lower levels of education, lack the knowledge for self-care and consequently lack knowledge regarding contraceptives. An educated woman may be more capable of avoiding the severe consequences of unintended

pregnancy and the risks of complications if an abortion is induced. An uneducated woman may have difficulty in understanding her own body and the consequences of an unplanned pregnancy and its health risks.

In the RSA, nearly 2½ million women over the age of 20 years have had no schooling (Census 1996:6). This then means that these women were indirectly affected as they could not read or even understand the pictorial messages of contraception on any bill boards. According to DOH (1999:15), the RSA has shown that fertility levels will only decrease significantly when 70% of the country's women become literate.

The United National Population Fund (UNPF) has expressed concern over the education backlog among women in Africa and Asia. It has been established that seven years of education, especially for girls, is the critical threshold for a decrease in the total fertility rate (TFR). In Brazil, women with no education have an average of 6,5 children, whilst those with secondary school training have only 2,5 children (UNPF 1998:10).

Women's education level affects their status, indirectly influences their use of contraception and the control which they have over sexual and reproductive matters. Young people have been found to lack knowledge about reproductive functions and consequently, lack knowledge about contraceptives (Ehlers et al 2000:48). Mayekiso and Twaise (1992:23) stated that many parents believed that it was sufficient to discuss menstruation and self-care following menarche with their daughters. They attributed the lack of parent/adolescent communication regarding sexual matters to the refusal of many parents to acknowledge that their daughters have sexual feelings and sexual desires.

### **2.8.1.3 Partner support**

Partner support is a significant variable influencing effective contraceptive practices. Lack of communication between husbands and wives or partners on sexual matters, the high value which men place on large families as signs of virility and the view that many children mean prosperity, have been cited by Bodibe (1994:104) and Dreyer et al (1997:60) as reasons for the failure of effective contraceptive practices. Men often use these as reasons for not supporting contraceptive use. Women end up hiding their contraceptives and even discontinuing their use if discovered, because of dependency and timidity in relation to their husbands. Hatcher et al (1997:7-5) recommend the use of injections as they are private and no one can tell whether a woman is using this method of contraception.

Maforah, Wood and Jewkes (1997:80) found that in some instances, women's partners disapproved of contraceptives and consequently they were unwilling to use them. This was an indication of a disempowerment of women within many sexual relationships. In communities where contraceptives are not socially accepted, women who use contraceptives can face difficult consequences. Some women may fear disapproval or retribution. Violence from their husbands, disdain from relatives and friends or ridicule in the community were reported in Mali and Bangladesh by women who were first in their village to use contraceptives (Waliullah in Caldwell et al 1999:34).

Involvement of male partners in contraception has been described by Nelson (1997:50) as a means of improving the emotional side of a sexual relationship. Open communication between women and men regarding contraception may actually contribute to effective use of contraceptives.

The importance of male participation and responsibility has become much greater with the emergence of the HIV/AIDS pandemic and the increasing prevalence of STDs where the use of the condom has become the only effective strategy for protection other than abstinence. The couple must therefore support, assist and remind each other in using either male or female condoms at each sexual intercourse.

Wood and Jewkes (2000:22) allege that teenagers were evidently too disempowered within their sexual relationships to request or enforce condom use, despite general awareness that disease could spoil their reproductive organs and cause infertility if not treated early. In the same study, one teenager described how her partner had refused to use condoms saying that 'plastic' made him sweat and she hadn't challenged him because she feared that he would beat her.

Women need the support of their partners also in the termination of pregnancies, as they go through traumatic experiences during and after CTOP. Maja (2000:18) found that women needed support from their partners, particularly those who regretted having terminated their pregnancies and women whose partners insisted that they should terminate their pregnancies. Without such support, women felt betrayed and experienced intense emotional pain. Shostak and McLouth (in Myburgh, Gmeiner & Van Wyk 2001:39) believe that men also have emotions such as anger with themselves and for their partners for being in situations of having to terminate a pregnancy; they may be afraid or feel guilty acknowledging that termination of pregnancy is murder and that they are accomplices. The authors maintain that men see their detachment as resulting in ill effects for the woman and for the couple's relationship. They should, therefore, be informed and involved when termination of pregnancy is contemplated and throughout the procedure, to assist the woman to adjust to the termination process.

Men might not be equipped with sufficient information and knowledge about sexual and reproductive health. They are often marginalised by these health services which do not have provision for males. The WHO (1998b:9) urge that males should be empowered through the provision of information and services targeting boys, youth and adults within the home, communities and work settings. Male involvement should be mainstreamed in all major thrusts of the strategic framework.

#### **2.8.1.4 Parity**

The variable of parity seems to have a bearing on contraceptive use. Multiparous women tend to neglect contraception even though they may still engage in sexual practices with their partners. Bongaarts and Bruce (1995:58) found that substantial numbers of women did not use contraceptives after reaching their desired family size. Women who participated in this study gave the following reasons for not using contraceptives: travel costs and time, payments to service providers, and more importantly, woman's fears of adverse health effects and disapproval of their husbands and other family members.

On the other hand, women without children, and with no intention of falling pregnant, ignored using contraceptives with the belief that they would never fall pregnant (Bankole, Singh & Haas 1998:118). Parents have been found to be influential in this aspect. They argue that prior to having families, young adults should not use contraceptives as these may have detrimental effects on their reproductive system – often becoming barren. Ehlers et al (2000:48) found that out of 111 adolescent mothers, 77% did not use contraceptives because they feared future reproductive problems and that they might never have children should they use contraceptives during adolescence.

### **2.8.1.5 Cultural beliefs, values and norms**

Culture consists of the shared products of a human group including values, language, knowledge and material objects. Dreyer et al (1997:61) maintain that negative restrictive laws, traditions and attitudes of certain cultural groups play a major role in contraceptive practices. In most African cultures, Northern Sotho, Tswana, Zulu, Venda and Tsonga, women need permission from their husbands to use contraceptives. If a man disapproves, because culturally women are expected to bear as many children as possible, then the woman has no choice but to accede to such beliefs. Vlok (2000:349) affirms that in a society geared to believe that to reproduce is a woman's ultimate destiny in life, the urge in a woman to have a baby or prove her fertility becomes even stronger.

Many clients are ambivalent about contraception because of culturally inculcated taboos against anything unnatural with regard to procreation – a function considered a sacred duty. According to DOH (1999:16) cultural beliefs about reproductive physiology, such as menstrual blood is bad blood which the body must get rid of, can lead to unfounded concerns about the effects of contraceptives. Other beliefs are that amenorrhoea is caused by Depo Provera leading to rejection of effective modern methods of contraception. Amenorrhea can be explained as a common side-effect of Depo Provera which may be considered normal especially after the first year of use. Campbell (1997:186) found that negative attitudes toward condom use were often based on cultural factors such as the desire for children and female sexual compliance as ways for financial gain from their partners.

### **2.8.1.6 Attitudes towards contraceptives**

The greatest influence on society's fertility rate results from individual and social attitudes towards contraceptive use. According to Popenoe

et al (1998:401), demographers have identified three general categories of means by which fertility may be controlled. These include factors that constrain sexual intercourse, such as the socially acceptable age of marriage, norms of premarital sexual behaviour and the value placed on chastity. In the second category are factors that limit conception, artificial birth control methods and ideals regarding family size. The last category consists of factors affecting the actual birth and survival of infants, such as abortion and infanticides.

For most of human history, societies have struggled to overcome both high death rates and under-population. Most traditional societies encouraged the highest practical command of 'be fruitful and multiply' which was widely reflected in social norms. Although a high national fertility rate is no longer desirable, attitudes and norms in most countries have not completely shifted to encourage fewer births. How to change these social attitudes, has become one of the most difficult problems facing developing countries. Most people in the developed world consider a two-child family as an ideal, and the average age of marriage has been steadily rising, reducing the number of married women of childbearing age (Popenoe et al 1998:401).

Side-effects and disadvantages of various contraceptives seem to contribute to negative attitudes of individuals towards effective contraceptive use. Wood and Jewkes (2000:13-15) found that teenagers stopped using injections and pills because they had not menstruated for months while using contraceptives. They perceived and interpreted this phenomenon in terms of blood having "accumulated" or clotted, usually in the womb or abdomen, head and feet which explained why the blood would not come out easily. Remaining in such a blocked state was perceived to cause other symptoms, including a large or painful abdomen, swollen body, headaches (if blood was seen to be blocked in the head region), tiredness, 'sores on the body', weight gain and skin changes.

Knowledge of side effects and disadvantages of contraceptives, including their management could reduce fears and negative attitudes of clients towards contraceptive use. Health care providers can play a significant role in their approach to dealing with side effects. Their positive attitude, empathic listening and nonjudgemental service to all clients could have positive implications with regard to contraceptive practices.

#### **2.8.1.7 *Ethnicity and religion***

Attitudes towards contraceptive practices, may be influenced by ethnic and religious ideologies. Ethnic groups refer to groups of people who speak the same language or have the same religion (Popenoe et al 1998:205). Some Christian denominations are against birth control as they maintain that it goes against God's word, that people shall multiply and be many. In the past, Christian churches generally adhered to the belief that procreation is one of the primary goals of marriage and were therefore opposed to contraceptive use. Other religions have lacked sharply defined doctrines concerning fertility control, or have shown support for contraception. In Thailand, for instance, Buddhists encourage and respect the autonomy of women, and therefore believe that they are entitled to make their own decisions regarding contraceptive use (Popenoe et al 1998:412).

Islam, with its strong patriarchal history, considers contraceptive use as a sin, encourages large families and regards the combined role of wife and mother as being a woman's primary role in life. Traditional Muslim values may be changing as Egypt and Pakistan, two Muslim countries with serious population problems, have embarked on successful national family planning programmes (Popenoe et al 1998:412)

According to Wood and Jewkes (2000:11), adolescent followers of the Zionist Christian Church (ZCC) in the RSA failed to use contraceptives as they did not want to defy the teachings of their church. Maforah et al (1997:82) agree with the statement when stating that women who became pregnant were forced to terminate their pregnancies in order to comply with the dictates of their churches.

Williams and Mavundla (1999:59) found that parents were in a dilemma between upholding the traditional and cultural values with religious beliefs at the expense of their daughters. Some parents were reportedly unhappy that their daughters may be taught sensitive sexual matters by people who do not have the same home values.

### **2.8.2 Situational factors**

The following factors have been identified by researchers as having an effect on contraceptive practices:

- Health care providers
- Accessibility to health services
- Organisation of contraceptive services
- Counseling and confidentiality

#### **2.8.2.1 *Health care providers***

Health care providers may contribute positively or negatively to patients'/clients' utilisation of health services. Patients/clients regard the overall quality of care, including the manner in which they are treated, as being the most important aspect of contraceptive service provision.

- Most patients/clients seeking contraceptives fear the use of various contraceptive methods. It is imperative, therefore, that health care

providers should be well-trained and fully knowledgeable by updating their knowledge with the latest developments in contraceptive services. Good interpersonal relations with clients should also be paramount in imparting information to clients. These dimensions may strongly influence clients' confidence in their choices and ability, satisfaction with services, the probability of a return visit, the consistence and continuation of the contraceptive method.

Research indicates that most health care services are not attuned to the services of adolescents (Jagananen 1999:78; Heunis, Van Rensburg & Ngwena 2000:54; Wood et al 1998:26). Adolescents have also reported feeling uncomfortable to express their feelings and health care needs in the presence of older persons. Their most important concerns when seeking contraception from public clinics were the attitudes of nursing staff towards them. Research conducted in the Northern Province, RSA by Wood et al (1998:26), revealed that adolescents were harassed by nurses who were rude, short tempered and arrogant. Similarly, nurses acknowledged that the effects of their comments were usually to make a teenager shy and "look down" silently and added that at times they would prevent contraceptive seeking. However, the nurses perceived that giving moral guidance to teenagers and discouraging sexual activity formed part of their roles.

Similar concerns were shared by the reproductive health task force, which revealed the lack of health education regarding contraception by health care providers. According to Mbananga (1999:42), nurses perceived that less value was attached to health information by their seniors, whom they felt were only interested in the number of contraceptives issued, rather than combining performance indicators and health promotion indicators. Klugman (1993:45) reported in a study among nurses in the Northern Province, that health care providers were not fully informed about contraception. Specific areas

that were deficient were emergency contraception, treatment of rape victims and STD treatment (Klugman 1993:45).

In contrast, Craig and Richter-Strydom (in Kunene 1995:49) believe that African teenagers were neither informed about nor educated in reproductive health matters within their family contexts because of a breakdown in traditional family lifestyles. They stated that traditional mores and structures such as rituals of initiation into adulthood existed as systems of sexuality education in many cultures. Many of these practices have disappeared in modern societies, leaving nothing in their place to educate adolescents about sexuality.

#### **2.8.2.2 Accessibility to health services**

Access to services for all clients remains critical. Even with sufficient knowledge of the means to avoid pregnancy, women may still experience unwanted pregnancies if appropriate and effective methods of contraception are not readily available to them, at the time they are needed.

WHO (1996:25) points out that despite the advances in contraceptive technology, large numbers of people and couples have only limited, if any, access to reliable methods of contraception. The WHO further believes that even when contraceptive methods are accessible and individuals wish to space or limit births, contraceptive services are often under-utilised owing to factors such as the gap between access to, and use of the services.

Distance from home to the clinic would also affect utilisation especially if clients live in remote areas where facilities such as buses and taxis are nonexistent or expensive. Clients would therefore be required to walk long distances to seek contraceptive services which would be another deterrent factor, leading to discontinuation of the method. With regards to adolescents, factors

such as intimidation by staff, resulted in under-utilisation of the clinic by clients (Little 1997:44; Wood et al 1998:26). Adults, on the other side, felt it not necessary to utilise health services for contraception, as they felt it is time-consuming, costly and not necessary as they have the number of children they wanted.

#### **2.8.2.3 Organisation of contraceptive services**

The organisation of health services seems to be another significant factor influencing the utilisation of these services positively or negatively.

Since 1991, the integration of vertical contraceptive services into PHC has been continuing. Integrated PHC services became widespread, especially in rural areas of the RSA, but many single-purpose clinics for contraceptive services remain in urban centres. In some clinics there is complete integration within the same health care centre delivering all services at all times. In other clinics there are special days for different services, or all services are provided every day by different health care providers.

Inequity in access to effective contraceptive services exists particularly in previously disadvantaged areas, as well as in many high density urban and peri-urban areas and informal settlements (UNPF 1998:49). Rigid and relatively short clinic hours for client consultations (generally from Monday to Friday from 08:00 till 13:00 or 16:00), reduce service availability and can contribute to many hours of waiting. Working women and school going children cannot attend during these times and cannot wait for hours. According to DOH (2000:10), the availability of contraception is further reduced at clinics in which contraceptive services have not been fully integrated into PHC services.

The ethnic and cultural appropriateness of care, including the language spoken during the care contact, are critical factors that facilitate or inhibit utilisation of contraceptive services. This is a particular problem where staff from different cultural backgrounds provide care, often without knowledge of the individual's cultural practices which may possibly influence her response to advice given. Leininger (1995:9) suggests that health care providers should take into account a woman's cultural orientation thus enabling both the client and the health care provider to benefit from the care provided.

WHO (1996:26) emphasises that adequate and appropriate equipment and supplies must be maintained and held in stock so that contraceptives can be offered when needed. Failure of services to provide clients with methods of choice or continual contraception because of lack of stock, may hamper the utilisation of such health services by clients.

#### ***2.8.2.4 Counseling and confidentiality***

Counseling provides an opportunity for the client and health care providers to share knowledge, perceptions and practices about contraceptive practices.

All health care providers should be fully trained to counsel clients presenting for contraceptives, using the necessary counseling techniques such as informing, clarifying, focusing, listening, validating and also affording clients the opportunity to express their views regarding any aspect of their health. All clients presenting for contraceptives should be afforded counseling regarding contraception to ensure that they are fully informed about their chosen methods. This could encourage the correct and consistent use of methods.

The following suggestions are recommended for effective counseling by DOH (2000:18):

Health care providers should

- be empathetic, respectful and nonjudgemental towards clients, regardless of their age, sex, race, religion, culture, disability or social status
- listen to each client's needs and establish open interactive communication
- use appropriate language and information, education and communication materials
- provide impartial information on the available contraceptive method mix
- assist the client to choose an appropriate contraceptive method(s), which suits his/her personal circumstances, is medically safe and takes into account the possibility of exposure to STI's/HIV
- provide complete information on the chosen method, including how to use it, resupply or removal requirements, common side effects and how to deal with them, warning signs of complications and emergency follow-up procedures

Bruce (1990:64-66) and DOH (2000:19) refer to specific contraceptive information that should be emphasised in order to allow clients voluntary choice of a contraceptive method. Such information should at least include:

- understanding of the relative efficacy of the method
- the risks and benefits of the method
- signs and symptoms which would necessitate a return to the clinic
- information on return to fertility after discontinuing method use and information on STDs

The health care delivery system must therefore be structured to allow confidentiality, with mechanisms for appointment scheduling, billing, record keeping and follow-up.

Privacy and respect should be afforded to all clients, including adolescents. Lack of confidentiality has been identified as a significant barrier to health care, including contraceptive service. The majority of adolescents have concerns they wish to keep confidential and have reported that they would not seek health services, because of confidentiality of concerns (Jagananen 1999:75; Proimos 1997:326). Commonly requested specific changes to services are that staff should be more understanding, and more available for explanation and counseling; clinics to have longer working hours, greater accessibility, reduced waiting times and more privacy; and that contraceptive services should be provided with other services at one clinic. The provision of adolescent-friendly services is a common request by clients (Bodibe 1994:66; Ehlers et al 2000:51; Heunis et al 2000:58).

### **2.8.3 Socio-economic factors**

Poor socio-economic development is associated with low contraceptive use. DOH (1999:14) refers to the legacy of inequitable development of people in the RSA during the apartheid years as being accountable for low socio-economic status of specific groups, mainly blacks. Differences in socio-economic development continue to differ for different ethnic groups, amongst provinces and between urban and rural populations. These have further impacts on fertility rates influenced by contraceptive use (DOH 1999:14).

According to DOH (1999:14), factors such as schooling or literacy level determine the status of women and their level of empowerment subsequently influences both contraceptive use and the control

which they have over sexual and reproductive matters. Low literacy level, which predominantly affects women, imply that most women cannot read or write, and may therefore not even be aware of the need to use contraception, the benefits and the implications of not using contraceptives.

Financial implications such as payment for transport and self-care may hamper unemployed women without support, particularly adolescents, to travel to health services for contraceptive supplies. Studies on adolescent reproductive health and adolescent pregnancies attest to this notion (Ehlers et al 2000:51; Kunene 1995:52; Richter 2000:21).

## **2.9 DESIRABILITY OF USING CONTRACEPTIVES EFFECTIVELY RATHER THAN USING TERMINATION OF PREGNANCY SERVICES FOR CONTRACEPTIVE PURPOSES**

### **2.9.1 Introduction**

Population control is a key element in a country's ability to maintain and improve its economic and social welfare. In most countries including the RSA, governments have established policies or legislation to reduce population growth. These include contraceptive services and programmes, as well as improving women's general education and economic opportunities.

Contraception saves lives, as compared to CTOP which risks lives. Contraception has positive implications which do not only benefit the individual but also his/her family. Communities and countries could benefit if men and women of all reproductive ages could utilise contraceptive services effectively, correctly and consistently. Benefits of contraception have been discussed in this thesis in chapter 2. Various contraceptive methods, legislation and policies regarding contraception have also been discussed in subsections of chapter 2 of this report. Throughout the report, emphasis was laid regarding effective and consistent contraceptive practices in order to

prevent unwanted pregnancies and related complications. In this section, the paradox of using TOP rather than contraceptives will be presented.

### **2.9.2 Costs of contraceptives**

Effective contraceptive practices could reduce unnecessary costs incurred in terminating pregnancies. An analysis of the contraceptive costs conducted in the USA revealed that 24% of USA women using a reversible method of contraception received contraceptive services in publicly funded family planning clinics or with Medicaid reimbursement. Assuming a shift in less-effective contraceptive practices, about 1,3 million additional unplanned pregnancies would occur per year in the absence of these services. These pregnancies would cost approximately \$1,2 billion in public funds for pregnancy care and abortions, compared with only \$412 million spent for family planning services (Forrest & Samara 1996:188). This then implies that publicly funded contraceptive services resulted in substantial savings to the USA. A similar scenario exists in the RSA. According to DOH (2000:2), the costs of contraceptives is far less than the costs involved in human suffering resulting from TOPS.

The contraceptive cost of avoiding a pregnancy remains small relative to the cost of having and rearing a child. Pritchett (1994:21-23) estimated the monetary cost of avoiding a single birth through the use of various forms of contraception. These costs depended on the cost per couple per year and the number of years of use needed to avert a birth. She stated that a fair guess of the cost range for the pill, which is a relatively expensive temporary method typically chosen to space rather than limit births would be US\$30-100 per birth avoided. For ending reproduction, sterilisation is a much cheaper option as it avoids all future births. Its cost per year of protection is low, ranging from US\$2,9-12,25 – a very high estimate

of the typical total direct contraceptive cost per birth avoided for a sterilised woman would be US\$50.

In addition to direct monetary expenditures, occasioned by an additional child, there are substantial opportunity costs incurred due to the time allocated to child care, which may be as high as the direct costs. Joshi (in Pritchett 1994:30) points out that evidence from the rural USA, in the early twentieth century, suggests that women spent 10 hours per week caring for young children. This could become an added strain if the child was unplanned or unwanted.

Women aged between 15 to 39 years in a Javanese village, spent 8,9 hours weekly on child care plus another 17,2 hours on household tasks, food preparation, and 10 hours on other household maintenance aspects, with more hours spent on larger families. In a Nepalese village, women aged between 15 to 39 years, spent an estimated 8,9 hours, 15,4 hours and 6,7 hours on the same activities (Pritchett 1994:30).

Gertler and Molyneax (in Pritchett 1994:28) used the Indonesian household survey data on fertility, combined with district and subdistrict level data on economic conditions, schooling and family planning programme efforts to explain the large (25%) decline in the TFR from 1982 to 1987. They found that, as an approximate determinant, increased contraceptive use explains 75% of the fertility decline.

### **2.9.3 Adolescent pregnancy**

Another point that has added benefits to using contraceptives refers to aversion of adolescent pregnancy. A significant number of adolescents become sexually active at an early age worldwide, implying that they need to protect themselves against unwanted pregnancies. According to DOH (1999:5), the 1998 South Africa and

Health Survey showed that 35% of adolescents were pregnant before the age of 20. Adolescent pregnancies result in health, social and economic implications for the mothers and their offspring including their families or extended families (Ehlers et al 2000:53; Fathalla 1994:109).

These could be averted by effective and consistent use of contraceptives as indicated by research conducted in the USA, claiming that the levels of contraceptive use in the USA averted an estimated 1,65 million pregnancies among the 15 to 19 year olds during 1995. If these women had been denied access to both prescription and over the counter contraceptives, 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 & Glei 1999:29).

Adolescent mothers experience higher morbidity and mortality during pregnancy and labour than adult women. The increased health problems include anaemia, STDs and AIDS, prolonged labour due to cephalo-pelvic disproportion and hypertensive disorders during pregnancy and labour.

A survey conducted among 128 adolescent mothers in the RSA, younger than 16 years of age, reported significant complications with regard to pregnancy induced hypertension, premature labour and anaemia (Goldberg & Craig 1983:863-864). Adolescents reportedly required more mechanical extractions during delivery than older women. In addition they also received significantly poorer antenatal care in Guadeloupe (Gallais, Robeillard, Nuisser, Cuirassier & Janky 1996:523-527).

Poorer neonatal outcomes of adolescent mothers' babies include prematurity, respiratory distress syndrome, congenital abnormalities

and feeding problems (Ehlers et al 2000:44; Mogotlane 1993:11). According to Boult and Cunningham (1993:1), adolescent mothers' children are more likely to suffer from malnutrition, be early school leavers, suffer financial hardships and end up as street children and prostitutes at an early age. A statistically significant association between age and low birth weight babies was established in Port Elizabeth area of the RSA (Boult & Cunningham 1993:1). Research reports from other parts of the world seem to support this correlation as reflected by the following studies:

- A high incidence of low birth weight infants and pre-term deliveries have been reported in Turkey among adolescent mothers (Bozkaya, Mocan, Usluca, Beser & Gumistekin 1996:146-150).
- In Minneapolis, a study conducted by Hallerstedt, Pirie and Alexander (1995:1139-1142) amongst 46 985 infants born to adolescent mothers aged 11 to 19, indicated that these neonates and infants were at greater risks for deaths due to accidents, infections and sudden infant death syndrome compared to infants born to mothers older than 19 years of age.

Research conducted in Ethiopia revealed that adolescent mothers' babies had a higher incidence of prematurity and low birth weight, and also exhibited lower measurement regarding other anthropometric parameters including length and head circumference. Furthermore, these babies had lower apgar scores reported at one and five minutes after birth than those born to nonadolescent mothers (Ali & Lulseged 1997:350-42).

Adolescent mothers frequently have to discontinue their education, causing difficulties in finding jobs leading to lifelong poverty. The only jobs available to unqualified or unskilled adolescent mothers are likely to offer salaries too low to provide for the baby's needs. These problems can be compounded by the necessity of combining

childcare responsibilities with full time jobs. Financial hardships can aggravate the mother's problems in coping with anxiety and social adjustment (Jones & Mondt 1994:152-159).

Sociocultural problems of adolescent mothers include that they might be forced to leave their parents' homes struggling to live alone with many responsibilities and few resources. Adolescent mothers in many societies still experience moral stigmas with consequences such as possible nonacceptance by men with markedly reduced prospects of marriage (Miller 1992:353; Sawchuk, Burke & Benady 1997:259-266). The adolescent mothers may face rejection by peer groups aggravating loneliness, and religious groups subjecting them to punitive measures, including being banned from attending church services or using holy sacraments.

In the RSA, HIV/AIDS has affected the youth more directly than adults. Antenatal clinic attendance statistics for the period 1995 to 1999 indicate the highest prevalence of HIV amongst women aged 20 to 24 years (Williams, Gouws, Colvin, Sitas, Ramjee & Karim 2000:305). If these adolescents were using condoms for prevention of unwanted pregnancies, they would have at the same time protected themselves against HIV infection.

According to the DOH (1999:71), it has been estimated that one million patients seek treatment for STDs every year at private practices, at local authority health clinics, and including those seen at outpatient departments and primary care clinics in the RSA. STDs affect both women and men although women suffer most because of the ascending infection which may lead to pelvic inflammatory disease, permanent infertility and the risk of ectopic pregnancy. Adolescents have been reported to comprise 65% of clients treated for STDs (Fathalla 1993:248; Diale & Roos 2000:137). If these clients were using barrier methods such as condoms and

diaphragms for preventing unwanted pregnancies, they would have protected themselves against STDs as well.

Williams and Mavundla (1999:59) refer to socioeconomic and psychological problems experienced by adolescent fathers and mothers. They believed that adolescent fathers are mostly unemployed, lack accommodation and have poor health resulting from early fatherhood. Adolescent pregnancy and early parenthood have added problems for mothers of these adolescents. Mothers caring for their daughters' young children in the RSA experienced their parenting roles as having added stressors, doing their daughters' duties, having life changes and lack of support systems in terms of lack of financial, material and health care support (Modungwa, Poggenpoel & Gmeiner 2000:62).

As indicated, adolescent problems continue to plague individuals, families, communities and all involved in health care delivery. A number of adolescents who use contraceptives effectively and consistently could begin to address these problems by preventing unplanned and unwanted pregnancies.

#### **2.9.4 Adolescents and termination of pregnancies**

Consistently high rates of adolescent pregnancies continue to cause public concern in many parts of the world, including the RSA. The majority of these teenage pregnancies are terminated either by illegal or legalised procedures.

According to the WHO (1998a:6), close to 17 million girls under the age of 20 years give birth each year. Most of these pregnancies are unplanned and it is estimated that as many as 4,4 million abortions are sought by adolescent girls each year.

The issue of induced abortion in most sub-Saharan countries has been highly controversial as the heated discussions of the International Conference on Population and Development in Cairo in 1994 clearly reflected. The issue became even more controversial when it concerns adolescent girls, who are not expected to be sexually active, though it has been repeatedly documented that they do indeed engage in sexual activities (Silberschmidt & Rasch 2001:1816; Visser 2000:18). Their early sexual activity is generally attributed to fundamental socio-economic change, the erosion of moral codes, familial control and abandoned rituals such as initiation ceremonies which serve to prepare adolescents for their roles and responsibilities as adults (Silberschmidt & Rasch 2001:1816).

Illegal abortions often result in complications which may have negative implications such as infertility and death. According to the WHO (1998a:8), of the 5 million unsafe abortions performed annually in Africa, these abortions constitute 13% of all maternal deaths. A study of four public hospitals in Dar es Salaam showed that about a third of women admitted with complications from illegal abortions were teenagers, 41.3% of whom were aged 17 years or younger (Mpangile, Leshabari & Kihwele 1993:21).

Among women hospitalised in Muhimbili gynaecological wards due to abortion-related complications, 54% were teenagers and illegally induced abortions contributed to 15% of maternal deaths in that district of Tanzania. One third of these abortions occurred among adolescent girls (Urassa, Massawe, Lindmark & Nystrom 1996:442).

Similar findings were reported in hospital-based studies from other sub-Saharan countries although the data on the extent of induced abortions in sub-Saharan Africa are unreliable. Community-based surveys tend to produce gross underestimates, and underreporting constitutes a major problem (Silberschmidt & Rasch 2001:1816). As a result of these unknown statistics, many aspects of adolescent

girls' sexual behaviour, and why they have induced abortion, are still underexplored. In the RSA, since the termination of pregnancy was legalised in 1996, the majority of adolescent girls reporting for CTOPs, had reportedly started the procedure with backstreet abortionists, claiming that they could not afford to wait for the long list before they could be attended to (Maja 2000:21).

### **2.9.5 Backstreet abortions**

Apart from human costs in terms of mortality, morbidity and suffering, unwanted pregnancies can place a burden on health resources of countries when women seek TOPs as solutions to their unplanned and/or unwanted pregnancies. According to Varkey and Fohn (2000:8), R18,7 million is spent annually to treat infections and complications associated with illegal TOPs in the RSA.

Deaths related to unsafe TOPs are estimated at 700 per 100 000 TOPs in Latin America; 400 deaths per 100 000 TOPs in Asia and 600 deaths per 100 000 TOPs in Africa. In contrast, the aggregate mortality rate from complications of legal TOPs in 13 countries for which accurate data was available, has been reportedly 0,6 deaths per 100 000 TOPs. The mortality rate in legal TOPs was low because in these countries TOP is performed largely by skilled providers using appropriate equipment under aseptic conditions (WHO 1992:5).

In the RSA, backstreet abortions have been reported to be increasing and are a concern to health care providers with almost 50% of the gynaecological and obstetrics caseload of public hospitals resulting from unsafe TOPs (Bateman 2000a:11). Backstreet abortionists operate in a clandestine manner, and in most cases without the necessary equipment or under unsterile conditions. Cornelissen (2000:11) warns that the spread of HIV may escalate because of the methods used by these unscrupulous operators. Similar findings

were reported by Maforah et al (1997:81) who found that self-induced methods such as laxatives, enemas, disprins, herbs, aloe balsam, dettol and super rose lotions were used as per prescriptions from either traditional healers or abortionists. Maja (2000:10) found that women who were desperate to terminate their pregnancies took strong mixtures of javel, quinine, and concoctions of mixed herbs as they were awaiting their dates for TOPs at specific health care centres. These health risks could be averted if women and men were using contraceptives effectively.

Fees charged by abortionists ranged from R350 to R1000 and in spite of their poor socioeconomic conditions, most women were willing to pay for such services (Cornelissen 2000:11; Maforah et al 1997:81). Abortionists were reportedly using a drug prescribed for ulcers, which they obtained at less than R2,00 each, gave the patient four tablets, charged each R350 for the consultation and sent them home to abort the foetus under absolutely no professional supervision (Cornelissen 2000:11). Health care professionals are therefore urged to take strides in informing and educating the community about the added danger of illegal TOPs, the use of contraceptives consistently and effectively and utilisation of designated TOP services.

Various studies concluded that between 30% and 50% of women presenting for CTOP were not using contraception at the time of their conception, and that similar proportions of pregnancies are unplanned (Bongaarts 1997:273; Fathalla 1994:245). A study investigating women's knowledge about emergency contraception, found that almost 50% of their respondents experienced unplanned pregnancies due to their lack of knowledge about emergency contraceptives. The majority of these women felt they would have used emergency contraception had they known about it (Crosier 1996:87). The widespread use of emergency contraception could

prevent 1,7 million unintended pregnancies and 0,8 million TOPs each year (Glasier & Baird 1998:1).

### **2.9.6 Legalised termination of pregnancy**

In the RSA, the restrictive Abortion and Sterilisation Act No 2 of 1975, provided TOPs under very strict conditions. The result of this law was that the majority of women who did not meet the criteria, could not be granted legal TOPs. As a result, these women, ranging between 200 000 and 300 000 resorted to illegal and often dangerous TOPs each year (Klugman 1993:44; WHO 1995:10).

In February 1997, the Choice on Termination of Pregnancy Act No 92 of 1996 was enacted. As with any legislation regarding issues of CTOP, there were strong debates both for and against the changes in the legislation. Even though there were, and still are various views regarding CTOP, these are facts about CTOP which make it a community health problem that needs to be recognised:

- Abortions performed illegally under unsafe conditions are a major cause of mortality and morbidity among women.
- The need for induced CTOP and for women to control their reproductive health is a dominant reality.
- When hygienically and correctly induced, the procedure is safe and women need not die or suffer from the consequences of unsafe CTOP, mortality and morbidity due to TOP are preventable (RRA 1999:2; De Pinho 1998:8).

TOP should not be used as a contraceptive method, but as a last resort which should be procured at designated facilities. In the RSA, by 2000, 289 hospitals and clinics were designated for termination of pregnancy, although according to Bateman (2000a:11), only 59 actually had staff trained for this service.

Since the enactment of the Choice on Termination of Pregnancy Act No 92 of 1996, the total number of legal abortions performed over the past three years were reported to be 150 000 to 155 624 across the RSA. DOH (2000:6), reported that between 2 500 and 3 000 CTOPs are procured per month and the concern is that the high demand for abortion could over-burden some facilities charged with this service. According to DOH (2000:6) these figures relate only to abortions done at state hospitals and clinics, excluding those done at private facilities such as Marie Stopes and other private services. In the Gauteng Province, 69 442 CTOPs were reported and adolescents accounted for more than half this figure (DOH 2000:6). Estimates were that backstreet abortions could have equalled or even exceeded this figure, bringing the total to over 300 000 (Bateman 2000a:11).

Various conclusions could be drawn from these statistics that

- women were making informed choices about their reproductive health
- there's a lack of education about reproduction and contraception where both males and females need to be fully informed about the utilisation of contraceptives to avoid unwanted pregnancies

Termination of pregnancy has social and psychological implications which could have long-term consequences to the woman, her partner and health care providers involved with CTOP clients. Reported psychosocial experiences include regret, anger, depression, ambivalence, shame and hatred towards parents and partners (Hustedfeldt, Hansen, Lynbers, Noddebo & Peterson 1995:214; Maforah et al 1997:80; Maja 2000:8-10; Suffla 1997:214).

Butlet (1996:39), a gynaecologist in the USA, reported case histories of women who suffered late psychological sequelae after CTOP. Some of these included severe depression, guilt-feelings, blame and regret which affected women's daily lives. Health care providers

involved with CTOP have been reportedly branded as "murderers" and "serial killers" by colleagues and community members (Maja 2000:23; Poggenpoel et al 1998:4; RSA TV Special Assignment Programme, 2 October 2001 at 21:30).

In KwaZulu-Natal, doctors in a community hospital indicated that they would not treat CTOP patients, even in hospitals' emergency departments (Cape Argus 03.04.1998). Gynaecologists who perform abortions in Edmonton and Vancouver were reported to be anxious and feared for their safety after threats and the killing of their colleague in his office, accused of being a "baby-killer" (Hunter 1998:1). The importance of effective and consistent use of contraceptives by both men and women, cannot be overemphasised. With the expanding contraceptive technology, involvement of governments and non-governmental organisations in the fight against unwanted pregnancies, it remains the responsibilities of men and women to face this challenge positively.

## **2.10 CONCLUSION**

Chapter 2 presented a synopsis of literature consulted regarding contraceptive practices. Historical perspectives, traditional and modern contraceptive practices were discussed including factors that could influence the use or nonuse of contraceptives.

Perspectives from countries such as China, Vietnam, Netherlands, Bangladesh and Cuba were discussed in terms of contraceptive practices of their respective clients (women and men). From these discussions, it became apparent that each country had its unique features regarding contraceptive practices which could be considered to promote the use of contraceptives effectively and consistently in Northern Tshwane and throughout the RSA. Significant characteristics of these are that China and Vietnam have strict one or two child(ren) policies which have become norms in these countries;

the Netherlands have effective contraceptive services which resulted in low TOP rates. Bangladesh, although overpopulated, achieved success with its Matlab project and community-based distribution (CBD) programme of contraceptives. Cuba's health care system, which guarantees accessibility, provides an ideal model to other countries.

Finally, the paradox of using TOPs rather than contraceptives was discussed, highlighting aspects such as costs, adolescent pregnancies, illegal and legalised TOPs. *"If contraceptives could be used consistently and effectively by all women and men within the reproductive ages to prevent unplanned and unwanted pregnancies, then it would not even be necessary to have abortion laws in statutory books,"* according to Mhlanga (in Bateman 2000b:750).

## CHAPTER 3

### Research methodology

#### 3.1 INTRODUCTION

This chapter outlines the research methodology, the research designs, namely quantitative and qualitative research, the target population from which the sample was drawn including the specific selection criteria. The nature and development of research instruments are explained, ethical considerations, data-collection methods and data analysis of both designs presented.

#### 3.2 OBJECTIVES

The purpose of the study was to

- identify contraceptive practices in China, Vietnam, the Netherlands, Bangladesh, Cuba and other countries to provide guidelines to be adopted in Northern Tshwane to achieve similar results
- explore the knowledge, perceptions and contraceptive practices of clients presenting for contraceptives and CTOP services
- describe how clients presenting for contraception and CTOP use contraceptives
- determine the contraceptive methods used by clients presenting for contraceptives

- determine factors influencing the use and non-use of contraceptives
- assess clients' knowledge, perceptions and utilisation of CTOP services
- describe nurses' knowledge, perceptions and their interventions when presented with CTOP clients
- determine the health care needs of women and men presenting for contraceptives and CTOP with regard to what a quality service of this nature should offer in order to improve the services on the basis of their inputs
- describe barriers experienced in offering adequate contraceptive services to clients, and how these could be addressed

### **3.3 RESEARCH DESIGN**

Burns and Grove (2001:242) refer to the research design as a blueprint for the conduct of a study that maximises the control over factors that could interfere with the desired outcomes from studies. The design of a study is the end result of a series of decisions made by the researcher about how the study will be implemented. Elements central to the study design are the presence or absence of a treatment, number of groups in the sample, number and timing of measurements to be performed, sampling method, the time frame for data-collection, planned comparisons and control of extraneous variables.

#### **3.3.1 *Descriptive design***

With the descriptive design, the researcher plans either to assemble new information about an unstudied phenomenon or to gain more information about characteristics within a particular field of study, for the purpose of providing the picture of the situation as it naturally happens (Burns & Grove 2001:268). A descriptive design will be

used in this study to describe the current situation as it prevails in contraceptive practices.

### **3.4 PHASE 1: QUANTITATIVE RESEARCH**

Quantitative research is defined by Cresswell (1994:2) as an enquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalisations of the theory hold true. Burns and Grove (2001:28) define quantitative research as a formal, objective, systematic process in which numerical data are utilised to obtain information about the phenomena. This research method is used to describe variables and determine the interactions between variables. The quantitative approach was used in the study to obtain more information about variables in contraceptive practices and examine their relationships to identify and suggest improved contraceptive practices which could reduce the large numbers of unwanted pregnancies in Northern Tshwane.

A quantitative research approach was deemed suitable for examining contraceptive practices and identifying male and female adults' and male and female adolescents' knowledge, perceptions and practices about contraceptives.

#### **3.4.1 Target population**

The target population for the study comprised clients presenting for contraceptives at the three selected health care centres (see section 1.6.2.1). These health care centres provide contraceptives to more than 50 clients daily, yielding a total of more than 150 clients daily from the three health care centers combined.

### **3.4.1.1 Criteria for inclusion in the population**

According to Polit and Hungler (1999:278), it is important when identifying a population to be specific about the criteria for inclusion in the population. These criteria are referred to as eligibility criteria. In this study, the eligibility criteria were as follows:

- respondents could be females or males
- they had to fall within an age range of 12 to 49 years
- participation had to be voluntary
- informed consent had to be provided for participating in the study
- they had to be consulting in Northern Tshwane health care centres for contraceptives

### **3.4.2 Sample**

A representative sample of clients who came for contraceptives at the three health care centres in Northern Tshwane had to be selected. Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Hungler 1999:279.) By selecting a representative sample, the researcher was able to obtain a reasonably accurate understanding of the aspects being investigated in the study, without having to gather information from the entire population. It is of the utmost importance to ensure the representativeness of a selected sample, in other words, to ensure that the sample will be as similar as possible in its characteristics to that of the population from which it is selected.

#### **3.4.2.1 Selection of the required sample**

Before selecting the sample, the researcher visited the three health care centres to determine the pattern of clients' visits and consultations to the health services. As it was not possible to predetermine which clients would be coming even though they might

have had appointments, a convenience sample was deemed the ideal sampling method to use. Convenience sampling, also known as accidental sampling, refers to the selection of the most readily available persons or units as subjects in the study (Polit & Hungler 1999:281). In convenience sampling, only those members available have a chance of being selected. This can have implications for the data which might contain biases (Burns & Grove 2001:324). The researcher and research assistants ensured that the sample comprised only respondents who met the sampling criteria.

Another advantage of using a convenience sample was to get males who visited health care centres for contraceptives, mainly condoms. This would not have been possible with other sampling methods as there are no census records for condom users.

A convenience sample of 85 women and 75 men presenting for contraceptives at the selected health services was selected. Out of 160 completed structured interviews, 154 (96,25%) were usable. Refer to table 3.1 for the distribution of respondents from the health care centres.

**Table 3.1: Distribution of respondents from health care centres**

HEALTH CARE CENTRES	FEMALES		MALES		TOTAL
	ADULTS	ADOLESCENTS	ADULTS	ADOLESCENTS	
Rosslyn Clinic	30	12	24	8	74
Odi Hospital	14	8	14	8	44
Ga-Rankuwa Hospital	16	3	10	7	36
<b>TOTAL</b>	<b>60</b>	<b>23</b>	<b>48</b>	<b>23</b>	<b>154</b>

Reasons for selecting the three health care centres were that they are the main state health care centres in Northern Tshwane catering for people from all socio-economic strata; clients coming from urban, rural and informal settlements in Northern Tshwane consult at these health care centres; and they were accessible to the researcher. The majority of 80 females and males were selected from Rosslyn clinic on the assumption that clients from different groups, that is, the rainbow nation would be represented. However, that did not happen as intended as only clients from one racial group (blacks) could be seen during the data-collection phase of this research.

### **3.4.3 Research instruments**

Certain important dimensions were considered by the researcher in developing the required data-collection instruments. Polit and Hungler (1999:212) refer to structure, quantifiability and objectivity as three of the important dimensions to be kept in mind when a researcher develops a data-collection instrument. As the researcher would be collecting the same basic information from all respondents, the instruments had to be structured, whilst at the same time allowing a certain degree of flexibility by giving respondents ample opportunity to add personal comments, where applicable. The collected data would be subjected to statistical analysis and therefore had to be collected in such a way that it could be quantified. In addition, the researcher remained as objective as possible in the collection of data required for this study.

Two separate research instruments were developed by the researcher for collecting data from the two categories of the target population. The first category included the females, both adults and adolescents, whilst the second category referred to adult and adolescent males. For the purposes of discussion, the two

structured interview schedules will be referred to as the female and male structured interview schedule respectively.

#### ***3.4.3.1 Design of the structured interview schedules***

The researcher developed each of the instruments once relevant information collected from literature sources had been considered. Items relevant to the research questions as stated, and in line with the objectives of this study, were drafted, categorised and outlined in the research instruments. A covering letter was attached on the front pages of all research instruments. The objectives of the study were stated clearly, and clear guidelines were given in both instances to assist respondents with the completion of the relevant research instruments.

Respondents were assured that all information collected would be treated confidentially and that no respondent would be identified by any name in the research report. Assurance was also given that the various health care centres would not be identified by name in the discussion of the responses to the various questions.

#### ***3.3.3.2 Content of the structured interview schedules***

Questions included in a structured interview schedule can either be open- or closed-ended. Open-ended questions refer to questions which allow respondents to respond to questions in their own words, whilst closed-ended questions are questions in which the response alternatives are designated by the researcher (Polit & Hungler 1999:214).

#### ***3.4.3.3 Female structured interview schedule***

This structured interview schedule comprised of two sections with 54 questions or items and 59 variables. Section 1 consisted of 12 items

requesting biographical information about respondents' ages, marital status, residential, educational, socioeconomic and cultural backgrounds. This information was considered essential to provide a descriptive profile of the respondents which could influence their contraceptive practices.

Section 2 consisted of 25 open-ended questions and 30 closed questions. Information about contraceptive knowledge, perceptions and practices of modern and traditional methods was required in order to determine which contraceptive methods were frequently used and the rationale for using or failing to use contraceptives.

Data regarding clients' sources of contraceptive information, their preferences of specific contraceptives and the reasons for such preferences formed part of section 2 of the research instrument. This information was particularly important to the researcher to determine how and where clients obtained information regarding contraceptives, whether such information could influence their contraceptive practices and finally, whether preferences of specific contraceptive methods were considered or not.

Information regarding knowledge, perceptions and use of emergency contraception, including legalised termination of pregnancy, was required to establish clients' utilisation of these services and whether such knowledge could impact on their use of contraceptives.

#### ***3.4.3.4 Male structured interview schedule***

The male research instrument comprised of two sections with 52 questions and 55 variables. Section 1 consisted of 12 questions requesting biographical information, similar to the female questionnaire. Similarly, this information could have an influence on clients' contraceptive practices.

Section 2, comprising 40 questions, was constructed similar to the female structured interview schedule, although there were differences with regard to contraceptive methods and practices.

Specific features of the male structured interview schedule was that it had more open-ended questions with regard to condom use. Various perceptions and uses of condoms included:

- availability of condoms
- frequency of condom use
- reasons for condom use and nonuse
- reasons for not getting condoms
- distance from home to places where clients get their condoms
- staff attitudes when requesting condoms
- problems and side-effects of condoms

All the questions which were included in the two research instruments were considered to be significant in relation to the objectives of this study. A copy the female and male structured interview schedules are included as annexure 3 and annexure 4, respectively.

#### ***3.4.3.5 Pretesting of the research instruments***

After the two research instruments were developed, they were submitted to colleagues of the researcher at the research capacity building project at the Technikon Northern Gauteng for comments. This was done to establish whether the structured interview schedules were clearly worded and would be correctly interpreted by the respondents.

Questionnaires were then submitted to 10 females and 10 males who presented for contraceptives at one of the health care centres in Northern Tshwane. These respondents were not included in the

actual research project. On completion of the questionnaires, the researcher held discussions with respondents to verify whether they had understood the instructions and questions in the questionnaire. Problems of understanding the contraceptive terms used were identified and the questionnaires were translated into Tswana, the language spoken by most people in Northern Tshwane.

### **3.4.4 Validity and reliability of the research instruments**

To ensure the quality of a data-collection instrument, it is important to establish its validity and reliability. Validity refers to the degree to which a test or instrument measures what it purports to measure. According to Woods and Catanzaro (1998:251), a valid instrument should truly reflect the concept it was intended to measure. Reliability of an instrument is the degree of consistency with which the instrument measures an attribute. Polit and Hungler (1999:255) refer to the dependent relationship between the reliability and validity of an instrument, and state that a "measuring device that is not reliable cannot possibly be valid". The reliability of the research instruments was ensured by administering research instruments to colleagues of the researcher. Other experts in Reproductive Health from the Department of Health and the Medical Research Council assessed the structured interview schedules and suggested inputs which were considered.

The content and face validity of the instruments used for this study were confirmed by the extensive literature study review, as well as by the pretesting and subsequent comments received from the experts referred to in section 3.4.4. Content validity of an instrument is based on judgement, and in this regard use was made of experts in the field of study (Polit & Hungler 1999:255). Both research instruments were pretested and problems identified were corrected. Problems identified during pretesting of the instrument were related to the medical and contraceptive terms used in the questionnaires.

Although the questionnaires were translated into Setswana, the dominant language spoken by clients in Northern Tshwane, most clients had difficulty in understanding contraceptive concepts even in Setswana. Even literate clients had to be assisted. To respond to this problem, the researcher, assisted by trained research assistants, conducted interviews using the questionnaires as structured interview schedules. The advantages were that the researcher and research assistants had face to face interactions with clients with the result that most questions were answered although the process became lengthy and costly.

In measuring the validity of the instruments used in this study, the researcher was aware of the fact that validity, like reliability, is not an all-or-nothing phenomenon, but rather a matter of degree, as an instrument cannot really be said to possess or lack validity (Polit & Hungler 1999:260).

### **3.4.5 Ethical considerations**

#### ***3.4.5.1 Covering letters, anonymity and confidentiality***

The structured interview schedules which were for completion by female and male clients at the selected health care centres in Northern Tshwane, were taken to the respective units by the researcher and research assistants on days of data-collection. In all instances prior permission to do so, as described further in this report, was obtained from the person in charge at each health centre. An explanatory covering letter, a copy of which is included as annexure 5, accompanied the research tools. The importance of participation in the project was emphasised. All respondents would be protected from public disclosure and that the utmost confidentiality would be honoured at all times. No health care centre or nursing staff would be identified by name in the research report.

Approval to conduct this study was sought from and granted by the relevant authorities. Although the researcher was granted permission by the relevant authorities to conduct the study, participation by respondents remained a voluntary process. The researcher respected the principle of self-determination which means that respondents have the right to decide voluntarily whether or not to participate in the research (Polit & Hungler 1999:412).

### **3.4.6 *Selection of training assistants***

Three registered nurses were recruited to participate as research assistants for data-collection. These registered nurses were given a one day training course prior the commencement of the study. The following aspects were addressed as part of their training:

- the study, its purpose and importance
- their approach to clients who seek contraceptive services
- obtaining informed consent from clients
- using verbal and nonverbal communication skills and techniques
- their approach to the hospital and clinic staff
- management of crises, such as clients becoming too emotional and sudden withdrawals during interviews
- how to use and refer to the interview schedule, how to ask questions, how to rephrase questions if not understood and how to indicate responses on the questionnaire

After training, these research assistants were introduced to the three health care centres included in the study to ensure prolonged engagement (Lincoln & Guba 1985:303). The three health care centres were then used for data-collection from clients meeting the sampling criteria presenting for contraceptive services. These research assistants were only engaged in data-collection from clients in phase 1.

### **3.4.7 Data-collection**

Data was collected on predetermined dates and times (during June and July 2001) at the selected health care centres. As the three health care centres were all accessible to the researcher and research assistants, it was possible for the researcher to assist, where necessary. In most instances, the researcher and research assistants had to ask respondents the questions as they appeared on the research instrument and fill in the answers, as respondents had difficulty in understanding the contraceptive concepts used.

### **3.4.8 Data analysis**

The data which the researcher collected by means of structured interview schedules (females and males) was encoded, whereafter the data capture was computerised using the SPSS by the Medical Research Council (MRC) statistical analysts. The results from the female and male research instruments were analysed separately using descriptive and inferential analyses in meaningful ways. Logistic Regression Analysis (LRA) was used to ascertain relationships among variables. These results will be presented in chapter 4 of this thesis.

## **3.5 PHASE 2: QUALITATIVE RESEARCH**

The researcher opted to combine quantitative and qualitative methods to expand the scope of the study. As Sandelowski (2000:247) proposes, different aspects of reality lend themselves to different methods of inquiry.

Cresswell (1994:1) defines a qualitative study as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words reporting detailed views

of informants, and conducted in a natural setting. Qualitative research is also descriptive, and is an excellent way of obtaining information and exploring a particular phenomenon. A qualitative research design was chosen to obtain information from nurses involved with clients presenting for contraceptives. This was deemed to be a holistic research approach, which allowed the researcher to gain a full view of the phenomenon under study.

### **3.5.1 Target population**

The target population comprised all nurses who provide contraceptive and CTOP services at the health care centres included in the study. Criteria for inclusion in the population were:

- respondents could be females or males
- respondents had to be working in units providing contraceptive services to clients in Northern Tshwane
- respondents had to have a relevant working experience of at least two years in the specified services in order to be acquainted with and be knowledgeable about contraceptive services
- participation was voluntary

### **3.5.2 Sample**

As there were only a few nurses involved with contraceptive and CTOP services at the three selected health care centres, all were recruited to participate in the study. A total number of 12 nurses volunteered to participate, but nine managed to attend and three could not attend because of work commitments.

### **3.5.3 Research instrument**

An interview guide was designed for data-collection from nurses who participated in the focus group interview. The research instrument

was developed in accordance with relevant information collected from the literature review. Questions relevant to the objectives of the study relating to nurses were drafted. In addition, after data-collection from clients in phase 1 of this study, the main focus areas were identified and also included in the focus group interview.

Four main questions with subquestions were designed. The following questions were asked:

**(1)     *Which modern contraceptives do you supply to clients seeking contraceptives?***

- What information do you give to clients regarding the use of modern contraceptives?
- Which barriers do you experience regarding modern contraceptives?

**(2)     *Which traditional contraceptives are used by clients coming to your health care centre?***

- How effective are these contraceptive methods?
- What guidance do you give to clients using traditional contraceptives?
- What barriers do you experience with clients regarding traditional contraceptives

**(3)     *Which emergency contraceptives do you supply to clients at your health care centres?***

- What are your perceptions regarding the use of emergency contraceptives?
- What guidance do you give to clients regarding the use of emergency contraceptives?

- Do you think any person who needs emergency contraceptives needs contraceptives?

**(4) *Can clients obtain CTOP services at your health care centres?***

- What information do you give to clients regarding CTOP?
- What are your perceptions of clients who choose to terminate a pregnancy?
- Under what conditions do you advise clients to seek CTOP?
- What barriers do you experience when dealing with CTOP clients?
- What is the policy regarding the supply of contraceptives to adolescents at your health care centres?

**3.5.4 Focus group interview**

In this phase, a focus group interview was used for data-collection from nurses providing contraceptive services at the selected health care centres. A focus group interview is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (Krueger 1994:6). Focus group interviews encourage group members to influence each other by responding to ideas and comments in a comfortable discussion, just as they would in real life. In this study, the aim of using a focus group interview was to encourage, and stimulate, participants to share their ideas, knowledge and perceptions on their clients' contraceptive practices in a conducive manner.

Holloway and Wheeler (1996:44) describe focus groups as involving a number of people with common experiences or characteristics who are interviewed by a researcher for the purpose of eliciting ideas,

thoughts and perceptions about a specific topic or certain issues, linked to an area of interest. Participants selected should have been exposed to contraceptive services to share their perceptions and ideas on this phenomenon under study. The purpose of the focus group was to obtain relevant information of a qualitative nature, from a predetermined and limited number of nurses. The researcher discovered the knowledge of the participants and their perceptions about contraceptive services provided to clients in a qualitative manner. The discussion was in a focused manner to study the phenomena in detail in order to discover all aspects pertaining to contraceptive practices. The aim was, however, to understand and interpret the meanings and interactions that underlie everyday human interactions within the actual context of rendering contraceptive services to clients. The researcher explored and stimulated ideas based on shared perception of subjects within the social world of providing contraceptives services (Holloway & Wheeler 1996:145). This method can be used jointly with a quantitative approach when in-depth information is needed, as in this study.

### **3.5.5 Data-collection**

A focus group interview was conducted at one family planning unit of a health care centre included in this study. A facilitator, who has a doctorate in nursing, and is skilled in conducting focus group interviews, facilitated the focus group, while the researcher took field notes and observed the respondents' interaction. Consideration was given to the room arrangement and the participants were seated in such a way that everyone was comfortable and visible. Opening remarks were made to introduce the topic and reassure participants. The facilitator set the norms of the group with the participants and these included no use of cellular phones, giving each other a chance to speak, active and objective participation by all and how to address each other. By so doing, a nonthreatening interactive environment

was created. The facilitator then asked questions listed in section 3.4.3 and probed intensively to ensure that in-depth data was collected. Other communication techniques included reflecting, paraphrasing, focusing, validating and using silence to make sure that no issues had been overlooked, omitted or left unattended until a point of saturation was reached. The researcher and facilitator recognised the repetition of issues with no additional information, which resulted in a point of saturation. At the end participants were thanked for their active participation during the focus group interview.

The interview was tape-recorded and later transcribed verbatim (Burns & Grove 2001:305). Initially, 12 nurses volunteered to participate, but three could not attend because of work commitments. The researcher then gave the three nurses naïve sketch questions to obtain their personal opinions regarding their clients' contraceptive practices, and their experiences with these clients. Cresswell (1994:159) refers to naïve 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 naïve sketches were similar to those posed for the focus group interview. The researcher collected the naïve sketches after completion by the nurses and the data was then transcribed with data collected from the focus group interview.

### **3.5.6 Measures to ensure trustworthiness**

The research instrument for the focus group interviews was tested for its validity and reliability, using Guba's model (Krefting 1991:215). This model is based on the identification of four aspects of trustworthiness that are relevant to qualitative research, namely truth-value, applicability, consistency and neutrality (Krefting 1991:215). Operational techniques to ensure trustworthiness are credibility (internal validity), transferability (external validity), dependability

(reliability) and confirmability (objectivity). (The words in brackets represent the quantitative approach's terminology).

### **3.5.6.1 Credibility**

According to Lincoln and Guba (1985:301), credibility refers to the truth value obtained from the discovery of human experience as it is lived and perceived by informants. Credibility includes activities that make it more likely that credible findings and interpretations will be produced. These activities include prolonged engagement, persistent observation, triangulation, peer debriefing and member checking.

#### **◆ Prolonged engagement**

In this study, the researcher made time to be with the nurses at the selected health care centres several times to establish rapport, demonstrate that their confidence would not be betrayed and their interests would be respected.

#### **◆ Persistent observation**

Lincoln and Guba (1985:304) maintain that persistent observation provides depth to inquiry. The researcher constantly engaged in tentative labelling of what were considered salient factors and crucial atypical events, and then explored them in detail as the interviewer directed the focus group interview. Rephrasing of questions, repetition or expansion of questions on different occasions increased the credibility of the data collected.

- ◆ **Triangulation**

Woods and Catanzaro (1998:453) define triangulation as a method of increasing credibility and research precision by measuring the same quality with multiple techniques. Denzin (in Woods and Catanzaro 1998:453) suggests three modes of triangulation that are useful in naturalistic inductive studies, multiple and different sources, methods and investigators. Multiple sources include different sources for the same information, such as more than one informant providing the same information or verification of responses from one source with another.

The researcher engaged an expert in interviewing and qualitative research to conduct the focus group interview. The researcher assisted by listening, observing and writing field notes on the behaviour, changing moods and gestures of participants as well as relevant ideas. For contextual validation, a tape recorder was used with the permission of the participants. An expert in interviewing and in qualitative research participated in coding qualitative data.

Mixed method research is a dynamic option for expanding the scope and improving the analytic power of studies (Sandelowski 2000:246). The researcher used a combination of methods to expand the scope of contraceptive practices by using different data-collection methods as well as obtaining views from nurses involved with these clients.

- ◆ **Member checks**

Lincoln and Guba (1985:314) maintain that member checking is the most crucial technique to establish credibility. In this study, the tape-recorded interview was played back to the focus group

participants for their comments immediately after the interview. This helped to assess what the participants intended and meant and also gave them the opportunity to correct errors and confirm individual points.

◆ **Structural coherence**

It was assumed that there were no unexplained inconsistencies between the data and the interpretations. Where data may be in conflict, credibility will be increased by interpreting and explaining the apparent contradictions.

◆ **Authority of the researcher**

The researcher participated in a number of research methodology workshops and other research activities. This study was supervised by experts in reproductive health and qualitative research. The interviewer is an expert in qualitative research, was trained in group dynamics and is interested in conceptual and theoretical knowledge.

### **3.5.6.2 *Transferability***

The researcher provided a description of the background information about informants, the research context and setting, to allow others to assess how transferable the findings will be. Lincoln and Guba (1985:316) see transferability as involving transferring research findings to another similar context or setting and still preserving the meaning, interpretations and inferences from the completed research.

### **3.5.6.3 Dependability**

Dependability was established by using triangulation (see section 3.4.6.1). Lincoln and Guba (1985:316) argue that there cannot be credibility without dependability. They also propose an inquiry audit as one of the measures for dependability. This audit inquiry will examine the process of enquiry, data-collection, findings, interpretations and recommendations and attest that it is supported by data and is internally coherent. An expert interviewer, knowledgeable in the subject and who has the ability to use interviewing techniques effectively, facilitated the focus group interviews.

### **3.5.6.4 Confirmability**

Guba's (1990:316) audit trail was used as follows:

- Raw data was recorded on tape and field notes were written by the researcher during the focus group interview. Data was reduced to coding and the product was analysed.
- Data was reconstructed and synthesized, including the structure of categories, themes, definitions and relationships, findings and conclusions, interpretations and inferences and the final report.
- The researcher and the independent coder reached consensus on categories.
- Process notes, including the methodological notes (rationale, procedure, design and strategies), trustworthiness, notes relating to credibility, dependability and confirmability. Lincoln & Guba (1985:321) urge that the research audit should, from the beginning of the study, prescribe the nature of the audit trail as well as other helpful details, to make sure that the research study

is acceptable, minimising many deficiencies that might not be repaired.

- The researcher aimed to ensure that reliability and validity, including trustworthiness, were maintained as described throughout the study. Table 3.1 presents the application of the model for trustworthiness.

**Table 3.1: Measures for ensuring trustworthiness**

STRATEGY	CRITERIA	APPLICABILITY
• Credibility	• Prolonged engagement	The researcher visited nurses at selected clinical settings several times prior to data-collection to become acquainted with the milieu and establish rapport with the nurses.
	• Reflexibility	Taking field notes.
	• Member checking	Follow-up interviews were done with nurses. Literature control regarding contraception and TOP was done.
	• Triangulation	Focus group interview and field notes were used as data-collection methods.
	• Structural coherence	The focus was clinical nurses involved with clients presenting for contraceptives and CTOP.
	• Authority of researcher	The researcher has attended a number of research methodology workshops and participated in other research activities and the research was supervised by experts in reproductive health and qualitative research.

STRATEGY	CRITERIA	APPLICABILITY
• Transferability	• Sample	A purposive sampling method was used.
	• Dense description	A comprehensive description of the design, methodology and literature control was given.
• Dependability	• Audit trail	Full description of research methodology was provided.
	• Dense description	Peer checking by colleagues and supervision by experts.
	• Peer evaluation Keeping personal records	Independent checking by colleague/devil's advocate and supervision by experts.
	• Peer evaluation • Code-recode procedure	Consensus discussion between the researcher and independent coder.
• Confirmability	• Audit trail	Keeping personal records and logs.
	• Reflexive analysis	Audit by the researcher.

### 3.5.7 Qualitative data analysis

Data analysis in qualitative research actually starts when data-collection begins. The process requires the full commitment of the researcher to understand the actual meaning of the data. Streubert and Carpenter (1999:24) describe data analysis as a process that requires the researcher to commit fully to understand what the data says. It also requires a significant degree of dedication to reading, intuiting, analysing, synthesising and reporting what is discovered.

The actual process of data analysis usually takes the form of clustering similar data. Themes are structural meaning units of data

that help the researcher to cluster information and discover the meaning intended in what is observed and heard during the focus group interview. Data needs to be re-examined for accuracy and completeness.

Data from the focus group interview was analysed using Tesch's model (Cresswell 1994:154-155), based on a qualitative approach. The eight steps suggested by Tesch were considered for data analysis. Immediately after the interview, the researcher took the following steps:

- (1) Got a sense of the whole by listening to the tapes, transcribing, reading through the transcriptions carefully and jotting down some ideas as they came to mind.
- (2) After the researcher had completed this task for several respondents, a list of all topics was made. Similar topics were clustered together and formed into columns that could be arranged as major topics, unique topics and leftovers.
- (3) The researcher then took the list and returned to the data. The topics were abbreviated as codes and these codes were written next to the appropriate segments of the text. The researcher tried out the preliminary organising scheme to see if new categories and codes emerged.
- (4) The researcher tried to get the most descriptive wording for the topics and turned them into categories. The researcher attempted to reduce the total list of categories by grouping related topics together. Lines were drawn between the categories to show the interrelationships.

- (5) The researcher and an independent coder decided on the abbreviation for each category to reduce the information into themes or codes.
- (6) The data material belonging to each category was assembled in one place and a preliminary analysis performed.
- (7) The researcher recoded some of the existing data to show the relationships among categories of information.

To increase trustworthiness, an independent coder who is a qualitative data analysis specialist, was engaged in data analysis and coding of the information gathered. The researcher and the independent coder met to discuss the results of data analysis and reach consensus on major categories and subcategories.

The results of the analysed quantitative data from the structured interviews are presented in chapters 4 and 5, while the qualitative data, based on the focus group interview, will be analysed and discussed in chapter 6.

### **3.6 CONCLUSION**

This chapter discussed the research procedure followed and described the design, methodology and conduct of the study. Particular attention was given to the development of and the response to, the three data-collection instruments developed for this study, including the data-collection process.

Chapter 4 covers the data analysis of the quantitative data. Chapter 5 discusses of the analysed results from chapter 4, and chapter 6 presents the qualitative data analysis. Finally chapter 7 conveys the

conclusions reached during this research, indicates to which limitations the research attempts were subjected, and supplies recommendations for enhancing contraceptive services, as well as for conducting future research.

## CHAPTER 4

### Data analysis of quantitative research results

#### 4.1 INTRODUCTION

This chapter discusses the results of the statistical analysis of the quantitative data derived from the completed questionnaires. The data focused mainly on women's and men's contraceptive practices, as well as the contraceptive methods they used, their knowledge and perceptions of contraceptives and their utilisation of contraceptive and TOP services.

Where applicable, comparisons were noted between women and men, but not substantiated as it was not the aim of the study to do gender-specific analyses. Statistical measures were limited to frequency distributions and percentages. These results are discussed in chapter 5 in terms of the overall objectives of the study.

#### 4.2 DATA ANALYSIS FROM FEMALE AND MALE STRUCTURED INTERVIEWS

Data from female and male respondents were analysed and presented in terms of the structured interviews.

*Item 1: Age distribution of respondents*

One of the criteria for inclusion in the study was the reproductive age range from under 16 years up to 50 years. Females and males presenting for contraceptive and CTOP services were considered and categorised as adults and adolescents. Adult ages ranged from 21 years to 40 years and above, while adolescent ages ranged from under 15 years to 20 years

The purpose of this categorisation was to enable the researcher to identify and distinguish contraceptive practices amongst adults and adolescents. The correlation of ages and contraceptive practices are indicated throughout the analysis. Table 4.1 presents an analysis of the age categories of respondents.

**Table 4.1: Age distribution of respondents**

AGE IN YEARS	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
Younger than 15	-	-	-	-	-	-	-	-
16-20	-	23 (27,7%)	23	27,7	-	23 (32,4%)	23	32,4
21-30	39 (47,0%)	-	39	74,4	19 (26,8)	-	19	56,2
31-40	14 (16,9%)	-	14	16,9	20 (28,2)	-	20	87,3
Over 40	7 (8,4%)	-	7	8,4	9 (12,2)	-	9	12,7
<b>TOTAL</b>	<b>60</b>	<b>23</b>	<b>83</b>	<b>100,0</b>	<b>48</b>	<b>23</b>	<b>71</b>	<b>100,0</b>

#### ***Item 2: Marital status of respondents***

Table 4.2 shows an analysis of respondents' marital status. Only 3 (5,1%) female adults were married and 55 (93,2%) were single. None of the female adolescents was married or divorced, implying that all 23 were single. Out of 71 males, 27 (56,3%) adult males were married, 18 (37,5%) were single and

almost all male adolescents were single. No females were cohabiting or divorced as compared to only 3 (4,2%) males who were cohabiting and 1 (1,4%) who was reportedly divorced. Marital status was included in the structured interview schedule as marital partners could influence each other with regard to contraceptive practices.

**Table 4.2: Marital status of respondents**

MARITAL STATUS	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
Married	3 (5,1)	-	3	5,1	27 (56,3)	-	27	38,0
Single	55 (93,2)	23 (100,0)	78	95,1	18 (37,5)	22 (95,7)	40	56,3
Cohabiting	-	-	-	-	2 (4,2)	1 (4,3)	3	4,2
Widowed	1 (1,7)	-	1	1,7	-	-	-	-
Divorced	-	-	-	-	1 (2,1)	-	1	1,4
<b>TOTAL</b>	<b>59</b>	<b>23</b>	<b>82</b>	<b>100,0</b>	<b>48</b>	<b>23</b>	<b>71</b>	<b>100,0</b>

### *Item 3: Residential areas of respondents*

The structured interview schedule distinguished five residential areas where the participants lived as depicted in table 4.3. Out of 153 respondents, 36 (43,9%) females and 33 (47,1%) males reported to be residing in the neighbouring townships of Soshanguve, Mabopane and Ga-Rankuwa. Informal settlements located in these townships were indicated as residences by 22 (26,8%) females and 13 (18,6%) males. Thirteen (18,6%) males compared to 5 (8,3%) females, were from Northern Tshwane. Eleven (13,4%) females and 7 (10,0%) males resided in rural areas not far from the townships indicated and a minority of females 8 (9,8%) and males 4 (5,7%), were from the city. Factors such as

contraceptive services, availability of contraceptives, staff attitudes and accessibility of contraceptive services in the environment where clients reside, could have an effect on clients' contraceptive practices. For instance, if health care services are available and accessible with nonjudgemental staff, clients will more likely utilise such services, while the opposite might discourage clients from using the services and therefore impact negatively on their contraceptive practices.

**Table 4.3: Residential areas of respondents**

RESIDENTIAL AREA	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
City	6 (10,0%)	2 (9,1%)	8	9,8	4 (8,5%)	-	4	5,7
Suburbs	5 (8,3%)	-	5	8,3	11 (23,4%)	2 (8,7%)	13	18,6
Rural	5 (8,3%)	6 (27,3%)	11	13,4	3 (6,4%)	4 (17,4%)	7	10,0
Informal	17 (28,3%)	5 (22,7%)	22	26,8	5 (10,6%)	8 (34,8%)	13	18,6
Township	27 (45,0%)	9 (40,9%)	36	43,9	24 (51,1%)	9 (39,2%)	33	47,1
<b>TOTAL ...</b>	<b>60</b>	<b>22</b>	<b>82</b>	<b>100,0</b>	<b>47</b>	<b>23</b>	<b>70</b>	<b>100,0</b>

**Items 4 to 6: Level of education of respondents**

Out of 60 adult females, 31 (51,7%) had passed Grade 12, 26 (43,3%) had lower qualifications than Grade 12 and 3 (5,0%) had no schooling. Fourteen (60,9%) female adolescents had passed Grade 12 while 9 (39,1%) had qualifications lower than Grade 12, which meant that all had some schooling. Of the adult males, 37 (52,1%) had passed Grade 12 and 11 (22,9%) had schooling up to Grade 11 and none had no schooling. Of the 23 (100,0%) male adolescents, 13 (56,5%) had passed Grade 12, 10 (43,5%) Grade 12 and none

had no schooling. The analysis of educational status indicated that most of the respondents did have schooling, which is an aspect that could positively influence their knowledge, perceptions and contraceptive use.

In addition, in item 4.5, 44 (56,4%) females and 32 (46,4%) males stated that they either had a tertiary qualification or were registered students at tertiary education institutions. Item 4.6 required respondents to indicate the qualification and the institution where they had obtained it. Respondents mentioned various qualifications and programmes, including:

- Diploma in Educational Management
- B Cur Nursing
- Diploma in Community Nursing
- BSc (Honours)

#### *Item 7: Home language of respondents*

Home language could indicate the respondents' ethnicity and cultural groups. Although almost all the respondents were from the same Black background, differences in subcultures could influence their contraceptive practices, either positively or negatively. As indicated in table 4.4, of the female respondents, 32 (39,0%) and of the males, 34 (47,8%) were Tswana. Sotho-speaking respondents ranked second with 21 (25,6%) females and 20 (28,2%) males. Other home languages were in the minority ranging from 8 (9,8%) females who spoke Zulu to 1 (1,4%) male who spoke Venda and 2 (1,4%) who spoke Ndebele. These different home languages could be attributed to the fact that the selected health care centres were predominantly in the Batswana and Basotho areas of Northern Tshwane.

**Table 4.4: Home language of respondents**

HOME LANGUAGE	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
Sotho	17 (28,3%)	4 (18,2%)	21	25,6	16 (33,3%)	4 (17,4%)	20	28,2
Tswana	22 (6,7%)	10 (45,5%)	32	39,0	23 (47,9%)	11 (47,8%)	34	47,9
Ndebele	-	3 (5,0%)	3	3,7	1 (2,1%)	-	1	1,4
Venda	1 (4,5%)	1 (4,5%)	2	2,4	-	1 (4,3%)	1	1,4
Tsonga	6 (10,0%)	1 (4,5%)	7	8,5	1 (2,1%)	3 (13,0%)	4	5,6
Xhosa	4 (6,7%)	-	4	4,9	-	-	-	-
Zulu	5 (8,3%)	3 (13,6%)	8	9,8	4 (8,3%)	2 (8,7%)	6	8,5
Swazi	1 (1,7%)	2 (9,1%)	3	3,7	3 (6,3%)	1 (4,3%)	4	5,6
<b>TOTAL . . .</b>	<b>56</b>	<b>24</b>	<b>80</b>	<b>100,0</b>	<b>48</b>	<b>22</b>	<b>70</b>	<b>100,0</b>

**Item 4.8: Religion of respondents**

As depicted in table 4.5, several Christian denominations, Jehovah's Witnesses and Muslims were represented in the sample: 15 (18,5%) females and 12 (17,4%) males were affiliated to the Apostolic and the Catholic Churches, respectively; 11 (13,6%) females and 10 (14,5%) males belonged to the ZCC; 10 (12,3%) females and 8 (11,6%) males were Methodists 2 (2,5%) females and 5 (7,2%) males were Anglicans; 2 (2,5%) females were Jehovah's Witnesses; 2 (2,5%) females belonged to the Apostolic Faith Mission, and 1 (1,4%) female was Muslim. Four (18,2%) males belonged to the Assemblies of God and 3 (13,6%) males were Muslims. As these religions were evenly represented, no religion could be singled out as predominating in contraceptive practices, although some religions have specific doctrines on contraceptive

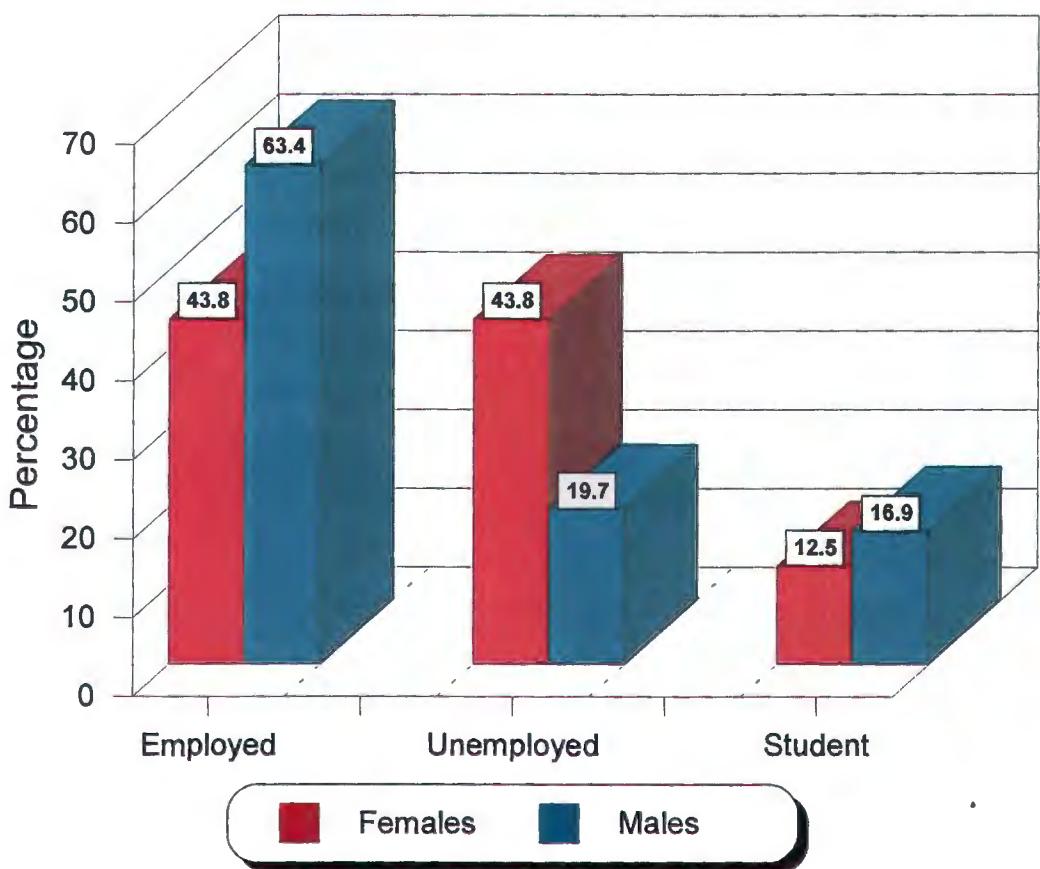
practices.

**Table 4.5: Religion of respondents**

RELIGIOUS AFFILIATION	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
Anglican	2 (3,4%)	-	2	2,5	4 (8,5%)	1 (4,5%)	5	7,2
Catholic	5 (8,5%)	4 (18,2%)	9	11,1	11 (23,4%)	1 (4,5%)	12	17,4
Methodist	9 (15,3%)	1 (4,5%)	10	12,3	5 (10,6%)	3 (13,6%)	8	11,6
Lutheran	6 (10,2%)	3 (13,6%)	9	11,1	5 (10,6%)	4 (18,3%)	9	13,0
Presbyterian	-	-	-	-	1 (2,1%)	-	1	1,4
ZCC	9 (15,3%)	2 (9,1%)	11	13,6	5 (10,6%)	5 (22,7%)	10	14,5
Apostolic	9 (15,3%)	6 (27,3%)	15	18,5	3 (6,4%)	4 (18,2%)	7	10,1
Jehovah's Witnesses	9 (15,3%)	1 (4,5%)	10	12,3	1 (2,1%)	-	1	1,4
Other	-	5 (22,7%)	5	8,5	3 (3,6%)	4 (18,2%)	7	10,1
<b>TOTAL</b>	<b>49</b>	<b>22</b>	<b>71</b>	<b>100,0</b>	<b>38</b>	<b>22</b>	<b>60</b>	<b>100,0</b>

**Item 9: Employment status of respondents**

Figure 4.1 shows an analysis of employment status of respondents. Forty-five (63,4%) males and 35 (43,8%) females were employed. Twenty-five (43,1%) adult females and 10 (45,5%) adolescent females were unemployed while 7 (14,6%) adult males and 7 (30,4%) adolescent males were without jobs. Out of 10 females, 4 (6,9%) were adults and 6 (27,3%) students who probably had no full-time jobs. Of the 12 males, 3 (13,0%) were adults and 9 (39,1%) adolescents.



**Figure 4.1: Employment status of respondents**

Having a job means having an income and being able to improve one's socio-economic status. Although contraceptives are freely available, clients need the financial means to reach health care centres for contraceptive consultation and supplies. In some health care centres, contraceptives may not always be available, or clinics may not be open after 16:00, therefore clients will have to consult private doctors where they pay for such services. Without the money to pay for these contraceptives, clients may end up risking unprotected sex which may result in unwanted pregnancy and undue exposure to HIV infections.

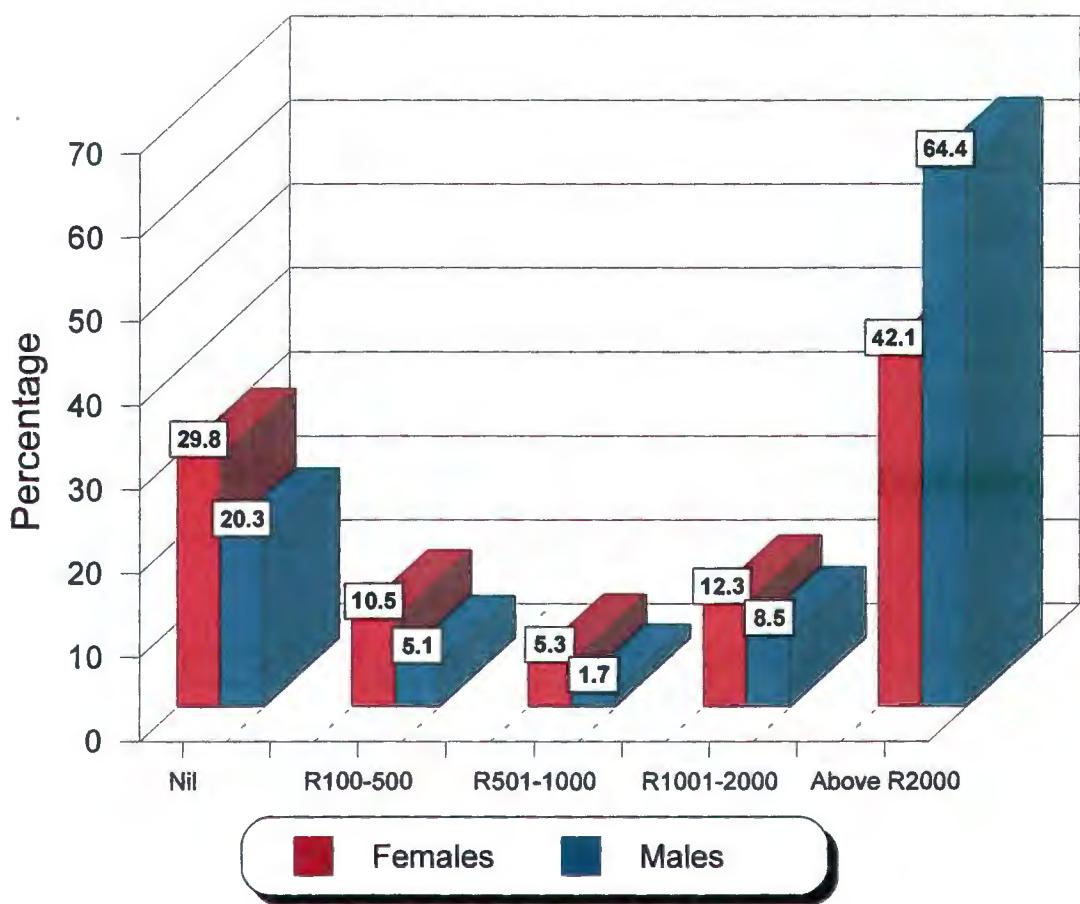
***Item 10: Respondents' personal income per month***

In response to item 10, 24 (42,1%) females and 8 (64,4%) males had incomes exceeding R2 000 per month. A further 7 (12,3%) females and 5 (8,5%) males received incomes ranging from R1 000 to R2 000 and 6 (10,5%) females and 3 (5,1%) males received between R100 and R500 per month.

Out of 17 (29,8) females and 12 (20,3%) males who did not have incomes, 11 (26,2%) were female adults and 6 (13,6%) were male adults. Six (40,0%) female adolescents and 6 (40,0%) male adolescents did not have incomes and were seemingly still at school as shown in figure 4.2. for these statistics.

***Items 11 and 12: Members sharing homes with respondents***

According to table 4.6, 37 (54,4%) females were staying with children while 29 (40,8%) males, 20 (87,0%) of whom were adolescents, stayed with their mothers. Twenty-nine (42,6%) females stayed with their mothers and 12 (17,4%) males stayed with their fathers. Out of the 12 (17,4%) males who stayed with their fathers, 9 (40,9) were adolescents, and only 3 (6,4%) were adults. Nineteen (27,9%) females and 26 (37,7%) males were staying with their partners.



**Figure 4.2: Respondents' personal income per month**

Brothers and sisters were other members who were staying with clients. Information regarding members staying with respondents was included as these members could probably share information regarding contraceptive practices.

The maximum number of people found to be living with clients was eight, and the minimum was five people. These large numbers of persons sharing the respondents' homes could indicate a lack of space which could motivate the respondents to use contraceptives in order to prevent further overcrowding at home.

**Table 4.6: Members sharing homes with respondents**

SHARING HOME	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
Father	15 (31,3%)	11 (61,1%)	26	39,4	3 (6,4)	9 (40,9%)	12	17,4
Mother	17 (35,4%)	12 (60,0%)	29	42,6	9 (19,8%)	20 (87,0%)	29	40,8
Partner	16 (33,3%)	3 (15,0%)	19	27,9	25 (52,1%)	1 (4,8%)	26	37,7
Brothers	11 (22,9%)	9 (45,0%)	20	29,4	6 (12,5%)	10 (45,5%)	16	22,9
Sisters	16 (33,3%)	11 (55,0%)	27	39,7	5 (10,4%)	9 (40,9%)	14	20,0
Children	29 (60,4%)	8 (40,0%)	37	54,4	23 (47,9%)	3 (14,3%)	26	37,7
Other	-	-	-	-	-	-	-	-

The total exceeds 100 as some respondents shared a home with more than one member.

***Item 13: Number of children respondents had***

Table 4.7 shows the number of children for both females and males. Thirty-one (37,8%) females and 27 (38,0%) males had no children, 21 (25,6%) females

and 24 (33,8%) males had one child and 19 (23,2%) females and 11 (15,5%) males had two children. Only 5 (6,1%) females and 7 (9,9%) males had three children. Only one adult female and an adult male had five children and none had six or more children.

Even though most respondents had only two children, no conclusion could be drawn about the ultimate number of children these clients would have as a further majority in both instances were single, and could still have children after marriage. Of particular concern was the number of both female and male adolescents who already had one, two or even three children prior to reaching adulthood. Most of these adolescents would probably get married in due course and could be expected to have more children once married.

**Table 4.7: Number of children respondents had**

CHILDREN	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	f	%	Adults	Adolescents	f	%
None	18 (30,5%)	13 (56,5%)	31	37,8	14 (29,2%)	13 (56,5%)	27	38,0
One	15 (25,4%)	6 (26,1%)	21	25,6	17 (34,4%)	7 (30,4%)	24	33,8
Two	15 (25,4%)	4 (17,4%)	19	23,2	10 (20,8%)	1 (4,3%)	11	15,5
Three	5 (8,5%)	-	5	6,1	5 (10,4%)	2 (8,7%)	7	9,9
Four	4 (6,8%)	-	4	4,9	1 (2,1%)	-	1	1,4
Five	1 (1,7%)	-	1	1,2	1 (2,1%)	-	1	1,4
Six	-	-	-	-	-	-	-	-
More than six	-	-	-	-	-	-	-	-
<b>TOTAL ...</b>	<b>58</b>	<b>23</b>	<b>81</b>	<b>100,0</b>	<b>48</b>	<b>23</b>	<b>71</b>	<b>100,0</b>

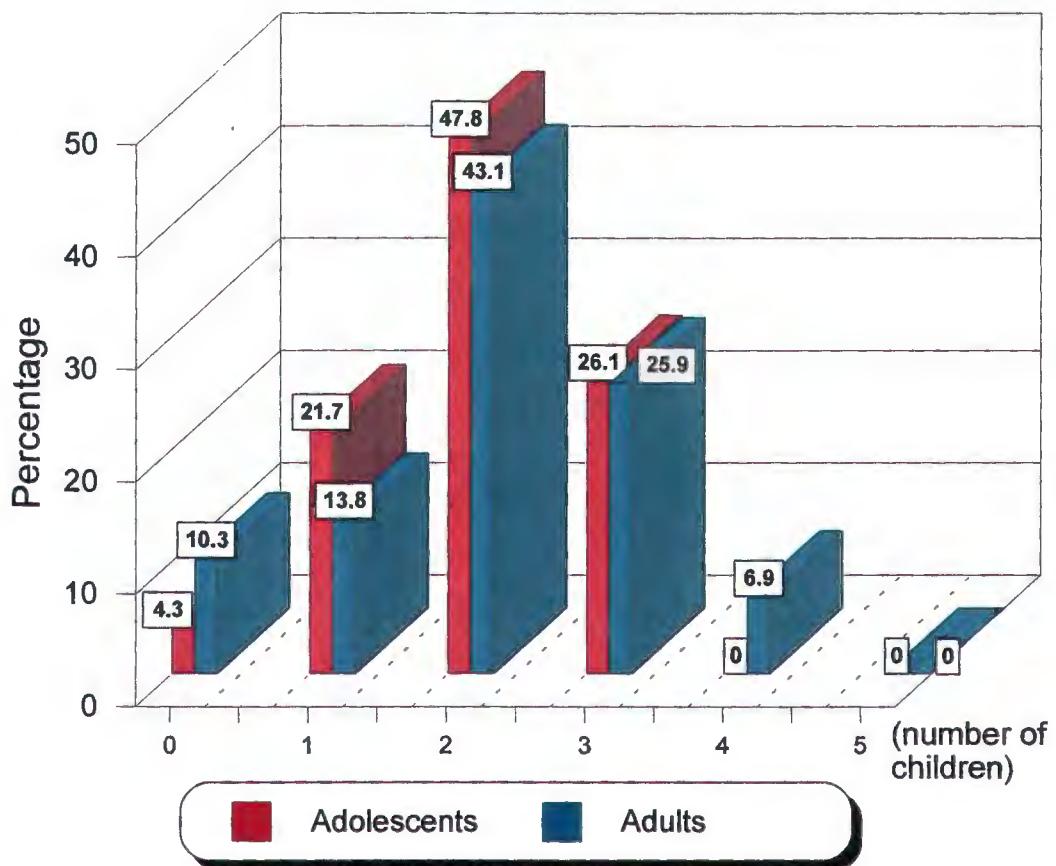
**Item 14: Total number of children respondents wished to have**

Figure 4.3 (a) indicates that 25 (43,1%) adults and 11 (47,8%) adolescents wanted to have only two children and 15 (25,9%) adults and 6 (26,1%) adolescents expressed a wish to have three children.

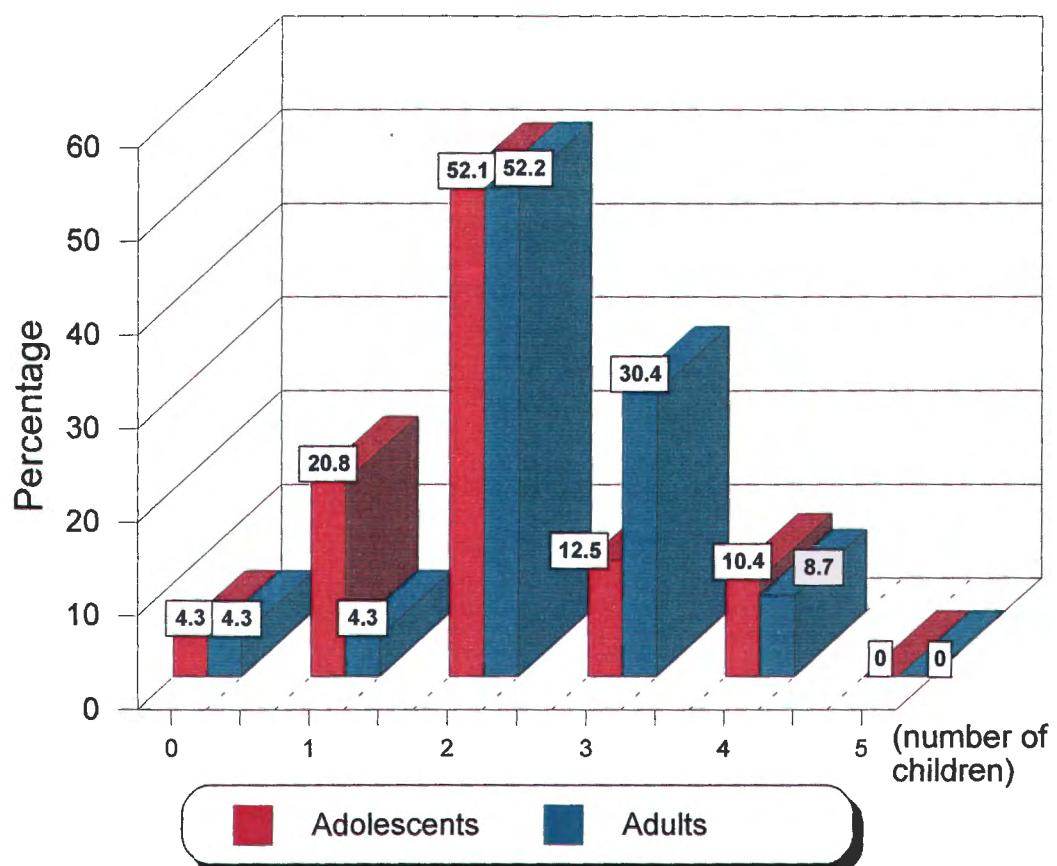
Furthermore, 8 (13,8%) adults and 5 (21,7%) adolescents wished to have only one child while 6 (10,3%) adults and 1 (4,3%) adolescent indicated a wish to have no children. Only 4 (6,9%) adults wished to have four children and no adolescent wanted to have four or more children.

Figure 4.3 (b) presents the analysis of the total number of children that males wished to have. Trends similar to those reported for females were found. The majority of males also indicated their intention to have fewer children. A total of 25 (52,1%) adults and 12 (52,2%) adolescents indicated that they wished to have a total of two children while 6 (12,5%) adults and 7 (30,4%) adolescents intended to have a total of three children. Furthermore, 5 (10,4%) adults and 2 (8,7%) adolescents wanted to have four children. Only 1 (4,3%) adolescent and 10 (20,8%) adults intended to have one child, 2 (4,2%) adults and 1 (4,3%) adolescent wished to have no children, and none of the respondents wanted to have more than four children.

It therefore becomes clear from these findings that both females and males, adults and adolescents, did not wish to have large families unlike previous generations. Reasons put forward by respondents for their intention to have smaller families are further indications that smaller family norms might become a reality in Northern Tshwane.



**Figure 4.3 (a): Total number of children female respondents wished to have**



**Figure 4.3 (b): Total number of children male respondents wished to have**

**Item 15: Reasons for the number of children respondents wished to have**

Respondents were asked to state their reasons for the number of children they wished to have, in order to assess their knowledge of the significance of using contraceptives effectively. The majority of respondents, 42 (56,0%) females and 38 (64,0%) males, were positive that they did not want to have more than two or three children as it was costly to feed, clothe and educate them. Comments received from 37 (52,0%) females and 21 (43,0%) males who indicated their awareness of contraception, included statements such as:

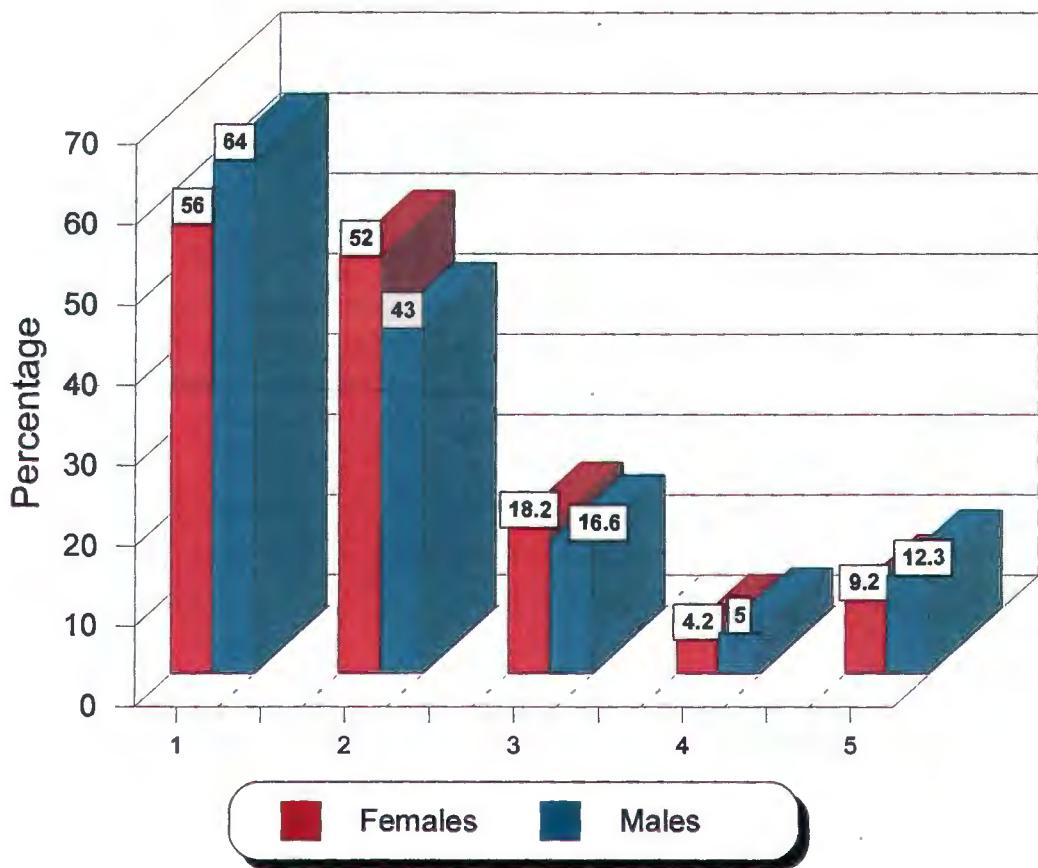
*We know that you can prevent pregnancies and STDs by using condoms.*

*Our clinic is always providing us with contraceptives, so there's no reason to have many children, you just choose what you want.*

A minority of respondents indicated that they purposely wanted a big family, and a few respondents had no specific reasons for the number of children they wished to have (see fig 4.4).

**Item 16: Knowledge about contraceptives**

Respondents were asked to indicate whether they had any knowledge about contraceptives. Of the respondents, 64 (84,2%) females and 53 (77,9%) males affirmed that they knew about contraceptives and only 11 (14,5%) females and 15 (22,1%) males claimed to be ignorant about contraceptives. Of the female respondents who affirmed that they were informed about contraceptives, 48 (87,3%) were adults and 16 (76,2%) were adolescents. Of the males, 36 (78,3%) adults and 17 (77,3%) adolescents knew about contraceptives.



**Key to reasons:**

- 1 = High cost of living
- 2 = Aware of contraception
- 3 = Not aware of contraception
- 4 = Purposely wants a big family
- 5 = No specific reasons

**Figure 4.4: Reasons for the number of children respondents wished to have**

***Item 17: Information about contraceptives***

Item 17 was an open-ended question asking respondents to state the information they had about contraceptives. Respondents provided the following information:

- knowledge about contraceptives (58 females, 50 males)
- knowledge of different methods of contraception (45 females, 38 males)
- knowledge of side-effects of contraceptives (38 females, 22 males)
- no knowledge of contraceptives (23 females, 20 males)

Generally, females were more informed about contraceptives than males, although males knew about some contraceptive methods used by women. Such knowledge could motivate individuals to use or improve their contraceptive practices.

***Item 18: Sources of contraceptive information for respondents***

Table 4.8 (a) shows an analysis of sources of information for both adult females and males. Mothers were the main source of contraceptive information for 15 (31,3%) females and for 26 (54,2%) males the main source was the media. The second source of information for 14 (29,8%) females was the media and for 11 (22,8%) males it was teachers. The fact that 12 (25,5%) females rated teachers as their third main source of information indicates that they do play a role in educating learners about aspects of sexuality and how to prevent unwanted pregnancies.

Females indicated that sisters, friends and nurses were equally their other significant source of information while males indicated friends and teachers as their other important source of information. Furthermore, 2 (4,2%) males indicated their sisters and nurses as their least important source of contraceptive information. A trend noted was that only 1 (2,1%) male and no

females received contraceptive information from fathers and brothers. Involvement of both females and males in sharing information about contraceptives and their effective use could help reduce the levels of unwanted pregnancies and prevent becoming infected with STDs and HIV/AIDS. Fathers and brothers could explain more about the use of condoms to prevent unwanted pregnancies and the risk of having many children. Such information could be shared with their partners and children. Others who shared information with 2 (4,2%) male respondents were colleagues and cousins.

**Table 4.8 (a): Sources of contraceptive information for adult respondents**

SOURCES OF INFORMATION	ADULTS		TOTAL	
	Female	Male	f	%
Mother	15 (31,3%)	7 (14,6%)	22	39,2
Father	-	1 (2,1%)	1	2,1
Brother(s)	-	1 (2,1%)	1	2,1
Sister(s)	7 (14,9%)	2 (4,2%)	9	16,0
Friend(s)	7 (14,9%)	10 (20,8%)	17	30,3
Teacher(s)	12 (25,5%)	11 (22,9%)	23	41,1
Media	14 (29,8%)	26 (54,2%)	40	71,4
Hospital/clinic/nurses	7 (14,9%)	2 (4,2%)	9	16,7
Other	-	2 (4,2%)	2	4,3

Table 4.8 (b) presents an analysis of sources of contraceptive information for both female and male adolescents. Seven (38,9%) females indicated mothers as their main source of contraceptive information and 13 (65,0%) males

indicated the media. From this it was concluded that adult and adolescent males learnt more from the media, such as reading newspapers and watching television, and adult and adolescent females obtained most information about aspects of life including contraceptive practices from their mothers and friends. Five (27,8%) females indicated the media as their third source of information compared to 4 (20,0%) males who indicated mothers and friends as their other source of contraceptive information. Like the adults, both female and male adolescents acknowledged that they did not receive any information about contraceptives from their fathers and brothers. Unlike the adults, adolescents did not receive any contraceptive information from nurses.

**Table 4.8 (b): Sources of contraceptive information for adolescent respondents**

SOURCES OF INFORMATION	ADOLESCENTS		TOTAL	
	Female	Male	f	%
Mother	7 (38,9%)	4 (20,0%)	11	42,3
Father	-	-	-	-
Brother(s)	-	-	-	-
Sister(s)	3 (16,7%)	1 (5,0%)	4	8,6
Friend(s)	7 (14,9%)	4 (20,0%)	11	23,9
Teacher(s)	2 (11,1%)	3 (15,0%)	5	10,8
Media	5 (27,8%)	13 (65,0%)	18	39,1
Hospital/clinic/nurses	-	-	-	-
Other	-	-	-	-

***Item 19: Contraceptive use***

When asked whether they used any contraceptive methods, 71 (86,6%) females and 50 (70,4%) males indicated that they used contraceptives. Of the females, 53 (88,3%) were adults and 18 (81,8%) were adolescents. Of the males, 34 (70,8%) adults and 16 (69,6%) adolescents were using contraceptives. Although females using contraceptives were in the majority, these statistics indicate that males were also using contraceptives and that it was not only the responsibility of women to prevent unwanted pregnancies. In addition, the majority of both female and male adolescents were using contraceptives.

***Item 20: Contraceptive methods used by respondents***

Respondents were asked to state the contraceptive methods used and instructed to choose more than one contraceptive method, if applicable.

Of the 73 female respondents, 26 (35,6%) adults indicated that they used the pill, and none of the female adolescents used the pill for contraception. A further 47 (64,4%) females had used the injection. Six (8,2%) respondents used the IUCD and 21 (28,8%) used the male condom while only 3 (5,6%) adolescents affirmed that they bought the femidom (female condom) as it was not available at health centres or clinics. None of the respondents indicated having used the diaphragm, the hormonal implant or sterilisation. Other methods used by respondents included abstinence 1 (1,4%) and LAM 1 (1,4%).

Of the 51 male respondents, 36 (70,5%) adults and 15 (68,2%) adolescents used condoms. Only 3 (16,1%) adults and 2 (9,1%) adolescents used withdrawal as a contraceptive method. Three (4,3%) male adults had been sterilised and added that they came to the clinic for condoms as protection against diseases (STDs).

**Table 4.9: Contraceptive methods used by respondents**

CONTRACEPTIVE METHODS	FEMALES		TOTAL	
	Adults	Adolescents	f	%
Pill	26 (46,4%)	-	26	35,6
Injection	35 (62,5%)	12 (70,6%)	47	64,4
Intrauterine contraceptive device (IUCD)	5 (8,9%)	1 (5,9%)	6	8,2
Condoms	14 (25,0%)	7 (41,2%)	21	28,8
Diaphragm	-	-	-	-
Hormonal implant	-	-	-	-
Withdrawal	-	-	-	-
Sterilisation	-	-	-	-
Other	2 (3,6%)	-	2	2,7

The total exceeds 100 as some respondents indicated more than one contraceptive method.

#### ***Item 4.21: Reasons for not using contraceptives***

Out of 82 females and 71 males, 11 (13,4%) females and 21 (29,6%) males were not using contraceptives although some had regular sex. They stated the following reasons for this:

- Did not know about contraceptives. (16 females, 12 males)
- Partner dislikes contraceptives. (8 females, 6 males)
- It is against their religion. (13 females, no males)

Specific religions stated were:

- Zionist Christian Church (8 females)

- Apostolic Church (3 females)
- Muslims (2 females)
- Do not trust contraceptives. (6 females)
- Did not have a boyfriend at that time. (3 females)
- No specific reason. (2 males)

***Items 22 to 24: Preferences of specific contraceptives methods***

Respondents were asked to state the specific contraceptive methods they preferred. The findings indicated that 51 (65,4%) females and 28 (40,6%) males preferred certain contraceptive methods as compared to 27 (34,6%) females and 41 (59,4%) males who did not have any specific contraceptive preferences.

◆ **Reasons for preferences of specific contraceptive methods by female respondents**

In response to items 22 to 24 about the reasons for preferences of specific contraceptive methods, respondents gave the following reasons:

- I prefer the injection, it is good and private (28 females)
- The method was chosen for me (12 females)
- I prefer the pill (13 females)
- The method was chosen for medical reasons (6 females)
- I prefer condoms rather than sterilisation Condoms are safe and protective against infections (6 females, 20 males)

**Item 25: Knowledge about the female condom**

Only female respondents were asked this question because the male questionnaire had in-depth questions about male condom use. Out of 82 respondents, 46 (56,1%) acknowledged that they knew about the female condom and only 3 (15,8%) indicated that they had bought the female condom from pharmacists as there were no supplies from the health services or clinics. Of the respondents who knew about the female condom, 32 (54,2%) were adults and 14 (60,9%) were adolescents. One respondent indicated her lack of information about the female condom by stating:

*I wish I could see how the female condom looks like ... why is it so scarce and expensive in our country?*

Another respondent who had no knowledge about the female condom added:

*The government must avail the female condom at hospitals, clinics and everywhere like the male condom ... I mean we can't afford to pay when men get their condoms free ... and we are the people who suffer the consequences ... it's unwanted pregnancy this side and STDs including AIDS.*

**Item 26: Availability of condoms from health care centres**

It was of concern to the respondents that the female condom was not readily available as women could use it in the absence of a male condom to prevent unwanted pregnancies. The purpose of the female condom was to empower women to make and implement the decision to protect themselves from unwanted pregnancies and STDs. The female condoms are reported to cost R14,00 for a packet containing only two condoms. This was too expensive for the majority of the female respondents.

When asked if they always received condoms, 39 (52,7%) females agreed that they always received and 29 (39,2%) did not always receive condoms when asking for them from health care centres. It should be noted, however, that the condoms referred to were male condoms as they are available at health services and some public places. Some females who responded positively to this question, indicated that they usually get condoms for their partners when consulting for contraceptives or other ailments.

***Items 27 to 31: Females' perceptions of contraceptive use***

Items 27 to 31 in the female questionnaire were open-ended questions and the answers given indicated a variety of respondents' perceptions about different contraceptive methods. These findings were coded and the main themes derived were positive, negative and neutral perceptions. These were then transformed into frequencies and percentages.

From the analysis in table 4.10, injections were perceived positively by the majority of 48 (59,3%) females, the majority of 42 (51,9%) females had negative perceptions about oral contraceptives. Of the 48 (59,3%) respondents who had positive impressions about injections, 20 (41,6%) were adolescents who indicated further that they preferred Nur-Isterate to Depo Provera. IUCDs were rated by 38 (46,9%) respondents negatively, comprising all 23 (100,0%) adolescents and 15 (25,9%) adults.

Regarding sterilisation, 34 (44,7%) female respondents rated male sterilisation positively compared to 22 (27,0%) for female sterilisation. These findings would seem to indicate that the women regard male sterilisation as a contraceptive method which could stop men from "forcing" women to have countless children, as shown by the following statement

*These men must be stopped from making babies all over by sterilisation. In fact, male sterilisation should be made compulsory for males who have at least two or three children with their wives.*

**Table 4.10: Perceptions of females about contraceptives**

PERCEPTIONS ABOUT CONTRACEPTIVES	FEMALES		TOTAL	
	Adults (58)	Adolescents (23)	f (81)	%
Female sterilisation (n = 72)				
• Positive	8 (13,8%)	14 (60,9%)	22	27,0
• Negative	11(18,9%)	9 (39,1%)	20	24,7
• Neutral	12 (20,7%)	18 (78,3%)	30	37,0
Male sterilisation (n = 76)				
• Positive	1 (1,7%)	19 (82,6%)	20	42,0
• Negative	6 (10,3%)	14 (60,9%)	20	25,0
• Neutral	8 (13,8%)	14 (60,9%)	22	27,2
Intra-uterine devices (n = 79)				
• Positive	3 (5,2%)	7 (30,4%)	10	23,5
• Negative	15 (25,9%)	23 (100%)	38	46,9
• Neutral	10 (17,2%)	12 (52,2%)	22	27,2
Oral contraceptives (n = 78)				
• Positive	15 (25,9%)	21 (91,3%)	36	44,4
• Negative	16 (27,6%)	16 (27,6%)	32	51,9
• Neutral	3 (5,2%)	7 (30,4%)	10	23,0
Injections (n = 72)				
• Positive	28 (58,3%)	20 (41,6%)	48	59,3
• Negative	12 (20,7%)	8 (34,8%)	20	24,7
• Neutral	3 (5,2%)	1 (4,3%)	4	4,9

Items 25 to 26 in the male questionnaire required respondents to indicate their perceptions about male and female sterilisation, respectively. Unlike the female respondents, (31,4%) males indicated positive perceptions about female sterilisation compared to (14,3%) who rated male sterilisation positively. This could indicate that females expected males to be sterilised and vice versa.

***Item 32: Perceptions of side-effects of contraceptives***

In response to this question, 29 (30,5%) females expressed positive perceptions, stating that they would not be discouraged by side-effects from using contraceptives. Twenty-six (22,0%) females indicated negative perceptions by stating that they could not tolerate some of the side-effects, such as weight gain, amenorrhoea and irregular menstruation. They gave these side-effects as some of their reasons for discontinuing their contraceptives. The following statement highlights the obstacles experienced by respondents with regard to contraceptives:

*These side-effects can be scary especially if nobody told you what to expect and what to do when you have heavy menstruation or no menstruation at all because you are using Depo Provera.*

***Items 33 to 36: Consultation of traditional healers for contraceptives***

The respondents had to indicate whether they had consulted traditional healers for contraceptives or not. Only 11 (13,4%) females and 4 (5,6%) males acknowledged having consulted traditional healers for contraceptive purposes. More female adults seemed to have consulted traditional healers than adolescents. Out of 11 females, 8 (13,6%) adults and 3 (13,0%) adolescents had consulted traditional healers for contraceptives. In contrast to the females, 3 (5,0%) adolescent males and only 1 (2,1%) adult had consulted traditional healers for contraceptive purposes.

Three (13,4%) females and 4 (5,6%) males who had visited traditional healers for contraception, mentioned the following prescriptions:

- medication for drinking before having sex (1 female, 3 males)
- prayers before and after sex for God to help prevent unwanted pregnancies (2 females)

- rope medicated with herbs and soaked in the woman's menstruation to be worn around the waist for the prevention of unwanted pregnancies (2 females)

In response to a separate question as to whether they would use the contraceptives prescribed by traditional healers, 15 females and 5 males indicated that they used such prescriptions as they wanted to prevent unwanted pregnancies. One female adolescent commented:

*I used the medicated rope around my waist to prevent unwanted pregnancy for the last eight months and it worked for me. I only came to the clinic for condoms as I don't want to be infected with AIDS.*

Of the respondents, 37 (71,2%) females and 63 (92,6%) males who declined to use medications prescribed by traditional healers based their assumptions on the belief that traditional healers lacked the scientific knowledge and therefore their treatments could not be trusted. Some respondents indicated that they were just taken to traditional healers by their mothers without their consent, when they started menstruating and were therefore forced to use the prescribed traditional contraceptives.

***Items 37 to 39: Knowledge of respondents about emergency contraceptives***

In response to whether they knew about any emergency contraceptives, 25 (31,3%) females and 24 (33,8%) males admitted having knowledge about emergency contraceptives.

In addition, 7 (28,0%) females could only mention that they had heard of the "morning after pill" which could be used after unprotected sex. Only (12,8%) females and (6,2%) males could provide details about other information they had regarding emergency contraceptives including:

- Emergency contraception could be used within 72 hours after unprotected sex.
- It was obtainable from the clinics.
- It should only be used in "accidents", not as routine contraception.

One respondent commented as follows:

*Health care providers don't seem to like this morning after pill. Even when they give us health education about contraceptives, they have never mentioned this method ... why? Is it a risky method or don't they trust it? We need to hear more about this method from the nurses and doctors, not from hear-say stories.*

None of the respondents knew that the copper-containing IUCDs could be used as emergency contraceptives.

#### ***Items 40 and 41: Use of emergency contraceptives***

Respondents were asked if they would use emergency contraception after unprotected sex to prevent unwanted pregnancies. Forty-five (54,9%) females and only 30 (44,1%) males agreed that they would use emergency contraception after unprotected sex.

Out of 45 females, 37 (62,7%) adults and 8 (34,8%) adolescents were positive that they would use emergency contraceptives when in need. In addition, 23 (50,0%) adult males and 7 (31,8%) adolescents indicated that they would encourage their partners to use emergency contraceptives. From these findings, it seems that more adult females and males would use emergency contraceptives when needed than female and male adolescents. More information about emergency contraceptives could allay fears and misconceptions about emergency contraceptives. During youth counselling and sex education, health care providers and teachers should explain the

importance of using emergency contraception which could save them from having unwanted pregnancies.

The respondents who felt positive about emergency contraception, gave the following reasons:

- It would prevent unwanted pregnancy. (16 females, 12 males)
- It is better than waiting anxiously for your next period. (11 females, no males)
- It is better than terminating a pregnancy. (9 females, 5 males)

Furthermore, 37 (45,1%) females and 38 (55,9%) males expressed their intention not to use emergency contraception. The following examples reflect the reasons for their intention not to use emergency contraception:

*Emergency contraception is just like murder ....*

*I cannot do it, nor promote it.*

*It is just like terminating a pregnancy, which is morally not right.*

*I am not sure of its action, what if I have serious complications in future?*

#### ***Items 42 and 43: Knowledge about legalised termination of pregnancy services***

Since 1996, in terms of the Choice on Termination of Pregnancy Act no 92 of 1996, women in the RSA have a legal choice to request the termination of their pregnancies during the first 12 weeks of gestation. In response to the question about knowledge of legalised TOP services in the RSA, 36 (61,0%) female adults and 12 (52,2%) adolescents knew about these services as compared to

21 (43,8%) male adults and 9 (39,1%) adolescents. In addition, these respondents indicated that they only had superficial information about these services, such as knowledge about legalised CTOP and that they could obtain such services from clinics or hospitals. These statistics could indicate that the mere legalising of TOP services does not necessarily imply that women know about their rights regarding CTOP. More information sessions at health care centres and schools could be provided to inform adults and youth about aspects of the Termination of Pregnancy (Act, 92 of 1996), which is often misunderstood and misinterpreted.

***Items 44 and 45: Utilisation of termination of pregnancy services***

Respondents were asked if they would utilise CTOP services if they had an unwanted pregnancy. Only 20 (35,9%) females were positive about CTOP and agreed that they would utilise the service.

Males seemed to be positive about CTOP as 30 (44,1%) respondents indicated that they would encourage their partners to terminate unwanted pregnancies, a sentiment expressed by 23 (50,0%) adults in contrast to only 7 (31,8%) adolescents.

Various reasons were given for using CTOP services included the following:

Out of the respondents who were positive about CTOP services, some explained their perceptions by stating:

*Legalised TOP is better than terminating at back yard abortionists.*

*It will save women from frustration or misery of an unwanted pregnancy.*

*It is safe with less complications.*

Respondents gave the following reasons for not intending to utilise CTOP services:

*CTOP is just like murder.*

*I can rather have the baby and give my child for adoption.*

*Our church is strongly opposed to CTOP, therefore I cannot defy my church teachings or doctrines.*

***Items 46 and 47: Permission from partner to terminate a pregnancy***

In response to this question, 26 (32,9%) females indicated that they needed permission from their partners for terminating a pregnancy while 52 (65,8%) respondents did not need any permission from their partners. Only 18 (26,9%) males said their partners could obtain a CTOP without their permission compared to 49 (73,1%) males who indicated that their partners had to obtain permission from them for a CTOP.

Some respondents gave the following positive reasons for sex partner to have to obtain permission for CTOP:

*I need to be informed as I have to support my partner socially and psychologically.*

*It should be our joint responsibility, after all, it was going to be our baby.*

*My partner must also be involved and experience the results of an unwanted pregnancy.*

Some respondents gave the following reasons for not seeking their sex partner, permission for CTOP:

*It's her body, I don't necessarily have to give permission for her to terminate her pregnancy.*

*She has the right to decide for herself, she's an adult.*

*The Act allows women to terminate a pregnancy without the partner's consent, so I don't have a say.*

*I don't have to get his permission, it's my pregnancy.*

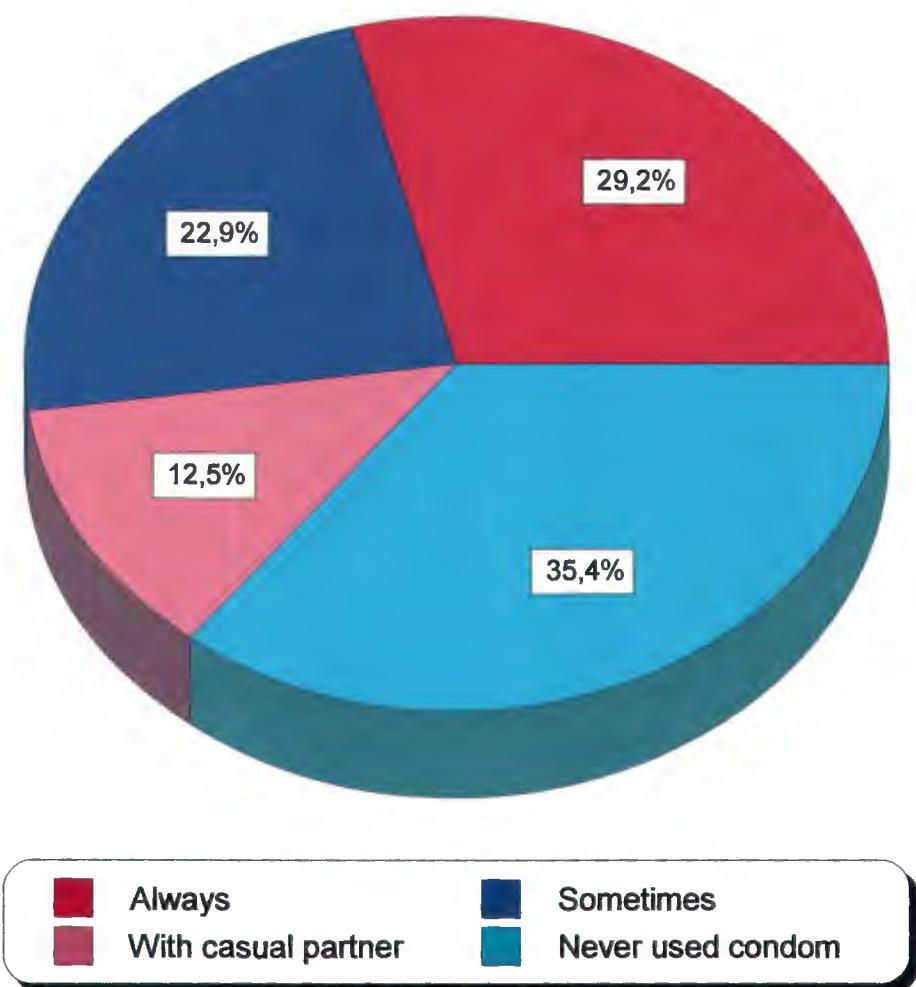
**Items 44 to 46: Use of condoms by male respondents (from male questionnaire)**

With regard to condom use, the respondents were asked to indicate whether they always used condoms every time when having sex, 48 adult males responded. As indicated in figure 4.5 (a), 14 (29,2%) respondents acknowledged that they always used condoms when having sex, 11 (22,9%) used condoms sometimes and 6 (12,5%) used them when having sex with a casual partner. Seventeen (35,4%) respondents did not use condoms at all when having sex with regular and/or casual partners.

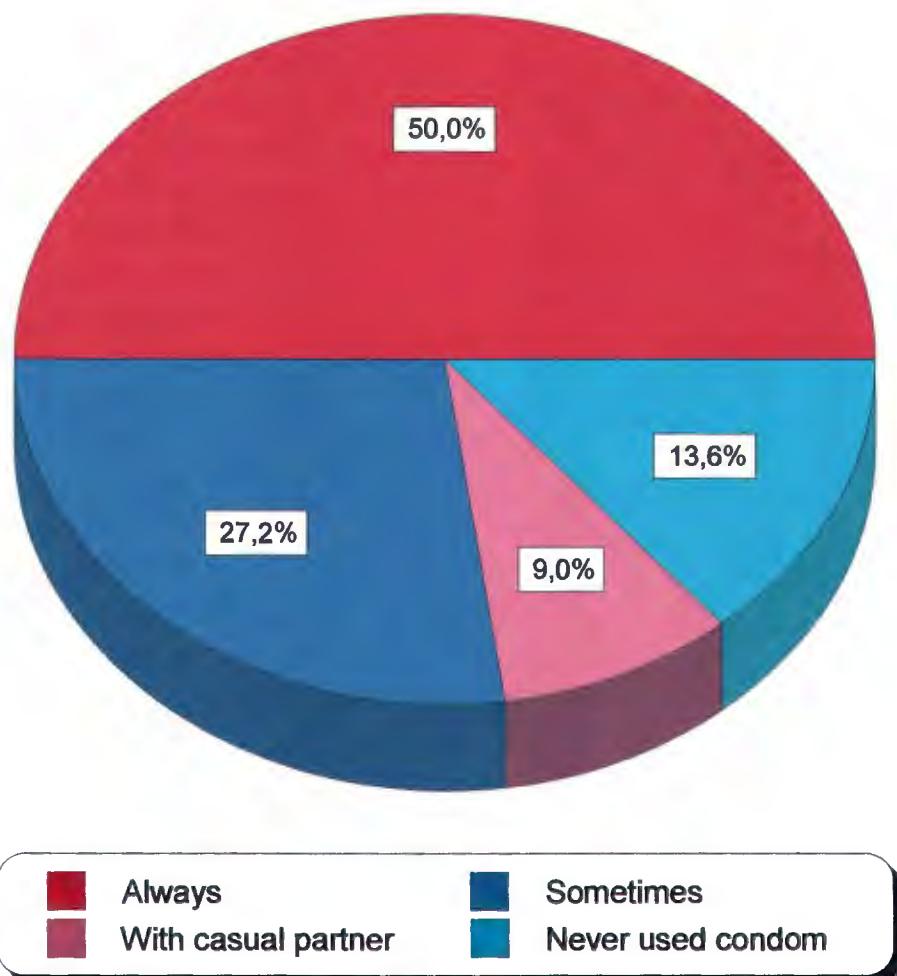
Figure 4.5 (b) presents an analysis of condom use by male adolescents. As compared to adults, 11 (50,0%) respondents always used condoms when having sex, 6 (27,2%) sometimes used condoms, 2 (9,0%) used condoms only when having sex with a casual partner and only 3 (13,6%) had never used condoms at all.

The respondents gave the following reasons for using condoms:

- protection against STDs and AIDS (15 adults, 18 adolescents)
- prevention of unwanted pregnancies (10 adults, 12 adolescents)
- don't trust my partner (7 adults, 12 adolescents)



**Figure 4.5 (a): Condom use by adult males**



**Figure 4.5 (b): Condom use by adolescent males**

The respondents gave following reasons for not using condoms:

- partner trust (16 adults, 12 adolescents)
- no sexual satisfaction when using condoms (12 adults, 9 adolescents)
- condom breakages (10 adults, 16 adolescents)
- condom slippages (8 adults, 18 adolescents)
- partner dislikes condoms (5 adults, 8 adolescents)
- not sure how to use condoms (5 adults, 7 adolescents)

***Items 46 and 47: Always receiving condoms when needed (from the male questionnaire)***

Out of 68 male respondents who answered this question, 53 (77,9%) affirmed that they always received condoms 15 (22,1%) respondents were unable to get condoms when they were needed. These findings show that male condoms are readily available, although they could be made more available in view of their dual purpose of prevention of unwanted pregnancy and STDs/AIDS infections.

The 15 (22,1%) respondents who stated that they did not always get condoms when needed, gave the following reasons:

- no stock (12 males)
- at times can't afford to buy condoms (9 males)
- nursing sisters not easy to approach (6 males)
- no specific reason – just hate condoms (5 males)

***Item 49: Contraceptive method(s) used by respondents***

Respondents were asked to state which contraceptive method(s) they were using at the time of data collection. Fourteen (19,7%) respondents indicated that they were using the pill, only 2 (2,8%) indicated using an IUCD, 24 (33,8%) said they were relying on their partner using a condom and 21 (29,6%)

mentioned that they were using an injection. Of the 21 (29,6%) respondents who were using the injection, 10 (43,5%) were adolescents. When asked which type of injection they were using, 9 (90,0%) stated that it was Nur-Isterate. Other methods indicated were abstinence (1,4%), prayers (1,4%) and sterilisation (1,4%).

***Item 50: Consistent and accurate use of contraceptives***

When asked if they used contraceptives constantly and accurately, (60,8%) females indicated that they did and (39,2%) indicated that they did not.

The respondents gave the following reasons for using contraceptives accurately and consistently:

- fear of contracting diseases, STDs and AIDS (48)
- fear of unwanted pregnancy (42)
- want to complete my studies (20)
- don't want to have many children (20)
- do not trust my partner (13)

The respondents gave the following reasons for failure to use contraceptives consistently and accurately:

- worried about side-effects (26)
- not comfortable about getting contraceptives from the clinic (12)
- clinic staff not welcoming to "us" (12)
- no boyfriend, so, no danger of an unwanted pregnancy (8)
- no clinics nearby, costly to travel (6)

**Item 51: Travelling time spent to reach nearest hospital/clinic**

Table 4.11 shows that the maximum travelling time spent by 35 (43,8%) females and 30 (48,4%) males was between 1 to 15 minutes, followed by 15 to 30 minutes as indicated by 22 (27,5%) females and 21 (33,9%) males. The longest travelling time indicated by only 2 (2,5%) females and 2 (3,2%) males was between one and two hours. The majority of respondents(see item 6) reside in townships and use taxis or buses to reach health care centres, implying that additional time needs to be spent waiting for transport.

**Table 4.11: Travelling time spent to reach nearest hospital/clinic**

TIME SPENT TO NEAREST HEALTH SERVICE	FEMALES		TOTAL		MALES		TOTAL	
	Adults	Adolescents	n	%	Adults	Adolescents	n	%
1-15 minutes	26 (74,2%)	9 (26,3%)	35	43,8	21 (48,4%)	-	21	48,4
15-30 minutes	17 (77,2%)	5 (46,5%)	22	27,5	13 (61,5%)	8 (38,1%)	21	33,9
30-45 minutes	11 (77,3%)	4 (26,3%)	15	18,8	2 (33,3%)	4 (66,7%)	6	97,0
45-60 minutes	4 (66,7%)	2 (33,3%)	6	7,5	-	3 (18,8%)	3	18,8
1-2 hours	-	2 (2,5%)	2	2,5	-	2 (3,2%)	2	3,2
More than 2 hours	-	-	-	-	-	-	-	-
<b>TOTAL:</b>	<b>58</b>	<b>22</b>	<b>80</b>	<b>100,0</b>	<b>46</b>	<b>17</b>	<b>63</b>	<b>100,0</b>

**Item 52: Nurses' attitudes towards adult clients**

Attitudes of staff seem to play a role in motivating or demotivating clients to use contraceptives. Table 4.12 (a) indicates that 34 (63,0%) females compared to 14 (40,0%) males found nurses to be helpful, 17 (31,7%) females and 4 (11,4%) males received health education, 19 (12,3%) were informed about

contraceptives, 1 (1,9%) female and 2 (5,7%) males reported nurses to be rude and 7 (13,0%) females and 6 (17,1%) males received no information from nurses. Other additional nurses' attitudes were that they did not have time to listen to adolescents' complaints and seemed to be busy all the time.

Some respondents' expressed their concern about the use of condoms as follows:

*I feel embarrassed to use a condom because I don't know how to use it ... I tried it once, but it was just a mess ... I was so deflated.*

Another respondent said:

*There should be demonstrations at clinics or so ... seeing those pictures of condoms on the walls is not enough ... we can't always follow those instructions – especially at the peak of the sexual excitement ... something definitely must be done to assist us ... and I know I am not alone.*

Male respondents were also, asked to list the side-effects of condoms and gave the following:

- condoms break easily, especially those received from the health services (28)
- condom slippages (26)
- discomfort (15)
- allergies (7)

**Table 4.12 (a): Nurses' attitudes towards adult clients**

STAFF ATTITUDES	ADULTS		TOTAL	
	Females	Males	f	%
Helpful	34 (63,0%)	14 (40,0%)	48	31,1
Gave health education	17 (31,5%)	4 (11,4%)	21	13,6
Rude	1 (1,9%)	2 (5,7%)	3	1,9
Polite	1 (1,9%)	-	1	0,6
Gave contraceptive information	15 (27,8%)	4 (20,0%)	19	12,3
Gave no contraceptive information	7 (13,0%)	6 (28,6%)	13	8,4
Other	4 (8,0%)	-	-	-

The responses summarised in table 4.12 (a) indicate that clients perceived nurses at the family planning clinics to be helpful and to provide health education as well as information about contraceptives.

Table 4.12 (b) presents an analysis of nurses' attitudes towards adolescents. Like the adults (see table 4.12 [a]), 21 (13,6%) adolescents reported nurses to be helpful, and 3 (1,9%) indicated that nurses provided health education and 10 (6,5%) indicated that they received contraceptive information from nurses. In addition, 10 (6,5%) found nurses polite. Eleven (7,1%) respondents had not received any contraceptive information and only 2 (1,2%) found nurses rude to them. Other nurses' attitudes indicated were that they were keen to listen and discuss contraceptive issues with clients.

**Table 4.12 (b): Nurses' attitudes towards adolescent clients**

STAFF ATTITUDES	ADOLESCENTS		TOTAL	
	Females	Males	f	%
Helpful	10 (47,1%)	11 (55,0%)	21	13,6
Gave health education	3 (14,3%)	-	3	1,9
Rude	2 (9,5%)	-	2	1,2
Polite	10 (47,6%)	-	10	6,5
Gave contraceptive information	6 (28,6%)	4 (20,0%)	10	6,5
Gave no contraceptive information	6 (28,6%)	5 (25,0%)	11	7,1
Other	4 (8,0%)	-	-	-

#### 4.3 LOGISTIC REGRESSION ANALYSIS RESULTS

Logistic regression analysis (LRA) was used with the aid of a computer program (Statistical Analysis Omnibus Tests of Model Coefficients). This analysis investigated the relationship between

- the clients' ages, marital status, home language, religion, educational level, employment status, income, residential area, the number of people sharing a home with clients and the contraceptive practices of these clients
- the clients' knowledge of contraceptives and their contraceptive practices
- the clients' perceptions of different contraceptive methods and their contraceptive practices
- the perceptions of nurses, clients' perceived values of the hospital or clinic, and clients' perceptions of contraceptive and CTOP services

### 4.3.1 Logistic Regression Analysis for the biographical variables

Table 4.13 presents the results obtained from LRA investigating the relationships between the clients' age, marital status, employment status, educational level, income, home language, religion, residential area, the number of members sharing home and contraceptive information with clients. These results indicate that there is no significant relationship between the abovementioned variables and the contraceptive practices of clients. However, marital status and residential area come close to exerting a significant influences on contraceptive practices of clients. If significance were reached ( $p < 0,05$ ), it would indicate that married couples and some residential areas are more likely to influence clients' contraceptive practices than unmarried couples and clients living in other residential areas.

**Table 4.13: Effect of selected demographic variables on contraceptive practices of clients (n = 154)**

INDEPENDENT VARIABLE	df	SIGNIFICANCE	Exp (Z)
Age	1	0,068	0,180
Marital status	1	0,145	1,341
Resident	4	0,006	0,862
Level of education	1	0,448	2,087
Employment status	2	0,633	0,922
Income	1	0,840	1,664
Number of people resident in the house	1	0,018	1,581

### 4.3.2 Results of Logistic Regression Analysis

The LRA investigating the clients' knowledge about different contraceptive methods and their contraceptive practices indicated that

knowledge about contraceptives exerts a significant influence on contraceptive practices. The level of significance reached was  $p < 0,044$  which means that those clients who had knowledge about contraceptives would more likely use contraceptives than those who lacked such knowledge.

#### **4.3.3 Results of clients' perceptions about contraceptive practices**

The results obtained from Logistic Regression Analysis to determine the relationship between the perceptions of clients about contraceptives and their contraceptive practices indicate that a relationship exists between the variables with regard to different methods of contraceptives. The probability value suggested that clients with positive perceptions towards contraceptives would more likely use contraceptives than those having negative perceptions.

#### **4.3.4 Relationship between the attitudes of nurses, clients' perceived value of the hospital or clinic, their perceptions of contraceptive and termination of pregnancy services with their contraceptive practices**

The results indicated that the attitude of nurses had a significant influence on clients' contraceptive practices. These findings are discussed in chapter 5 of this report.

Respondents made the following suggestions to improve contraceptive services:

- The government should make modern contraceptives, such as Norplant and the female condom freely available.
- The quality of male condoms should be improved.

- Sex education should be started from home, schools, organisations, and media to inform children as early as 9 or 10 years, about abstinence.
- Health care services should have facilities for youth and personnel should not display a judgemental attitude to clients coming for contraceptives.
- Men (fathers and brothers) should provide sex education to boys and other men.

#### **4.4 CONCLUSION**

This chapter presented the results of the structured interviews with females and males. The respondents were categorised as adults and adolescents and analysed as female adults and adolescents and male adults and adolescents. Correlations and comparisons were pointed out and highlighted. Data obtained from open-ended questions were categorised and frequencies calculated for specific categories' responses.

Chapter 5 discusses the findings of the quantitative analysis.

## CHAPTER 5

### Discussion of quantitative research results

#### 5.1 INTRODUCTION

Since the 1970s there have been significant advances in the development of new contraceptive technologies, including transitions from high dose to low dose oestrogen combined oral contraceptives and from inert to copper and levonorgestrel containing IUCDs to prevent unwanted pregnancies.

Despite these attempts and the publication of findings, many women and men still do not utilise contraceptive services and do not use contraceptives effectively. In addition, unwanted pregnancies and deaths from complications of illegal TOPs continue to be reported.

This chapter discusses the information collected during phase 1 and analysed in chapter 4, with specific reference to contraceptive practices of women and men in Northern Tshwane. The data analysis enabled the researcher to conceptualise the research questions stated in chapter 1 of this study.

Continued review and consideration of relevant newly published data throughout the study supported the results. The findings are discussed under the headings and subheadings used in the two data collection instruments. In some cases, related headings are grouped under headings that reflect similar themes.

## 5.2 DESCRIPTION OF BIOGRAPHICAL DATA

### *Item 5.1: Age and marital status*

Age was considered an important variable because of its potential to influence people's perceptions of an event or situation, determine the frequency with which they have been exposed to that particular situation and how they might practise or implement the knowledge gained – in this instance, contraceptive practices. The study found that age had an influence on the type of contraceptive methods the respondents used and how they used them. The analysis indicated similarities and differences between women and men, adults and adolescents in their contraceptive practices.

According to literature, adolescents are for various reasons, least likely to use contraceptives effectively (Buga et al 1996:526; Kunene 1995:45; Wood & Jewkes 2000:11). Similarly, older women have been reportedly using contraceptives ineffectively as they believed that they have reached maturity and would not be fertile anymore and that it is costly in terms of money and time to travel for contraceptives (Piccinino & Mosher 1998:6).

Table 4.2 shows that most of the adult females and almost all the adolescents were single while a few of adults were married and only one respondent was divorced. Similarly, all the adolescent males were single and a significant number of adult males were married in contrast to female adults.

### *Item 5.3: Residential areas*

Item 4.3 of the study indicates that the majority of the respondents stayed in townships and neighbouring informal settlements. A few respondents resided in rural areas around and in the city of Northern Tshwane. Despite the fact that since 1994, all provincial health services were opened to people regardless of

race or ethnicity, the health care centres included in this study served people mainly from black ethnic groups.

Factors in the utilisation of contraceptive services outlined in section 4.3 seemed to play a role in contraceptive use by individuals from different residential areas. The LRA of the data found that residential areas had a significant effect ( $p<0,05$ ) on the contraceptive practices of individuals. This significant relationship suggests that clients from residential areas where contraceptive services are available with nurses who are supportive, nonjudgemental and caring, will more likely use contraceptives effectively than clients who come from residential areas that lack these attributes.

#### ***Items 5.4 to 5.6: Level of education***

Level of education provides the extent of information the clients might have which could influence their contraceptive practices. Level of education has been cited by a number of authors as having an influence on utilisation of services including contraceptive services and subsequently on the use or nonuse of contraceptives (DOH 1999:15; UNPF 1998:10). According to these authors, individuals who did not complete their high school education were less likely to use contraceptives than those with high school education. The frequency results from this study indicate that almost half the numbers of both women and men had passed grade 12 and that the remaining majority were below grade 12 with none who had no schooling. Furthermore, remarkable numbers of females and males either had tertiary education qualifications or were busy with such qualifications. The results of the LRA, although insignificant, came close to the level of significance ( $p<0,05$ ). If significance had been reached it, would have indicated, in line with the findings of other studies, that the more educated people are, the more likely they are to be knowledgeable about aspects of life, including self-care and contraceptives.

*Item 5.7: Home language*

As the majority of the sample of women and men included in the study were blacks who spoke Tswana and Sotho, it was not possible to comment on the differences in contraceptive practices in relation to other groups. One of the health centres selected for the study is located in a suburb and caters for different ethnic groups. A sample of 80 respondents was drawn from this health care centre on the assumption that a "rainbow" nation would be represented. Such was not the case, however, as none of the other ethnic groups could be seen during data collection. Even the results of the LRA indicated no significant relationship between home language or ethnicity and contraceptive practices.

Communicating with clients in a language other than their home language might pose problems in understanding the instructions given by nurses regarding the use of contraceptives. Clients who do not understand the language used by nurses may also experience problems in formulating their thoughts into words or even misinterpret what nurses say with regard to contraceptive use. Nurses should therefore use clients' language when giving instructions, health education and counselling to ensure that they understand what is being communicated to them.

*Item 5.8: Religion*

Certain religions have specific practices which they require of their followers. In the analysis presented in chapter 4, item 4.6, religions such as the ZCC, Apostolic and Muslims had an influence on contraceptive practices of mainly females who failed to use contraceptives claiming that it was against their church teachings. Furthermore, some clients reportedly used water that was prayed over by their priests from the ZCC and Apostolic churches, to drink after having sexual intercourse. These clients argued that even though they used these methods for contraception, they still needed contraceptives from health

services to ensure double protection against unwanted pregnancies.

These findings could be compared with those reported by Wood and Jewkes (2000:11), who found that teenagers who attended the ZCC were not using contraceptives because their church discouraged the use of biomedical contraceptives. Contraceptive methods recommended by the church were strong coffee or tea mixed with medicines to drink after sexual intercourse.

***Items 5.9 and 5.10: Employment status and respondents' income per month***

Items 4.9 and 4.10 from both the female and male questionnaires indicated that the majority of the respondents were employed and received reasonable incomes to afford basic human needs. Slightly less than half the adults were unemployed, which meant that they may not even afford transport to health care centres for contraceptives. In instances where neighbouring services would not have enough stock, it meant that clients had to buy contraceptives from pharmacies or private medical practitioners. With little or no income, clients may not afford to buy contraceptives and might engage in unprotected sex. MacPhail and Campbell (2001:1623) concur with this, stating that adolescents and young people in the South African township of Khutsong, indicated that poverty was a powerful agent in preventing them from purchasing condoms. They believed that diseases would not end if condoms were sold as people in their community were so poor that if someone got R5, they would rather spend it on bread and candles, not on condoms.

***Items 5.11 to 5.12: Members sharing home with respondents and the total numbers of people in household***

The majority of the respondents were staying with other members of the families, such as mother, father, sister(s), brother(s) and children. Staying with other people could mean that they would talk about life events, including

contraception. Such information might give individuals better insight and even influence their contraceptive practices compared to clients who might not have anybody with whom to share information.

However, the maximum number of people indicated as living with respondents was eight, which could mean, that if they were members of the same nuclear family, it was the parents and six children. As the majority of these respondents were from the townships and informal settlements where most houses comprised four rooms (except self-built or extended) and two or one room (informal settlements), it meant that some families were overcrowded. This could encourage clients to consider using contraceptives effectively to prevent unwanted pregnancies or having many children.

### 5.3 DESCRIPTION OF CONTRACEPTIVE PRACTICES

#### *Item 5.13: Number of children respondents had*

As indicated in figures 4.2 (a) and 4.2 (b), 31 (37,8%) females and 27 (38,0%) males had no children, one child or at most, two children. A conclusion could not be drawn as to whether these clients would not increase the number of children they had as the majority were single and could still have more children after marriage. It should further be noted that from these findings, the majority of adult respondents had none, one or two children although they could still increase their families as they were still within reproductive ages. Out of the 23 female adolescents, 10 (43,4%) had one or two children, implying that these adolescents were not using contraceptives at the time of their conception. In addition, 8 (34,8%) male adolescents admitted having one or two children, whilst 3 (8,7%) acknowledged having three children.

In spite of freely available contraceptives, however, close to half the total number of adolescents already had children, emphasising to the problem of

teenage pregnancies in this country.

***Item 5.14: Number of children respondents wished to have and their reasons***

From the analysis presented in figure 4.3 in item 4.14 of this study, the majority of both females and males, adults and adolescents expressed their wish to have two or three children. These findings suggest that women and particularly men do not want to have many children as evidenced by the reasons cited for the number of children they wished to have.

For the majority of clients, the high cost of living was the main reason for not wishing to have more than three children. They added that "everything is expensive and our modern children are demanding, they do not understand when told that there is no money to buy what they want".

Dreyer et al (1997:49) support this view, stating that young people prefer to limit their family sizes in order to have a higher material standard of living. Additional reasons indicated were that respondents felt they were aware of contraceptives which could be used to prevent unwanted pregnancies. This is in line with CDC (1999:232) which states that contraception allows individuals and couples to plan at least one aspect of their lives, which entails when to have children and how many. Such planning increases the likelihood that mothers and their children will enjoy the health benefits of having intentional rather than unintentional pregnancies.

***Item 5.16: Knowledge about contraceptives***

As indicated, the majority of respondents were informed about contraceptives. Depending on what and how much they knew about contraception, such information could influence their contraceptive practices. If the information they had was positive, then individuals or couples would probably benefit and be

motivated to use contraceptives effectively. Conversely, if negative, they would either use the method ineffectively or discontinue using it.

The respondents indicated the extent of information they had regarding contraceptives in response to item 4.17, stating the following contraceptive methods:

- condoms (50 females, 36 males)
- injections (42 females, 30 males)
- pills (35 females, 28 males)
- LAM (21 females, 16 males)

Common side-effects mentioned were

- condom breakages (8 females, 15 males)
- condom discomfort (6 females, 18 males)
- weight gain (22 females)
- amenorrhoea (20 females)
- continuous menstruation (15 females)

The conclusion drawn from these findings was that respondents were informed about some contraceptives. None of the respondents indicated having knowledge of Norplant. They lacked knowledge about emergency contraceptives as modern contraceptives that could be used to prevent unwanted pregnancies. Correct information is also essential as it may be a decisive factor determining how people will avoid unplanned pregnancies. Silberschmidt and Rasch (2001:1819) found that all the girls in their study except one illiterate girl knew several types of contraceptive measures, including oral contraceptives and injections. Their knowledge was superficial however, with a common belief that the pill should only be taken on the day of intercourse.

In addition, 75,0% of the respondents had used one or more forms of contraception, whilst 25,0% had never used contraception despite being made aware. Similarly Ehlers et al (2000:48) indicated that 60 (50,1%) of adolescents in their study knew about contraceptives and could mention:

- injections (46)
- pills (38)
- condoms (26)
- intra-uterine devices (6)
- sterilisation (2)

Such knowledge did not guarantee that all would use contraceptives effectively as it depended on what specific information they had about the contraceptive methods indicated. However, 48 (43,3%) respondents affirmed that they used

- injections (32)
- condoms (19)
- pills (16)

The results of the LRA yielded that knowledge of different contraceptives varied and that in some cases had a significant relationship with contraceptive practices, whereas with other contraceptive methods, knowledge could not exert any influence on the individual's use of contraceptives.

#### ***Item 5.18: Sources of information on contraceptives***

As indicated in items 4.18, mothers were the main source of information for both adult and young women and the media were the main source for the majority of adult and young men. Friends and sisters contributed to imparting information about contraceptives to both female and male adolescents.

Nevertheless health care centres, fathers and brothers did not play any role in

discussing contraceptives with respondents. This could deprive individuals of important information regarding contraceptives, particularly adolescents who may be staying only with fathers and brothers. Concerning health services, Ehlers et al (2000:59) suggest that contraceptive services, locations and times could be better advertised by including a pamphlet in the monthly water and electricity bills of households. Furthermore, other people could be informed by leaving pamphlets at clinics and shops in all areas, including informal settlements and rural areas, at youth clubs and beer halls.

With regard to media as a source of information, Simmons (1996:263) found similar results. Women who participated in the Matlab Project in Bangladesh acknowledged that in particular, the radio exposed them to new information and values regarding contraceptives and to a broader set of new influences and ideas.

#### ***Items 5.19 to 5.24: Contraceptive methods used***

The analysis of in item 4.19, indicated that both females and males were using contraceptives. The findings seem to correspond with the positive responses provided to item 5.16, which revealed that the majority of females and males were informed about contraceptives. The conclusion can therefore be drawn that the relationship between knowledge about contraceptives and contraceptive practices exists. The results of the LRA of the data indicate that knowledge about contraceptives exerted a significant effect ( $p<0,05$ ) on the use of contraceptives. This significant relationship suggests that individuals and couples who are informed about contraceptives, were more likely to use contraceptives effectively than those without such knowledge.

In their study, Adanlawo and Moodley (1999:99) found that 75,0% of the women who came for CTOP, were informed about contraceptives and had used one or other form of contraception. However, these women came for CTOP because they had used contraceptives inconsistently and ineffectively.

Although a significant number of respondents acknowledged using contraceptives, only a few respondents, including adolescents used other contraceptive methods such as the IUCD. Perhaps health care providers could dispel myths and fears about IUCDs, especially for adolescents who believe unfounded stories. The advantages of IUCDs, such as their long-lasting effect, no risk of forgetting as it will be in situ, no hormonal side-effects and no need to visit health care centres every month should be emphasised (Hatcher et al 1997:12-15).

The reasons given by respondents for not using contraceptives revealed that they were not correctly informed about contraceptives in spite of having indicated other sources of information in item 4.15. This lack of correct information about contraceptives could contribute to harbouring false fears about contraceptives and further inhibiting their contraceptive use.

The WHO (1996:18) refers to adequate information given to clients by highlighting aspects that should be pointed out during client counselling or health education to provide clients with better information about contraceptives. These aspects include understanding the correct use of the method, common side-effects, health risks and benefits of the method; signs and symptoms which would necessitate a return to the clinic; and information on return to fertility after discontinuing method use.

In addition, the majority of the females (65.4%) and males (40.6%) acknowledged preferring specific contraceptive methods and stated reasons for their preferences. Respondents indicated further that they were using the preferred contraceptives at the time of data collection.

***Items 5.25 to 5.27: Knowledge of female condoms, their availability and reasons for not getting condoms***

Slightly more than half the number of female respondents knew about the female condom although only three had actually seen, bought and used them.

Research suggests that the more choices women have available, the more likely they are to use a contraceptive method (Cates 1996:18; Fathalla 1994:245). This would suggest that augmenting prophylactic options will also increase the use of methods that prevent unintentional pregnancies. Some women may want to use modern contraception but fail to do so because many methods require visits to clinics which are often inaccessible. The availability and accessibility of the female condom may provide a solution to these problems.

In this regard, the need for the government to make free female condoms available becomes evident. Knowledge of female condoms without the means to get them does not solve the problem women have with risks of unwanted pregnancies. Female condoms afford women more control than the male condom because the woman herself uses the device. It is crucial that women have access to methods they can use for protecting themselves against unwanted pregnancies.

***Items 5.28 to 5.31: Perceptions about contraceptive methods***

Findings reported in table 4.10 of this study revealed that the majority of female respondents had positive perceptions about injections. These findings seemed to tally with those reported by Adanlawo and Moodley (1999:100) who found that the majority of women in their study had positive attitudes towards injections. According to Ehlers et al (2000:48) the majority of 94.6% adolescents knew and had positive attitudes towards injections. Of these, 62.2% 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 three months would be more feasible than monthly visits.

◆ **Perceptions about sterilisation**

Differences of opinions were reported by females regarding male sterilisation as compared to male perceptions. Their positive perceptions about male sterilisation were endorsed by the statements made implying that males should limit their endless procreation by compulsory sterilisation after having two or three children.

Males on the other hand, argued that male sterilisation should not be promoted, instead they stated that female sterilisation should be used as they felt it was better for women than men. In this regard Popenoe et al (1998:406) contended that effective fertility control programmes may be designed to fit with established traditions and life styles of the local population. The authors refer to the case of India where most people regard the hospital as the place to die. Sterilisation attract more business if they are set up in railway stations as they are traditional places for large groups to congregate. In addition, family planning festivals are held during which sterilisations are performed and other contraceptive methods are publicised. Incentives in the form of transistor radios are given to those who agree to sterilisation. Other similar strategies could be used to encourage men and women to be sterilised if they have two or three children.

◆ **Perceptions about the pill**

The analysis of items 4.28 and 4.31 indicated that respondents perceived the pill more positively following the injection. In this regard both adults and adolescents expressed similar sentiments.

With regard to adolescents, these results were contrary to findings by Wood et al (1998:26) who found that teenagers from their study regarded oral contraceptives as inconvenient and easily forgettable. These teenagers further indicated that forgetting to take one pill would probably result in pregnancy.

◆ **Perceptions about intrauterine contraceptive devices**

Perceptions about IUCDs were negative as indicated by the majority of 60,5% adolescents and 39,5% adults. These findings seem to correspond with the analysis of contraceptives used by respondents in item 5.19 of this section with regard to IUCDs. A few respondents, 8 (8,2%) were using IUCDs as compared to other contraceptive methods, implying that perceptions could influence behaviours. In line with the HBM, the perceived threat of using IUCDs influenced respondents negatively.

Duncan et al (1990:114) referred to the use of barrier methods of contraception, particularly condoms which have been heavily promoted as a result of HIV/AIDS pandemic. This has coincided with extensive publicity on the risks attached to the use of both the IUCD and the oral contraceptive pill. In this regard, if clients express negative perceptions about any of the contraceptive methods, nurses could assist positive information with emphasis on the advantages and benefits of using such a contraceptive method.

***Item 5.32: Perceptions about side-effects of contraceptives***

Clients had mixed perceptions about side-effects of contraceptives, depending on the type of contraceptives and their side-effects. Positive and negative perceptions of contraceptives can motivate or demotivate individuals or couples to use or fail to use contraceptives respectively. Furthermore, clients should be informed about the possibilities of side-effects related to the contraceptive method used to allay their fears and misconceptions about contraceptives. The

CDC (1999:236) recognises the importance of using contraceptives despite their side-effects by contrasting the significant risks of death from pregnancy-related complications with the risk of death from using contraceptives, which is exceedingly low. Indications are that some contraceptives may increase health risks by introducing hormones that affect the cardiovascular system or the development of some cancers, others may involve the risk of surgical or invasive procedures. At the same time, some contraceptives as such decrease health risks by providing protection against certain reproductive cancers or STDs and HIV infections. It should be emphasised that all contraceptives decrease the risk of maternal mortality from pregnancy-related causes.

***Item 5.33 to 5.36: Consultation of traditional healers for contraceptives***

In response to consultation of traditional healers, only 13,4% females and 5,6% males acknowledged having consulted traditional healers and only a few of these respondents admitted using medications prescribed by traditional healers. Traditional contraceptives may either be effective or ineffective, depending on what is used and how it is practised. How important these traditional practices are to clients depends also to a larger extent on where contraceptive services are provided. According to CDC (1999:246), people working in urban clinics and hospitals will probably see fewer individuals who actively use traditional means to prevent unwanted pregnancies. Findings from this study seem to be in line with this notion.

The majority of respondents, females, males, adults and adolescent thought it would not be ideal to consult traditional healers for contraceptive purposes and indicated that they would not use any of these methods. These respondents believed that oral medications prescribed by traditional healers might be harmful as evidenced by their reasons for not using such prescriptions.

Studies on traditional practices have reported positive and negative responses in this regard. In many rural areas of developing countries, the traditional

healer is the only health care practitioner accessible. The shortage and maldistribution of biomedical practitioners which results in inadequate health services in the rural areas have served as an impetus for governments to look at alternative health care systems (Ojanuga & Gelfand in Abdool-Karim et al 1994:14). Most biomedical practitioners and researchers, however, tend to associate traditional healing with myth and magic and a primitive culture that uses nonscientific techniques. They therefore view collaboration with or integration of traditional healers as a backward step (Abdool-Karim et al 1994:14). Other views are that there should be a nationally legislated policy to incorporate traditional healers in the primary health care system (ANC 1994a:12).

***Items 5.37 to 5.39: Emergency contraception***

From the analysis presented in chapter 4, items 4.37 and 4.38, it became evident that the majority of females and males, adults and adolescents lacked knowledge about emergency contraceptives, their availability and the fact that it should be taken within 72 hours after unprotected sex. A further concern was that only a minority of female adolescents had information regarding the dose, when and under what circumstances emergency contraceptives could be used. Emergency contraception has a significant role to play in the prevention of unplanned and unwanted pregnancies among all age groups, but its use is determined by a woman's or man's awareness and knowledge of its availability and its action.

The findings reported by Ehlers et al (2000:49) in the survey conducted among adolescent mothers in Gauteng Province of the RSA, revealed similar results in that 67,6% of these adolescent mothers did not know about the availability of emergency contraceptives and therefore could not use it. Similarly, Netshikweta (1999:18) found that 73,1% of student nurses in the Northern Province of the RSA had no knowledge about emergency contraceptives and that none of the respondents managed to access it in spite of the fact that they

were student nurses.

In addition, similar percentages of females and males felt that they would not use or encourage their partners to use emergency contraceptives. Respondents justified their reasons for and against their perceptions about emergency contraceptives. Although not all reasons stated were similar, most sentiments expressed were identical to those reported by Ehlers et al (2000:48) who found that adolescent mothers did not use emergency contraception as they feared that the baby might be malformed if they took pills, they did not believe that the pills would be effective and one did not have sufficient information to obtain these pills, their boyfriends wanted the babies, one respondent did not want the clinic sister to know about her sexual activities and another respondent indicated that her mother discouraged her from using emergency contraceptives.

The above information indicates a real need for more information about emergency contraception to be made available to women and men of all ages. These services would need to be advertised in clinics, at schools and possibly also during radio and television broadcasts. These services could be offered at 24-hour emergency care centres in all communities. Better utilisation of emergency contraceptives could reduce the need for legal and illegal CTOPs and could enable women and couples to postpone having children until they are ready socially, emotionally and financially to care for their children.

Respondents raised additional concerns about negative attitudes of nurses with regard to imparting information about emergency contraceptives to clients. These respondents indicated that they could neither use nor promote emergency contraceptives as they lacked information in this regard, and claimed they could not get details even if they asked nurses about it.

Above all, the availability of emergency contraception would enable all women to have their babies when they wanted them, with minimum disruptions to their

lives and schooling for adolescents. Further research should be conducted into the availability and accessibility of contraceptives, including emergency contraceptives from private pharmacies as well because this may be the first place where individuals may turn for help. A survey done among pharmacies and pharmacists in the Gauteng Province found that 56,3% 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). Proposals that emergency contraceptives be made readily available without a prescription were reported in the study of the effects of self-administering emergency contraception, which suggested that emergency contraception could be made available safely at home and added that it may reduce the risk of unintended pregnancies (Glasier & Baird 1998:4). According to Glasier and Baird (1998:1), 98,0% of the women who self-administered emergency contraceptives, used them correctly and found that making emergency contraceptives more easily available does not harm and could reduce 1,7 million unintended pregnancies, including the prevention of 0,8 million TOPs each year in the USA.

The need to provide accurate information about what emergency contraception is and how long after unprotected sex it can be used and how it can be accessed must be addressed in the Northern Tshwane region.

***Items 5.42 to 5.45: Knowledge about legalised termination of pregnancy services***

The legalisation of CTOP in the RSA in 1996 ushered in a new era where all women, young or old, rich or poor, rural or urban could access a safe, legal CTOP. Knowledge about the legalised CTOP services is imperative for women to utilise these services in the event of unwanted pregnancies. Findings regarding knowledge about CTOP services indicated that slightly more than half of the total percentage of females and less than half the total percentage of males knew about legalised CTOP. Such information could motivate women

to utilise these services rather than resort to illegal backstreet abortionists in the event of having unwanted pregnancies.

When considering the fact that the Choice on Termination of Pregnancy Act has recently been enacted in the RSA, the conclusion drawn from these results could be that the general public is gradually being informed about legalised CTOP although it could still be improved.

The majority of females (64,1%) and males (73,5%) indicated negative perceptions about CTOP and vowed that they would not utilise CTOP services nor encourage their partners to utilise these services. They justified their objections by citing various opinions which were summarised as, "CTOP being tantamount to murder and some believing that it was against their moralistic views and church doctrines to terminate a pregnancy".

Inadequate knowledge regarding CTOP, legalised and designated CTOP services indicate another need to educate women, men and adolescents about these services. Health services have a wealth of resources that, if applied correctly, could have an impact in reducing levels of maternal mortality and morbidity from unsafe abortions. A cooperative effort, founded in a clear community health perspective on CTOP services could offer a better course for the effective transferral of knowledge to combat this problem.

#### ◆ **Permission from partner to terminate a pregnancy**

Positive and negative opinions were raised regarding obtaining permission to terminate a pregnancy. The majority of females (52,0%) felt it was not necessary to obtain such permission from their partners and argued that in terms of the Choice in Termination of Pregnancy Act no 92 of 1996, they have the right to terminate a pregnancy without the permission of their partners. Similar sentiments were expressed by males (26,9%) who added that women

may legally terminate a pregnancy without their partner's consent.

Another dimension was that a minority of females (32,9%) believed that they needed permission from their partners, whilst the majority of 73,1% indicated that their partners should obtain permission to terminate a pregnancy from them. Females based their arguments on the fact that CTOP should be their joint responsibility as they needed the support from their partners to go through the traumatic experiences of terminating a pregnancy. Males felt that they needed to be informed as they had to support their partners socially, psychologically and financially. Similar findings were reported in a study of the role of male partners in teenage-induced abortion in Dar-es-Salaam (Mpangile, Leshabari & Kihwele 1993:35-38). The same study found that one third of the partners had advised the girls where to go for CTOP and almost half of them had paid the fees required for the service.

Myburgh et al (2001:32) found that biological fathers of their partners' termination of pregnancy, expressed powerlessness related to having a choice in the decision of CTOP and experienced emotional turmoil related to the impact of the decision on interpersonal and intrapersonal relationships. The conclusion that can be made is that CTOP does not only affect the women involved, but that partners should be involved as they are also affected by CTOP decisions of pregnant women.

#### ***Items 5.44 to 5.47: Condom use, availability and reasons***

With regard to frequency of condom use, the majority of 77,9% respondents always received condoms when needed, but only 29,7% adult males and 50,0% adolescents always used condoms when having sex, whilst 36,1% adults and 13,6% adolescents never used condoms. This would indicate them, that in spite of being readily available, condoms could not be used every time when having sex to prevent unwanted pregnancies as none of the respondents had indicated that they were intending to have a baby. The results of this study

seemed to correspond with those found in the following studies:

Peltzer (2001:55) found that among the first year students at the University of the North, RSA, almost 29,2% of the sample had never used condoms, 35,4% always used condoms, 19,8% did so regularly and 8,5% used condoms irregularly over a three month period.

In India, Sharma et al (1997:709) indicated that 74,0% of sexually active men had never used condoms, 24,4% were irregular users and only 1,8% reported regular use.

#### ◆ **Reasons for using condoms**

Positive reasons for using condoms consistently (see Chapter 4, items 44 to 46) suggest that the respondents were aware that condoms could prevent unwanted pregnancies as well as offer protection against STDs and HIV/AIDS infections. In terms of the HBM, the belief that following a particular health recommendation would be beneficial in reducing the perceived threat. Similar reasons for using condoms were found by Ndubani and Höjer (2001:109) in their study of sexual behaviour and STDs among men in Zambia, who indicated that the majority of 96,8% felt that condoms protected them against STDs. MacPhail and Campbell (2001:1613) found that protection against STDs and AIDS and the prevention of unwanted pregnancies were recognised by young and older women, who overcame social distrust of carrying female condoms and believed in their own norms and decision-making capacity.

#### ◆ **Reasons for not using condoms**

This study found that the main reasons for not using condoms during sexual intercourse were breakages and slippages, lack of trust of their partners, failure to enjoy sex, and lack of skill in using condoms which resulted in fear of using

them.

When used properly, condoms have been documented to be a fairly reliable method of contraception. Sharma et al (1997:711) found that among condom users, educational status and not regularity of condom use appeared to be the most important independent factor influencing knowledge about proper use. This is important since many of men who use condoms, obtain them from health workers or health care institutions. It is therefore imperative that the distribution of condoms should be coupled with education about correct use, and active efforts be made to dispel the myths and false beliefs associated with condom use.

***Items 49 to 50: Consistency in using contraceptives***

The respondents indicated that they were using a variety of contraceptive methods, such as the pill, injections, condoms and IUCDs, at the time of the study. It soon became evident that other methods, such as Norplant, the female condom and emergency contraceptives, were not being used. As indicated in chapter 4, item 49, respondents had no knowledge of these contraceptives, which were not available at their health centres.

Furthermore, as many as 39,2% of the female respondents were not using the contraceptives indicated consistently. This means that these respondents were at risk of having unwanted pregnancies even though they were using contraceptives.

Consistency in using contraceptives is an important aspect in the prevention of unwanted pregnancies. Clients should be fully informed about the significance of complying and taking contraceptives regularly according to the respective directions and that they should report to health centres for any untoward reactions without discontinuing the method on their own.

***Item 5.51: Travelling time to nearest hospital/clinic***

Most of the respondents, both women and men, spent the maximum travelling time of 1 to 15 minutes and 15 to 30 minutes. This means that there were health care centres in the residential areas (see section 5.6) in line with the principles of primary health care. Four respondents stated that they travelled between one and two hours to reach the nearest health care centre. Transportation to health care centres is closely linked to accessibility of health services. The closer the health care centres are to where the people live, attend school or work, the less time they will spend getting there and the less money will be spent on transport to the health care centres.

***Item 5.52: Nurses' attitudes towards clients***

The majority of both female and male adult respondents indicated that nurses were helpful, and provided health education and contraceptive information when required to do so. Similarly, the majority of female and male adolescent respondents found nurses helpful and polite and that they gave contraceptive information. Among both adult and adolescent respondents, significant numbers were not offered contraceptive information, and minorities of two or three adults and adolescents indicated that nurses were rude to them. The adult respondents generally found that nurses were keen to listen to their concerns regarding contraceptives, whereas the adolescents felt that nurses did not take the time to listen to them and seemed to be busy all the time.

With regard to adults, the findings correlate with Adanlawo and Moodley's (1999:99) and Engelbrecht et al's (2000:13) findings of positive nurses' attitudes towards adult clients.. Furthermore, findings on the adolescents indicated that nurses were helpful, gave health education, but did not provide contraceptive information and only a few found nurses rude. This contrasts with Kunene's (1995:49) and Wood et al's (1998:26) findings that nurses were

judgemental, arrogant and insensitive to adolescents' needs.

#### 5.4 CONCLUSION

This chapter presented the results of the structured interviews with clients presenting for contraceptive services. Particular attention was given to their contraceptive practices, their knowledge of different contraceptive methods, as well as how they perceived and used specific contraceptives. The availability, accessibility and affordability of contraceptives were also discussed including the reasons for the use and nonuse of contraceptives. Similarities and differences in contraceptive practices of adult and adolescent females and males were also highlighted.

The following conclusions were made with regard to contraceptive practices:

- adults had knowledge of, perceived and used contraceptives, such as the pill and traditional methods, more than adolescents
- adolescents had better knowledge and perceptions of and used modern contraceptives, such as Nur-Isterate, emergency contraceptives and CTOPs, more than adults;
- both adult and adolescent women and men had knowledge about condoms although adolescents used condoms more frequently than adults
- nurses' attitudes towards adults and adolescents were generally positive and encouraging for effective contraceptive practice by clients. Chapter 6 covers the qualitative analysis and discussion of the findings obtained during a focus group interview conducted with nurses working in health care centres in Northern Tswane.

## CHAPTER 6

### Analysis and discussion of qualitative research findings

#### 6.1 INTRODUCTION

This chapter presents an analysis and a discussion of the data that was collected from nurses who constituted the second category of the sample in phase 2 of this study. This data was collected by means of a focus group interview collect information about nurses' knowledge and perceptions of and experience with clients coming for contraceptives at the respective health care centres. The data focused on the contraceptive practices of the clients and how problems leading to nonuse, incorrect and inconsistent use could be addressed.

The findings are discussed in the context of the literature review (see Chapter 2).

#### 6.2 DATA ANALYSIS

The researcher utilised the reasoning strategies of inductive reasoning, bracketing, intuiting and finally, analysis to code and analyse the data collected. In inductive reasoning the researcher embarks on a research project without an explicit conceptual framework and uses general statements to guide the study. Once the data had been generated, the

researcher tried to discover relationships or patterns through close scrutiny of the data. The data was interpreted by means of inductive abstraction. Finally, the strategy resulted in a more systematic description of a conceptual framework (Mouton & Marais 1990:103).

Burns and Grove (2001:768) refer to bracketing in qualitative research as the process by which the researcher suspends or lays aside what is known about the experience of what is being studied. The researcher gets rid of preconceived ideas and reconstructs. The exercise facilitates seeing all the facets of the phenomenon and the formation of new constructs. The researcher has to avoid misinterpreting the phenomenon as the individuals experience it. This needs conscious awareness of self throughout the study. Intuiting is a process of actually looking at a phenomenon in qualitative research. Intuiting requires researchers to focus all their awareness and energy on the subject of interest, in order to allow an increase in insight. Intuiting requires absolute concentration and complete absorption with the experience being studied (Burns & Grove 2001:774). Persistent observation and prolonged engagement allow the researcher to be involved in order to understand the actual setting to look at the phenomena, with interest which in this study was clients' contraceptive practices. Analysis is a reasoning strategy with the objective of taking a complex whole and resolving it into its constituent parts. The constituent factors, relevant to understanding a phenomenon or an event, are isolated by means of analysis (Mouton & Marais 1990:102).

Qualitative analysis is an active process which requires the researcher to apply identified principles, strategies and cognitive methods to give meaning to and also to understand the relationship of data accordingly. This is done to avoid losing the richness of the findings and to capture the essential relationships among the statements in preparing an exhaustive description of the phenomenon under study. Tesch's model

(Cresswell 1994:154-155) was used to analyse the unstructured data. The eight steps of Tesch's model were adhered to throughout (see section 3.4.8).

The focus group interview was based on the following questions:

### **6.2.1 Modern contraceptive methods**

Modern contraceptives refer to westernised contraceptives which are used by women and men in modern times. These contraceptives include contraceptive pills and injections, IUCDs and condoms which are obtainable from health care centres and pharmacies. In addition, condoms are also made available and accessible in public places. Respondents were asked:

- (1) Which modern contraceptives do you supply to clients seeking contraceptives at your health care centre?
- (2) What information do you give to clients regarding the use of modern contraceptives?
- (3) What barriers do you experience regarding modern contraceptives?

### **6.2.2 Traditional contraceptive methods**

In this study, traditional contraceptive methods refer to contraceptives prescribed by and obtainable from traditional healers and (see section 2.2.2). Traditional contraceptives also include any contraceptive measures used in specific communities which are not supplied by clinics or other Western health care centres. Here the questions were:

- (1) Which traditional contraceptives are used by clients coming to your health care centre?
- (2) How effective are these contraceptive methods?
- (3) What guidance do you give to clients using traditional contraceptives?
- (4) Which barriers do you experience with clients regarding traditional contraceptives?

#### **6.2.3 Emergency contraceptive methods**

Emergency contraception is a safe and effective contraceptive method of preventing pregnancy after unprotected intercourse or a contraceptive accident. The following questions were asked:

- (1) Which emergency contraceptives do you supply to clients?
- (2) What are your perceptions regarding the use of emergency contraceptives?
- (3) What guidance do you give to clients regarding the use of emergency contraceptives?
- (4) Do you think any person who needs emergency contraceptives need contraceptives?

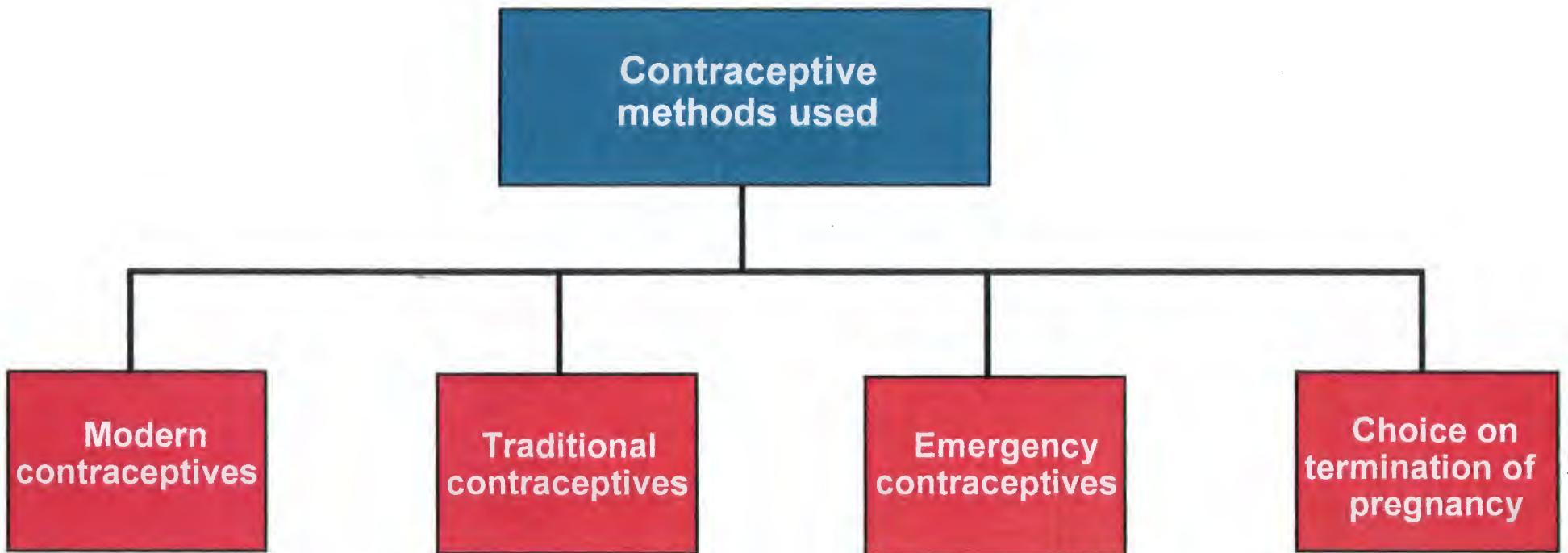
#### **6.2.4 Choice on termination of pregnancy**

Here respondents had to answer the following questions:

- (1) Can clients obtain legalised TOP at your health care centres?
- (2) What information or education do you give to clients regarding CTOP?

- (3) What are your perceptions of clients who choose to terminate a pregnancy?
- (4) Under what conditions do you advise clients to seek CTOPs?
- (5) What is your policy regarding the supply of contraceptives to adolescents?
- (6) What barriers do you experience when dealing with CTOP clients?

The focus group interview lasted over three hours. An independent coder was involved in the categorisation of the collected data. The independent coder then met with the researcher to reach consensus over identified themes and subthemes. Lincoln and Guba's (1985:314) method of testing trustworthiness was followed (see section 3.4.6).



**Figure 6.1:** Coding system for contraceptive methods

### 6.3 DESCRIPTION OF DATA FROM THE FOCUS GROUP INTERVIEW

Table 6.1 presents the categories and subcategories of the data collected from the focus group interview.

**Table 6.1: An overview of major categories and subcategories of the results of nurses providing contraceptives to clients**

MAIN THEME	CATEGORIES	SUBCATEGORIES
1 Modern contraceptives given to clients at health centres	<ul style="list-style-type: none"> <li>• The pill</li> </ul>	<ul style="list-style-type: none"> <li>• Types of pills available:           <ul style="list-style-type: none"> <li>— Triphasil</li> <li>— Ovral</li> <li>— Nordette</li> <li>— Lack of stock in some health centres</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>• Injections</li> </ul>	<ul style="list-style-type: none"> <li>• Depo Provera</li> <li>• Nur-Isterate</li> <li>• Nonavailability of Nor-plant at most health centres</li> </ul>
	<ul style="list-style-type: none"> <li>• Condoms</li> </ul>	<ul style="list-style-type: none"> <li>• Male condoms</li> <li>• Female condoms not available at health centres</li> </ul>
	<ul style="list-style-type: none"> <li>• Sterilisation</li> </ul>	<ul style="list-style-type: none"> <li>• Male sterilisations – only a few referred to hospitals</li> <li>• Female sterilisations – limited numbers done</li> </ul>
	<ul style="list-style-type: none"> <li>– IUCDS</li> </ul>	<ul style="list-style-type: none"> <li>• Only limited numbers inserted at health care centres</li> </ul>
• Provision of information regarding modern contraceptives	<ul style="list-style-type: none"> <li>• Information about:           <ul style="list-style-type: none"> <li>— Contraceptives used</li> <li>— Side-effects</li> <li>— Directions for use</li> </ul> </li> <li>• Lack of time to explain fully due to staff shortages</li> <li>• Failure of clients to report side-effects</li> </ul>	<ul style="list-style-type: none"> <li>• Specific information regarding the particular contraceptive used by client and specific side-effects</li> <li>• Lack of time to explain may result in:           <ul style="list-style-type: none"> <li>— Lack of adequate information regarding contraceptives</li> <li>— Inadequate use of contraceptives</li> </ul> </li> </ul>

MAIN THEME	CATEGORIES	SUBCATEGORIES
<ul style="list-style-type: none"> <li>• Barriers experienced with regard to modern contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of contraceptives including female condoms</li> <li>• Shortage of staff</li> <li>• Some men are not receptive</li> <li>• Resistance to talk about side-effects of contraceptives</li> <li>• Defaulting clients</li> <li>• Uncooperative clients</li> <li>• Knowledge deficit</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of stock results in: <ul style="list-style-type: none"> <li>— Overcrowding of neighbouring health centres</li> </ul> </li> <li>• Resistance results in: <ul style="list-style-type: none"> <li>— Inconsistent use of or abandoning the method</li> </ul> </li> </ul>
2 Traditional contraceptive methods used by clients	<ul style="list-style-type: none"> <li>• Natural contraceptives</li> <li>• Contraceptives prescribed by traditional healers: <ul style="list-style-type: none"> <li>— Douching after sexual intercourse</li> <li>— Solutions used for drinking after sexual intercourse</li> </ul> </li> <li>• Substances used: <ul style="list-style-type: none"> <li>— Rope worn around waist by client</li> <li>— Padlock on labias</li> <li>— Female genital mutilations</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Withdrawal, LAM, calendar method, abstinence</li> <li>• Solutions used for douching: <ul style="list-style-type: none"> <li>— Coca-Cola</li> <li>— Soapy or plain boiled water</li> </ul> </li> <li>— Drinking strong tea or coffee that has been prayed over by the priest</li> <li>— Rope soaked in mixture of menstrual fluid and solutions obtained from traditional healer</li> <li>— Padlock used to lock labias by client's husband to prevent penetration which might result in unwanted pregnancies during husband's absence</li> <li>— Cultural method used to prevent unwanted pregnancies</li> </ul>

MAIN THEME	CATEGORIES	SUBCATEGORIES
<ul style="list-style-type: none"> <li>Information given to clients regarding traditional contraceptives</li> <li>Effectiveness of traditional contraceptives</li> <li>Barriers experienced by nurses regarding traditional contraceptive methods</li> </ul>	<ul style="list-style-type: none"> <li>Information about: <ul style="list-style-type: none"> <li>Using safe methods</li> <li>Empowering women</li> <li>Positive reactions</li> <li>Negative reactions</li> <li>Reluctance of male clients to use some methods</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Safer methods: <ul style="list-style-type: none"> <li>LAM</li> <li>Withdrawal</li> <li>Abstinence</li> </ul> </li> <li>Women's empowerment: <ul style="list-style-type: none"> <li>About their rights to say no to unwanted sex, and to use contraceptives</li> </ul> </li> <li>Encouraged harmless contraceptives such as: <ul style="list-style-type: none"> <li>LAM</li> <li>Withdrawal</li> <li>Abstinence</li> <li>Rope around waist</li> </ul> </li> <li>Discouraged contraceptives such as: <ul style="list-style-type: none"> <li>Douching</li> <li>Padlock</li> <li>Drinking prescribed coffee or tea</li> </ul> </li> <li>Abstinence</li> <li>LAM</li> <li>Withdrawal</li> </ul>
3 Emergency contraceptives given to clients presenting at health centres	<ul style="list-style-type: none"> <li>Only two types of pills were given to a few clients who knew about emergency contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>Types named: <ul style="list-style-type: none"> <li>Ovral</li> <li>E-gen-C</li> <li>Other types, such as the IUCD, unknown</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Information given to clients regarding emergency contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>Information only provided to a few clients who knew about emergency contraception</li> <li>Clients without knowledge of contraceptives were not informed for fear of using contraceptives irresponsibly</li> </ul>	<ul style="list-style-type: none"> <li>Such information included: <ul style="list-style-type: none"> <li>Emergency contraceptives to be given within 72 hours of unprotected sex to be used only in emergencies</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Nurses' perceptions about emergency contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>Positive perceptions</li> </ul>	<ul style="list-style-type: none"> <li>Positive <ul style="list-style-type: none"> <li>Emergency contraception is better than having unwanted pregnancies</li> </ul> </li> </ul>

MAIN THEME	CATEGORIES	SUBCATEGORIES
	<ul style="list-style-type: none"> <li>Negative perceptions</li> </ul>	<ul style="list-style-type: none"> <li>Negative           <ul style="list-style-type: none"> <li>— Encourages protected sex (male condoms)</li> <li>— Unreliable method</li> <li>— Emergency contraception is tantamount to murder</li> <li>— Uncomfortable feeling about emergency contraception</li> <li>— General hatred towards emergency contraception</li> </ul> </li> </ul>
4 Choice in termination of pregnancy	<ul style="list-style-type: none"> <li>Provision of CTOP services:           <ul style="list-style-type: none"> <li>— Only two hospitals were designated to conduct CTOPs in the area where the study was done</li> <li>— Nurses working at CTOP units are not allocated but had to volunteer</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>— Clients referred from clinics to these hospitals</li> <li>— Some clients go directly to these hospitals when in need of CTOP services</li> <li>— Only a few nurses volunteer to work at CTOP units</li> </ul>
	<ul style="list-style-type: none"> <li>Information imparted to clients</li> </ul>	<ul style="list-style-type: none"> <li>Information regarding CTOP and contraceptives</li> </ul>
	<ul style="list-style-type: none"> <li>Perceptions about clients who chose to terminate a pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>Perceptions about clients who choose to terminate a pregnancy:           <ul style="list-style-type: none"> <li>— Positive perceptions</li> <li>— Negative perceptions</li> <li>— Ambivalent perceptions</li> </ul> </li> </ul>

MAIN THEME	CATEGORIES	SUBCATEGORIES
• Barriers regarding CTOP	<ul style="list-style-type: none"> <li>• Overcrowding of health care centres</li> <li>• Failure of health care centres services to function in spite of being designated</li> <li>• Repeat CTOPs</li>   <li>— Being branded "murderers" or "serial killers" by some colleagues and community members</li> </ul>	<ul style="list-style-type: none"> <li>• Barriers result in: <ul style="list-style-type: none"> <li>— Overburdening staff</li> <li>— Poorly informed clients</li> <li>— No time to provide quality care</li> <li>— Increased backstreet abortions</li> <li>— Noncompliance in using contraceptives</li> <li>— Nurses involved feel threatened</li> </ul> </li> </ul>
• Policy regarding the supply of contraceptives	<ul style="list-style-type: none"> <li>• Policies regarding: <ul style="list-style-type: none"> <li>— Contraceptives</li>   <li>— Choice on Termination of Pregnancy Act no 92 of 1996</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>— Any client coming for a contraceptive method from 14 years or even younger</li> <li>— No half dose injections given</li> <li>— Counselling regarding CTOP</li> <li>— Correct use of contraceptives, mainly adolescents</li> </ul>

#### 6.4 DISCUSSION OF FINDINGS

In discussing the findings in the various categories, the examples given by respondents are quoted verbatim in order to highlight the quality of the description. The following major themes and subthemes emerged:

◆ **Theme 1**

● **Modern contraceptive methods and practices**

Respondents indicated various modern contraceptives which included injections, pills, condoms, spermicides, sterilisation and IUCDs. However, they expressed concern about other

contraceptives such as Norplant and the female condom, which were not available from their health centres: As one respondent stated:

I was embarrassed one time when a client came and asked for Norplant to be inserted on her arm. I had no clue what she was talking about. She was more informed about it because she even demonstrated its rod like structure and indicated that it's a very good contraceptive which lasts for five years.

Another respondent added this way:

This reminds me of female condoms. They are so scarce, we only have one for demonstrating to clients. Most clients would actually ask for the only condom stating that they have never seen one ... I mean even with staff, most nurses do not even know how a female condom looks like and yet we should inform clients about how they work, when to put it on and the technique of inserting a female condom.

Furthermore, respondents indicated that lack of stock in neighbouring clinics posed an added problem of overcrowding at their clinics. Health care providers should keep abreast of the latest developments to be in a better position to motivate and order new contraceptives on the market. With regard to female condoms, it is imperative that they be made freely available for women to take further responsibility of their protection and prevention of unwanted pregnancies.

The WHO (1997:30) contend that information must be available for all, including potential users, service programme managers and community leaders and groups. Strategies for obtaining the product and making it available at an affordable price must be in place. Furthermore, contraceptives must be made accessible to

potential users together with the information and counselling required to use the method appropriately.

- **Client education or information given regarding modern contraceptives**

The importance of educating clients about specific contraceptive methods was shown by respondents who agreed that they explain every detail regarding the contraceptive method given to clients.

This was evidenced by the following:

We explain everything about the particular method, especially to new clients ... we tell them about side-effects, reassure them if anxious - and explain the importance of honouring return dates.

Other information:

I actually show them the pack and show them how to take the pill starting from day 1, 2, 3 and so forth ... hmm ... colleagues don't take these clients for granted ... you may think they know only to get surprises. I had a client who was just taking any pill from the packet as she wished without following the sequence. When I asked her why she did that, she said she did not think it was wrong to do that ... nobody had told her how to take those pills.

- **Barriers experienced by nurses with regard to modern contraceptives**

- **Noncompliance and irregularity of contraceptive use**

Respondents indicated that the noncompliance of some clients using the pill and injections as problematic and causing friction between themselves and clients. Common problems reported by

respondents were that young girls often defaulted to come on specified return dates claiming that they did not have time or displaying negative behaviour when questioned. This was highlighted in the following statements:

Most of these young girls do not always comply or come on specified dates ... and when you ask, they just become aggressive. We explain the importance of taking pills regularly and consistently or come for injections on certain days, but they just ignore the dates or change dates on cards ... the next thing, they fall pregnant and end up in termination units.

This concurs with Wood and Jewkes (2000:13), who found that adolescents in the Northern Province defaulted as a result of disruptive side-effects, such as amenorrhoea, weight gain and heavy bleeding. In some instances, adolescents stopped the contraceptive method without informing the nurse.

➤ **Resistance of clients to contraceptive use**

Respondents indicated resistance from both female and male clients pertaining to sterilisation and condom use. They reported that some of these clients harboured myths about these contraceptives:

When you encourage some of these men who have more than four children to consider sterilisation ... they tell you that you want to destroy their sexuality ... they do not want anybody to interfere with their manhood ... it's against their culture as men were never stopped to have as many children as they wanted.

Almost all the respondents expressed concern about problems expressed by their clients with regard to male condoms. The respondents stated that something needs to be done from

government level to provide good quality condoms as their clients would not listen to their guidance on how to use condoms and the importance of consistent use of condoms to prevent unwanted pregnancies.

One respondent stated:

Every time we give health talks about the correct and consistent use of condoms, both female and male clients complain about the poor quality of condoms. Clients allege that condoms from health services break easily, slip off and are uncomfortable to use.

Another respondent added:

I think we need to have more males to provide contraceptive services mainly to male counterparts, because males don't even pay attention to female nurses ... they feel so shy and belittled when we show condoms and explain how to put them on and take them off.

Additional comments made by respondents included:

Some women actually tell you that they don't want their partners to use condoms as they don't feel safe or protected ... these condoms are loose and slippery, what if he becomes hyperactive and it's left in the womb?

Both men and women should participate actively and encourage one another in using contraceptives effectively. When used properly, condoms are reported to be a 88,0% to 96,0% reliable method of contraception (WHO 1995:8).

- **Nurses perceptions regarding modern contraceptives**

Respondents expressed various views about modern contraceptives which were categorised and almost all indicated positive perceptions. Having positive perceptions about modern contraceptives could motivate clients to be positive and even use such contraceptives consistently to prevent unwanted pregnancies.

I take time ... enough time to explain the importance of using contraceptives ... I mean in addition to promoting good health, using contraceptives has advantages such as enjoying sex without unnecessary complications ... they are free of charge, hospitals and clinics are available to all ....

I work with school girls ... I don't just inject Nur-Isterate for the sake of doing it. I give thorough health talks, indicate the significance of using contraceptives correctly and encourage open communication. At times I win or lose ... but I take it they are kids and need to be guided. I stress the importance of using contraceptives instead of resorting to CTOP.

According to Smith (1995:138) and Orr (1995:140), fertility regulations should be aggressively propagated in South Africa to avoid abortions. Specific emphasis on female education and counselling regarding contraceptive information and services should be a priority.

- ◆ **Theme 2: Traditional contraceptive methods and practices**

Respondents indicated a variety of traditional contraceptive methods practised by clients coming from different areas.

Our clients seem to prefer LAM to withdrawal or calender methods. They always want to know more about how to use it and at times they use it jointly with abstinence ... and depending on the health status of the woman, we encourage the use of these methods after thorough explanations.

I had a client ... a young girl who said she was using a sanitary pad soiled with her menses by her grandmother who had apparently gone to an inyanga. She said her grandmother dug a hole in their yard and buried the pad when she went for grade 8 stating that she's protecting her against misuse by boys. She came to the clinic to get an injection as she could not trust the pad protection.

At one clinic where I used to work, one day a woman came with a padlock inserted on her labias by her husband ... and it was locked. The doctor did a vaginal examination with the lock in situ. Seemingly the purpose of the padlock was to prevent the woman from having sex with other men whilst the husband was away.

Other traditional methods used were specific church prayers, drinking strong tea or coffee prayed over by church leaders for followers of the ZCC, Coca Cola and soapy douching after unprotected sex, female genital mutilation, sex per rectum and tying a rope soaked in menstruation and herbs around the waist (see Table 6.1).

- **Client education regarding traditional contraceptive methods**

Some traditional contraceptive methods were promoted whilst others were discouraged by nurses. They generally felt that abstinence, LAM and withdrawal could be encouraged. Other methods indicated by clients were not encouraged by nurses.

Women should be assisted and empowered about their rights ... some women do not know that they have the right to say no to their partners when forced to engage in unwanted practices.

Women should be fully informed about their reproductive health, bodies and know how to protect themselves by using appropriate modern contraceptives ... we have that responsibility as health care professionals to understand their plight and take the challenge.

These findings are supported by Wood and Jewkes (2000:16), who found that adolescents in the Northern Province of the RSA used medicated ropes around their waists, prayers and "inyanga" medications to prevent unwanted pregnancies.

In their study in the Gauteng Province of the RSA, Silberschmidt and Rasch (2001:1823) also found that sexually active girls used strings in which they made knots tied around their waist as contraceptive means. One knot represented one year, so that if the girl wanted to prevent pregnancy for more than one year, she tied the required number of knots

- **Barriers experienced by nurses regarding traditional contraceptives**

Some methods such as withdrawal and LAM were found to be unpopular amongst black males. Respondents indicated that males failed to use condoms when having sex even though LAM was not practised fully nor was withdrawal used for preventing pregnancies. This implied that males engaged in unprotected sex and women were at risk of having unwanted pregnancies.

Educating of men on the use of different alternatives, such as condoms, should be included in health education programmes. Adequate information should also be made available to the community about natural and modern methods of contraception.

- **Nurses perceptions towards use of traditional contraceptive methods**

Compared to modern contraceptives, the respondents had negative perceptions about the use of most traditional contraceptive methods, which they regarded as unacceptable and that they should not be endorsed.

Let us join hands to discourage the use of hazardous methods such as padlocks, soiled pads and ropes. Other methods may be accommodated in the absence of modern contraceptive methods ... these may be LAM, withdrawal, abstinence and condoms could be used in addition as a method mix.

It must be pointed out to clients that these methods are not effective because we still see lots of clients with unwanted pregnancies whilst using these traditional methods ... I mean, except for abstinence, most of these traditional methods are just psychological.

According to the CDC (1999:423), health care providers should be fully informed about traditional contraceptive methods so that they are able to guide and recommend appropriately certain contraceptive methods, while discouraging harmful medications used for contraceptives. The CDC (1999:923) adds, however, that the cultural values and locations of clients should be considered, particularly in rural areas where traditional healers may be the only health care providers. Perhaps programmes and

health education regarding contraceptives could be offered to traditional healers to improve their services, particularly where they are the only providers of care.

◆ **Theme 3: Emergency contraceptive methods**

Although there are different emergency contraceptive methods, respondents indicated that they were only aware of two methods: Ovral and E-gen-C, which they recommended to clients. They added that most clients were not aware of the emergency contraceptives that could be used after unprotected sex and therefore could not request them from nurses.

● **Client education regarding emergency contraception**

Very little came out of this as respondents indicated that most clients were not aware of emergency contraception. The respondents had some knowledge about emergency contraceptives that could be used within 72 hours after unprotected sexual intercourse at intervals of 12 hours. Strikingly, all except two nurses, acknowledged that they were not in favour of informing clients about emergency contraception as they maintained that clients would stop using contraceptives and resort to emergency contraceptives.

I personally ... (looking around at others) do not tell clients about emergency contraception. My view is that, already I have lots of problems with clients who do not comply ... they hardly come on due return dates ... they default giving all sorts of reasons. If I tell them about emergency contraception, will I not be encouraging them to default and use it repeatedly like contraceptives?

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 ... what will I say if clients ask questions needing more information about emergency contraception?

According to these nurses, one of the arguments against sharing information about emergency contraceptives was that it would be taken irresponsibly by women. This argument is not supported by Glasier and Baird (1998:4) who conducted a self-administration trial of emergency contraceptives in Edinburgh. They investigated how women might behave were emergency contraception more widely available and the effect this might have on numbers of unwanted pregnancies. The women were assigned randomly to the treatment group, given a packet of emergency contraceptives with instructions to use, a contact telephone number and a notification form to complete if they used the product or the control group. The control group was given information about emergency contraceptives and where to obtain them, and a notification form.

The study found that the treatment group was no more likely than the control group to use emergency contraceptives more than once, that is 11,0% compared to 12,0% in the control group. The treatment group's use of other contraceptive methods was no different from that of the control group's – they did not abandon more usual methods of contraception in favour of self-administered emergency contraceptives. Glasier and Baird (1998:1) maintain that making emergency contraceptives more easily obtainable does no harm and may reduce the rate of unwanted pregnancies. They calculated that the widespread use of emergency contraceptives could prevent 1,7 million unintended

pregnancies and 0,8 million TOPs each year in the USA.

- **Perceptions about emergency contraception**

- **Positive perceptions (n = 2)**

Only two nurses expressed positive perceptions about emergency contraception. They indicated that all clients presenting for contraceptives should be informed about this method to allay fears, anxieties and even risks of going for illegal TOPs.

Lets give them a chance and see how they will behave after being told about emergency contraception ... I mean not all clients can be irresponsible. Why can't we abandon old ideologies? ... This is change and a challenge to all of us. If it is used in advanced countries, we can learn from them.

Emergency contraception could relieve women of continual stresses and fears of unwanted pregnancies if they are adequately informed about how and under what circumstances it should be used. In the UK, emergency contraception was introduced in 1984 and various studies relevant to its use have been conducted with success (Quinn 1999:39).

- **Negative perceptions (n = 8)**

Eight nurses expressed discomfort and insisted that they would not encourage clients to use emergency contraceptives even after unprotected sex. They maintained that emergency contraception is tantamount to murder because conception has already 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 ... it's against my principles and my church doctrines. I mean the fact that women experience nausea and vomiting implies that there was conception, which was then interfered by emergency contraceptives.

Inaccurate information about emergency contraceptives still persists among nurses. This lack of correct information creates obstacles in the use of emergency contraceptives. Some nurses indicated that they were not aware that they could use Ovral for emergency contraception and argued that their health care centres could not afford to get E-gen-C in stock (Wood & Jewkes 2000:15).

➤ **Ambivalent perceptions (n = 2)**

Two respondents indicated their reactions towards emergency contraceptives. They felt that providing emergency contraceptives depended on the client's 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.

I really feel uncomfortable to give emergency contraceptives to the same clients every other day ... I mean an accident can occur once or so, not every day. Why can't people take contraceptives effectively with no hassles?

◆ **Theme 4: Choice on termination of pregnancy (n = 5)**

With regard to legalised CTOP services, five out of twelve nurses agreed that their services offered CTOP services whilst the remaining seven respondents were only referred clients for CTOP, to designated health care centres. Out of the seven, five respondents added that they did, however, offer precounselling before referring clients to respective CTOP health care centres, and two indicated that they rarely got clients seeking CTOP services.

● **Client education regarding choice on termination of pregnancy**

All respondents were of the opinion that CTOP should not be used as a contraceptive method. They stated that this was part of their health talks and counselling they provided to clients coming for CTOP at their services. Respondents described client education regarding CTOP:

We consider pre- and postcounselling to be very important for CTOP clients to assist them to go through the traumatic process of terminating a pregnancy and thereafter to continue with her life without difficulties

Clients are encouraged to use contraceptives regularly to prevent unwanted pregnancies ... and consult at neighbouring health services if in doubt about contraceptives.

● **Barriers experienced by nurses in provision of care to CTOP clients**

There are various barriers that adversely affect the provision of

quality care to CTOP clients. These should be avoided or overcome if designated facilities for CTOP are to be utilised effectively. The subcategories that emerged included lack of knowledge regarding the legalisation of CTOP services, lack of resources for providing CTOPs, nurse-client conflicts and being branded by colleagues and community members.

➤ **Lack of knowledge regarding the legalisation of termination of pregnancy services**

Respondents acknowledged that most clients were not aware that they could get safe, legalised access to CTOP services at health centres. A considerable number of clients come to the CTOP units as referrals from gynaecological units or directly from outpatient departments with complications from backstreet abortionists.

During health talks about CTOP, I usually ask clients to mention any information they have about CTOP and their sources of information in this regard. In most occasions the majority of respondents state that they did not know about the CTOP services or that they were afraid to ask nurses about these services.

Widespread information about CTOP and contraceptive services should be made available at schools, workplaces and communities to inform adolescents and adults. Similarly, Poggenpoel et al (1998:5) suggested that adequate information should be made available to the community and added that showing videos to communities at certain meetings could assist in spreading information about CTOP.

Lack of adequate information about the Choice on Termination of Pregnancy Act by health care providers creates additional obstacles for its effective implementation. Some respondents indicated that they did not have full details about the Choice on Termination of Pregnancy Act 92 of 1996, such as how and where to refer clients because their health services were not involved in terminating pregnancies. Consequently, clients end up being referred to the wrong health care centres, which results in it being too late to undergo the procedure. In terms of the Choice on Termination of Pregnancy Act 92 of 1996, pregnancy may be terminated upon the request of a woman during the first 12 weeks of the gestation period of her pregnancy. From the 13<sup>th</sup> up to and including the 20<sup>th</sup> week of the gestation period, if a medical practitioner, after consultation with the pregnant woman meets the criteria (as indicated in section 2.4.10 (b) of this thesis). De Pinho and Hoffman (1998:790) state that primary health workers, including general practitioners, nurses, particularly those working in community health care centres, and community health workers must ensure that women are able to access CTOP services correctly. The Reproductive Rights Alliance (RRA) publishes the designated centres for CTOP in the RSA, statistics and additional details about the Choice on Termination of Pregnancy Act no 92 of 1996 regularly to inform health care providers and members of the communities about CTOP. Copies of these journals, pamphlets and posters with information about CTOP should be displayed at all health care centres to reach all concerned (RRA 1999:16).

➤ **Lack of resources for providing termination of pregnancy services**

Increasing the availability of CTOP services and trained nurses are critical to ensure that women's needs are met at primary health care level. All the respondents expressed concern about the inadequate resources in terms of personnel and facilities for CTOP which hampers their delivery of quality care to CTOP clients. This can be seen in their responses:

At our hospital, we are only two nurses who volunteered to work at CTOP units. If one nurse is off duty, then you have to do everything ... I mean starting from precounselling, procuring the termination, that caring aspect and end with postcounselling ... it becomes too heavy.

More nurses should be encouraged to participate in CTOP services to overcome shortage problems.

Jewkes, Fawcus, Rees, Lombard and Katzenellenbogen (1997:230) contend that health planners and managers should ensure that health facilities are accessible with adequately trained personnel, having sufficient resources for provision of health care needed to provide better care to CTOP clients..

Dickson-Tetteh (1999:20-21) points out that midwives were identified as a critical category of health care providers that could ensure that CTOP services were available at PHC level and therefore accessible to all. The author adds that all provinces have developed a three-year implementation plan for the programme to develop the capacity to provide safe, efficient and accessible CTOP care services in public hospitals and clinics.

This programme further aims at addressing shortage of personnel by appropriate training to ensure that good quality care is provided to all clients.

Additional problems are compounded by those health care centres that fail to provide CTOP services in spite of having been designated by the National Department of Health to offer these services. As a result, a few health services which do provide CTOP services become overloaded with clients and cannot offer quality service. The government and the relevant health services should provide the necessary interventions to address this problem. Providing quality CTOP care entails offering post CTOP contraceptive services which would probably address the problem of repeat CTOPs and inform other community members about the significance of using contraceptives effectively.

- **Nurse/patient relationships**

Respondents expressed concern about the number of repeated CTOPs by the same women, especially adolescents. This often created conflicts between nurses and clients as one respondent indicated:

The big quarrel comes when you question them about repeated CTOPs. They state that the CTOP Act does not limit the number of CTOPs a woman should have. Even when you indicate the dangers of repeat CTOPs, it sounds as if you are just threatening them. Once or twice should be enough ....

I personally have serious problems with repeaters ... I mean if you don't set limits, you'll end up doing the same procedure to the same clients every other day.

Altafut (in Poggenpoel et al 1998:5) found that within nine months of the procedure being legalised in New York some women were already having their third legal abortion and it seemed that women couldn't care less about their unborn babies, having used abortion for birth control even when contraception was easily available to them.

In the RSA, contraceptives are freely available and accessible to the majority of citizens (DOH 2000:12). All individuals in the reproductive age should therefore use contraceptives effectively and consistently to prevent unwanted pregnancies, which often result in CTOPs. There is a need to review certain sections of the Choice on Termination of Pregnancy Act no 92 of 1996 particularly regarding the number of CTOPs a woman could have.

- **Being branded by colleagues and community members**

All five nurses involved directly with CTOP clients expressed their concern about the untoward reactions they heard and received from their colleagues and some community members.

A pregnant woman went to a health centre apparently looking for a unit for CTOPs. A nurse said to her: I am not a baby killer, go to unit X, you'll find serial killers there.

I was on my way from work and met a group of men talking ... suddenly when I came closer they started swearing and passing remarks about hospitals which are so negligent ... killing patients and even unborn babies. How could we trust people who kill our children ... they asked as I passed ... I was so threatened.

Negative and judgemental remarks by colleagues are compounding problems for nurses who are willing to provide care

to clients. There is a clear need for continual information and clarification about CTOP and the Choice on Termination of Pregnancy Act no 92 of 1996. The Reproductive Rights Alliance (1998:2) supports the need for continual values clarification workshops to assist nurses in attitudinal changes towards CTOP. Similarly, Engelbrecht et al (2000:10) found that nurses who attended values clarification workshops were more positive and had improved their effectiveness in dealing with CTOP clients and community attitudes.

- **Nurses' perceptions towards termination of pregnancy**

It is evident that CTOP entails a number of controversial issues, causing wide-ranging differences in opinion among health care providers. Respondents expressed a variety of perceptions towards CTOP which ranged from positive, negative and ambivalence.

- **Positive perceptions (n = 7)**

Seven nurses portrayed positive attitudes, stating that legalising CTOP was a breakthrough for women as opposed to their negative perceptions of emergency contraception. They indicated further that CTOP is justified and could save women from using backstreet abortionists.

I am so involved and passionate about working with CTOP clients ... Women can now access safe, legal abortions without risking their lives. If you think of how many women have experienced complications and died from illegal abortions, you'll appreciate that the CTOP Act has brought significant changes to women's lives.

Engelbrecht et al (2000:10) support CTOP as an important step and human right. In this study, 14 out of 16 service providers felt positive towards the Choice of Termination of Pregnancy Act, 92 of 1996; and 11 out of the 14 added that their work morale was good.

➤ **Negative perceptions (n = 3)**

A few respondents differed vehemently in their views, mainly on the justification of CTOP and preservation of human life, as well as the religious and moral problems regarding CTOP as can be seen in their responses:

I want to repeat what I said with emergency contraception ... that CTOP is murder. I cannot condone murder ... my duty is to bring life and not end it.

According to Orr (1995:40), moral values and belief systems should not be imposed on patients. No nurse should be forced to perform or be part of an abortion. Nurses working with CTOP clients have the right to choose by volunteering and not being forced.

In this regard, values clarification workshops could assist by informing nurses about changing mind-sets when dealing with CTOP clients.

➤ **Ambivalent perceptions (n = 2)**

Two nurses were ambivalent and indicated that at some stages they felt it necessary to support the Choice on Termination of Pregnancy Act 92 of 1996.

I do not know whether to be polite or harsh to these clients. If you are polite to them, they think you are endorsing what they have done and encouraging them to use CTOP as a substitute for contraceptives. If you are harsh to them, it seems you are pushing them back to the backstreet abortionists.

In contentious issues, such as CTOP, nurses might be confronted with the ethical dilemma of what is the correct decision to make. According to Botes (2000:29), nurses who think in a rational, purposeful manner can justify their decisions on rational grounds and logical reasoning could assist them to make appropriate decisions when dealing with CTOP clients.

Nurses should therefore think, reflect and make responsible decisions when involved with CTOP clients. This could assist them to feel better without guilt feelings.

- **Policies regarding contraceptives to adolescents**

In response to their health centres' policies regarding adolescents and contraceptives, all the respondents indicated that they gave contraceptives according to the needs and medical prescriptions. With regard to half doses, the majority of the respondents acknowledged that they were not aware of any half dose contraceptive injections being given to adolescents.

After data collection, member checking was done with six nurses who participated in the focus group interview. On further exploring the issue of policies about adolescents, two nurses confirmed that although it did not happen at their present health care centres, they used to give half doses of Depo Provera injections to adolescents in the absence of Nur-Isterate. They

indicated that it was the norm as there were no policies regarding contraceptives given to adolescents. The rationale for giving half dose injections was that the effect would not be as strong as when giving full doses.

Three of the six nurses explained that there were no specific policies for adolescents at their health care centres and that they treated adolescents just like adults. With regard to half dose injections, they revealed that adolescents were given double doses of Nur-Isterate so that the effect could last longer. Instead of reporting back after six weeks, they were told to come back after 12 weeks. They indicated that they acted this way because in most instances their clinics did not have enough stock even though they ordered as much as they needed. These nurses added that lack of stock resulted in most clients travelling long distances to seek contraceptives at different health care centres as the nearest ones might not have any stock.

The respondents indicated, however, that they provided counselling to all clients, including adolescents. They expressed concern about the apparently high level of adolescent pregnancies in most communities and other health risks, such as STDs and HIV/AIDS, in spite of the freely available contraceptives.

It is a policy at our institution to provide counselling and explain fully to these adolescents about sexuality issues including contraceptives, abstinence and so forth ... At times I feel discouraged and think that we are not doing enough when you see all these mishaps about these young girls.

Policies regarding contraceptives should be made available at respective health care centres and all nurses involved in contraceptive services should be conversant with such policies. Lack of appropriate information could lead to unprofessional action as indicated by the respondents who stated that there were no policies at their health care centres.

#### **6.5 CONCLUSION**

This chapter presented the results of the focus group interview with nurses involved with clients presenting for contraceptive and CTOP services.

Although the nurses were informed about most contraceptive methods, their lack of knowledge on methods such as Norplant and emergency contraceptives, led to a lack of guidance on these methods. The respondents' perceptions of various contraceptive methods indicated that they viewed modern contraceptives more positively than traditional contraceptives. Regarding CTOP, there were diverse opinions although most of the respondents viewed CTOP positively. They also described various barriers regarding the implementation of contraceptive policies.

The majority of the nurses were not willing to advise clients about the use of emergency contraceptives. Some nurses experienced moral problems in administering emergency contraceptives. The nurses also revealed a lack of clear policies on supplying contraceptives to adolescents.

The next chapter presents the conclusions, limitations and recommendations.

## CHAPTER 7

### Conclusions, limitations and recommendations

#### 7.1 INTRODUCTION

Chapter 1 presented the nature of the problem and the rationale and objectives of the study. Unwanted pregnancies pose a problem throughout the world, including Northern Tshwane in the RSA.

These unwanted pregnancies are mainly terminated legally or illegally. Unwanted pregnancies occur in spite of the expanded availability of contraceptive methods, the commitment of governments and all involved in population control including health care providers.

This study was conducted to determine and describe the contraceptive practices of women and men in Northern Tshwane, Gauteng Province.

An extensive literature review on contraceptives, contraceptive practices and CTOP, internationally and locally, was done. The HBM was used to explain why people use or fail to use contraceptives (see figure 2.1). Literature control was done pinpointing the similarities and differences to validate the research findings.

## 7.2 RESEARCH DESIGN AND METHOD

The study was conducted in two phases. In phase 1, an exploratory, descriptive and quantitative research design was used to the research problem. The population and sample comprised all women and men (adults and adolescents) who presented for contraceptive and CTOP services at the selected health care centres in Northern Tshwane, Gauteng Province.

A convenient sample of 83 females (60 adults and 23 adolescents) and 71 males (48 adults and 23 adolescents) who participated in the study, were selected from the three health care centres. A structured interview schedule was developed, pretested and used for data collection. Data was collected at these health care centres on predetermined dates and times during June and July 2001, by the researcher and research assistants.

The Statistical Package for the Social Sciences (SPSS) was utilised to obtain computerised analyses of the data. A statistician was involved for computerisation of data. Content and inferential analyses were used including the Logistic Regression Analysis to ascertain relationships amongst certain variables.

### 7.2.1 Phase 1: Summary of research findings

#### ◆ Biographical data

The most important research findings concerning the personal characteristics of women and men presenting for contraceptives included:

- The majority (108) of the female and male respondents were adults and the minority (46) were female and male adolescents.
- The majority (55,0%) of females were single. Of the adult males, 56,3% were married, 37,5% were single and only one was divorced.
- The highest percentage of the respondents (43,9% females and 47,1% males) resided in the townships of Soshanguve, Mabopane and Ga-Rankuwa, informal settlements (26,8% females and 18,6% males), rural areas, (8,3% females and 18,6 males) and suburbs (13,4% females and 10,0% males), (9,8% females and 5,7% males). Residential areas had a significant effect ( $p<0,05$ ) on individuals' contraceptive practices suggesting that clients residing in areas where contraceptives are available, probably used contraceptives more effectively than clients who could not access contraceptives.
- A high percentage of the adult respondents (51,7% females and 52,1% males) had passed Grade 12 compared to adolescents (60,9% females and 56,5% males). Only 5,0% of females had no schooling while none of the males had no schooling.
- As many as 56,4% of the females and 46,4% of the males held tertiary education qualifications or were registered students at tertiary education institutions. The results of the Logistic Regression Analysis came close to the level of significance, implying that the level of education did not necessarily influence clients' contraceptive practices.

- The majority 39,0% females and 47,9% males were Tswana speaking followed by 25,6% females and 28,2% males who spoke Sotho. No significant relationship was found between home language and contraceptive practices.
- Although the majority of 18,5% females and 17,4% males were affiliated to Apostolic and Catholic Churches, respectively, most denominations were evenly represented. Clients from the ZCC and the Apostolic religions relied on prayers and drank water that was prayed over by their priests after having sexual intercourse, and Muslims discouraged the use of contraceptives.
- Most of the respondents (43,8% females and 63,4% males) were employed. Almost half the adolescent females and males were unemployed and were probably still at school. Slightly less than half the adult females and males were unemployed, which meant that they did not have any income. This meant that they could not afford to travel to the nearest health care centres for contraceptives.
- The majority of the respondents (54,4% females and 40,8% males) stayed with their children and mothers, respectively. Other members who shared households with clients included father, sister(s), brother(s) and partners. The maximum number of people found to be living with clients was eight. Living together with many people in a household could have influenced clients to consider using contraceptives effectively.

◆ **Clients' contraceptive practice data**

- Almost half of the female and male adolescents already had one or two children, including two male adolescents who had three children, thus indicating that they were either not using contraceptives or failed to use them effectively. This adds to the problem of adolescent pregnancies and early parenthood.
- A greater number of adult and adolescent females and males indicated a desire to have fewer children, that is two or three.
- Various reasons were given for their intentions to have fewer children. Although most reasons could influence clients' contraceptive practices, the most important were that the cost of living was high and that they were aware that contraceptives could play an effective role in limiting the number of children they wished to have.
- More than half the majority of adult females and males were informed about contraceptives. As many as 76,2% of female adolescents and 78,3% of male adolescents knew about contraceptives, which they could name, and their side-effects. Generally, females were more informed about contraceptive details than males. Although the respondents were informed about other contraceptives, the apparent lack of modern contraceptives, such as Norplant and female condoms, was evident as none of the respondents indicated having knowledge about these contraceptives. Only a small number of respondents knew about the IUCD, referring to it as the "loop".

- Of those respondents who had information about contraceptives, 31,3% of adult females and 38,9% of adolescent females obtained such information from their mothers while as many as 54,2% of adult males and 29,8% of adolescent males obtained contraceptive information from the media. Sharing information about contraceptives with clients was nonexistent from fathers and brothers, implying that those who depended solely on these family members, could not be informed about contraceptives. A small number of adult females (14,9%) and of adult males (4,2%) indicated that they were informed by nurses regarding contraceptives. None of the female and male adolescents had received contraceptive information from nurses. The involvement of both females and males, including nurses, in sharing information about contraceptives and their effective use could help reduce the levels of unwanted pregnancies and prevent infection with STDs and HIV/AIDS.
- The majority of 88,3% of adult females and 81,8% of adolescent females compared to 70,0% of adult males and 69,0% of adolescent males were using contraceptives:
  - injection (62,5% adults, 70,6% adolescents)
  - pill (26,4% adults, no adolescents)
  - IUCD (8,9% adults, 5,9% adolescents)
  - female condom (no adults, 5,6% adolescents)
  - LAM (1,4% adults, no adolescents)
  - abstinence (no adults, 1,4% adolescents)
- Nonavailability of the female condom at health care centres emerged as a concern to clients who lacked knowledge about it and expressed the desire to use the condom if it was made

freely available. At R14,00 for a packet containing two condoms, the majority of women felt it was too expensive to buy.

- Male condoms were satisfactorily available from health care centres to the majority of clients who needed them. A minority of clients could not receive condoms when needed, mainly because the health care centres were out of stock and the clients were shy to approach nurses for condoms.
- Despite the availability of condoms, only a small number of adults used them always when having sex compared to half the number of adolescents who always used condoms with every sexual intercourse act. The main reasons for not using condoms included:
  - trusted partner – no fear of STDs or HIV/AIDS infection
  - failure to enjoy sex when using condoms
  - lack of skill in the use of condoms
  - breakages and slippages of condoms
- Perceptions about different contraceptive methods varied between positive, negative and ambivalent.
  - The majority of females (59,3%) perceived injections positively with as many as 41,6% of adolescents clearly naming Nur-Isterate as their injection of choice. The pill was rated second positively by 44,4% of females.
  - The majority (46,9%) of females, comprising 25,9% of adults and all the adolescents, perceived IUCDs negatively.

- A total of 37,0% of females were ambivalent about female sterilisation and 24,7% were negative towards female sterilisation. More females (42,0%) felt positive towards male sterilisation compared to those (27,0%) who claimed to be positive towards female sterilisation. As many as 31,4% of males were positive towards female sterilisation compared to only 14,3% who rated male sterilisation positively.
- The side-effects of contraceptives were perceived positively by slightly less than half the number of females, who would not be discouraged from using contraceptives by side-effects. Only 22,0% of females indicated negative perceptions of the side-effects of contraceptives. These respondents indicated that they could not tolerate the use of contraceptives which resulted in complications such as weight gain, amenorrhoea and irregular menstruation.
- A minority of clients believed in traditional contraceptives, and would use the prescriptions of traditional healers. A few clients, mainly adult females, used ropes soaked in menstruation fluid mixed with herbs around their waists, prayers before having sexual intercourse, and drinking strong coffee after sexual intercourse to kill sperm. The majority of clients who used these traditional methods, used condoms as an added measure to ensure adequate prevention against unwanted pregnancies as they did not trust traditional contraceptive methods prescribed by traditional healers. The few adolescents who used traditional contraceptives were forced to do so by their mothers or grandmothers.

- A lack of knowledge about emergency contraception was evident as the majority of clients had no idea of what it entails and that emergency contraception would save them from unwanted pregnancies. In addition to having no knowledge of emergency contraception, the majority of female and male adolescents were not convinced that emergency contraception could be helpful in the event of unprotected sex. These adolescents felt that they would not use emergency contraceptives even if they could have unprotected sex, stating that emergency contraception is just like murder and that they were not sure what might happen to them in future.
- None of the adult and adolescent clients knew about the copper containing IUCDs which could be used as emergency contraceptives.
- A minority of respondents who were positive about emergency contraceptives knew that it was referred to as the "morning after" pill. Furthermore, these respondents thought that they would use emergency contraception in the event of unprotected sex as they believed that it would be better than waiting anxiously for the next period and that it was better than termination of a pregnancy.
- More than half the females (adults and adolescents) knew about legalised CTOP, although they could not establish which health care centres were designated to procure the procedure. Less than half the males (adults and adolescents) had limited information about legalised CTOP seemingly from the media, and could not expand on the procedure.

- In spite of having knowledge about legalised CTOP, only a small number of females (adults and adolescents) were positive about CTOP and agreed that they would utilise the service. The majority of adult males were more positive about CTOP and vowed that they would encourage their partners to terminate unwanted pregnancies at legal health care centres.
- A minority of respondents who expressed negative perceptions about CTOP stated that they would not encourage anybody to terminate or to utilise CTOP services as it was tantamount to murder or against their moralistic views. Males would not encourage their partners to terminate pregnancies as they held similar negative views regarding CTOP.
- The majority of females who were positive about CTOP, did not feel it necessary to obtain permission for the procedure from their partners compared to nearly the same number of males who wanted their partners to obtain permission for CTOP from them.
- The main reason given in favour of obtaining permission for CTOP from partners was that partners had to be involved and experience the consequences of CTOP. The main rationale against obtaining permission for a CTOP was that females felt that it was their right to control their bodies. Males added that women had the right to decide what they wanted to do with their bodies.
- Slightly more than half the numbers of females were using contraceptives consistently to prevent unwanted pregnancies and infection with STDs and HIV/AIDS.

- As many as 39,2% females were not using contraceptives consistently and accurately mainly because they were concerned about side-effects and were not comfortable about getting contraceptives from health care centres.
- The majority of both female and males travelled for less than 30 minutes to health care centres for contraceptives.
- Slightly less than half the number of adult females, and fewer adolescents (including a few males) found nurses helpful by providing health education. A minority of adolescents (females and males) had received no contraceptive information from nurses and only two females found nurses rude.

#### **7.2.2 Phase 2: Summary of research findings**

In phase 2, an exploratory, descriptive and qualitative research design was used to explore and answer the research questions:

- What modern contraceptives are provided to clients at health care centres?
- What traditional contraceptives are used by clients coming to health care centres?
- What emergency contraceptives do you supply to clients?
- Can clients obtain legalised TOP at your health care centres?

The research objectives were to

- assess nurses' knowledge and perceptions of contraceptives and their interventions with clients presenting for contraceptives

- assess nurses' knowledge and perceptions of CTOP and their interventions when presented with CTOP clients
- describe barriers experienced by nurses in providing adequate contraceptive services to clients
- describe barriers experienced by nurses in providing CTOP services to clients

The population comprised a purposive sample of 12 nurses providing contraceptive and CTOP services to clients at selected health care centres (see section 7.2). A focus group interview was held with nine of the nurses and the three nurses who could not be available because of work commitments, completed naive sketches to share their opinions regarding their clients' contraceptive practices.

Tesch's model (Cresswell 1994:154-155) was used to analyse the data. An independent coder was engaged in data coding and consensus on categories was reached with the researcher to ensure the trustworthiness of the study.

Four main themes, categories and subcategories emerged and are discussed.

### **(1) Modern contraceptive methods and practices**

All the respondents were providing modern contraceptives, such as injections, pills, condoms, spermicides and IUCDs. Sterilisations were only done at hospitals and female condoms were unavailable from all the selected health care centres.

- Shortage(s) of stock at some health care centres caused problems of overcrowding of clients at neighbouring health

care centres. This subsequently resulted in overburdening nurses where contraceptives were always available.

- Nurses could only provide information to clients regarding contraceptives which were available and therefore lacked detailed information on Norplant and female condoms, which were not available at their health care centres.
- Nurses had problems with noncomplying clients, particularly adolescents, such as failure to report back on scheduled dates, display of negative behaviour by adolescents and the resistance of male clients to use contraceptives, like sterilisation and condoms, because they harboured myths about these contraceptives.
- Nurses' perceptions about modern contraceptives were positive, illustrated by their encouragement of clients to use modern contraceptives.

## (2) Traditional contraceptive methods

- Very few clients used traditional contraceptives, such as the following:
  - A padlock inserted by the husband to prevent the woman from having sexual intercourse during his absence.
  - A sanitary pad soaked with menstruation fluid and herbs from an inyanga. This pad was then buried in the backyard by the girl's grandmother, who

would dig it out when the girl was ready for pregnancy.

- Drinking strong tea or coffee prayed over by church leaders or priests, Coca-Cola and douching with soapy water after unprotected sex. Female genital mutilation and sex per rectum were rarely used for contraceptive purposes.
  - A rope soaked in menstruation fluid and herbs was tied around the waist to prevent unwanted pregnancies.
- 
- The majority of nurses had negative perceptions about traditional contraceptives and could therefore not promote these to clients, stating that traditional contraceptives were just psychological and ineffective.

### (3) Emergency contraception

- All the nurses seemed to have information 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 contraception, all except two of the nurses, were not prepared to share this with clients because they held that clients would use emergency contraceptives irresponsibly.
- The majority of the nurses had negative perceptions of emergency contraception, stating that their duty was to

teach clients about effective use of contraceptives, not to encourage misuse or nonuse of contraceptives.

#### (4) Choice on termination of pregnancy

Seven nurses were positive about CTOP as compared to the negative perceptions expressed about emergency contraception.

- **Barriers experienced by nurses in the provision of care to CTOP clients**

Obstacles that adversely affect the provision of quality care to CTOP clients included:

- *Lack of adequate resources*

The nurses perceived the lack of human and material resources as an obstacle to the provision of quality care to CTOP clients, adding to stress and frustration.

- *Repeat termination of pregnancies*

The majority of the nurses were concerned about adolescents who terminated pregnancies repeatedly without realising the implications such as infertility. Adolescents insisted that it was their right to terminate as many pregnancies as they wished as the Choice on Termination of Pregnancy Act 92 of 1996 does not limit the number of

terminations a person could have.

— *Being branded by colleagues and community members*

All the nurses involved with CTOP felt threatened by colleagues and community members who were judgemental towards them. In addition, community members posed an even bigger threat, referring to them as "murderers" and "baby killers". Furthermore, nurses urged that measures be taken by the authorities to protect them.

● **Policies regarding contraceptives to adolescents**

Most of the nurses confirmed that they had policies regarding adolescents and contraceptives at their respective health care centres although a few indicated that they did not have specific policies for adolescents. None of the respondents indicated having given half-dose injections to adolescents.

— The lack of policies at some health care centres resulted in nurses taking unprofessional actions. Two nurses stated that at their previous health care centres adolescents were given double doses of Nur-Isterate injections so that the effect could last longer as most of the time there was a shortage of stock. The nurses seemed to ignore the complications that could arise from over dosages, claiming that they were preventing unwanted

pregnancies.

- Two nurses confirmed that they were feeling despondent that in spite of their efforts to provide counselling, the rate of adolescent pregnancy, STDs and HIV/AIDS was escalating in their area in Northern Tshwane.

### **7.3 LIMITATIONS OF THE STUDY**

The area of research was limited to three health care centres in Gauteng Province. Although similar findings may be made elsewhere, the results of this study cannot be generalised to other areas.

Not all the invited nurses involved with CTOP clients were able to attend the focus group interview because of staff shortages. As a result, the researcher requested them to complete naive sketches which had similar questions to those discussed in the focus group interview. Out of the five naive sketches, only three were returned. Active participation by colleagues from other institutions might have contributed more data.

The problem of male consultation for contraceptives was addressed by targeting those males who came to collect condoms and those accompanying their partners for CTOP services.

The two structured interview schedules developed for the study, in spite of having been pretested, did not have filter questions for two items which could have yielded additional information.

#### 7.4 RECOMMENDATIONS

The findings of this study led to the following recommendations. Future research should improve upon the shortcomings encountered in this study or explore relevant issues in greater depth.

To enhance contraceptive practices, including the effective utilisation of contraceptives, emergency contraceptives and TOP services, the following recommendations are made:

- Education about sexuality, early pregnancy and how to prevent it should commence from the age of 10, since the physical, social and emotional characteristics of youth make them unique and already start to emerge from this age. Teachers, parents and others involved in child rearing should participate actively in this role. Topics of intimacy, gender role expectations, communication, anatomy and physiology, including contraception, should be addressed so that those who are at risk of unintentional pregnancy can prevent it.
- Sexuality and contraceptive education should be an ongoing process using a variety of approaches, including the media. The level of awareness can be maintained by giving constant attention to the need for mass media, public information campaigns and service delivery. These sources of information should focus on positive aspects, such as the benefits of contraception, to attract peoples' attention.
- Sexuality and contraceptive education should be related to the real needs, feelings and experiences of women, men and adolescents.
- There should be more structured (formal) education on the proper use of both the female and the male condoms. All nurses involved with

instructing clients on condom use should be assisted to understand the importance of all the critical points of condom use while taking care not to alienate the client and use a combination of verbal and demonstration tests to confirm the competency of clients in the subject.

- In-service education programmes should be developed for training nurses in aspects relevant to the promotion of sexuality education, self-care and contraceptive services.
- Voluntary health care workers should be encouraged to attend short courses in sexuality education and contraceptive services. Male motivators should be attracted to work at health care centres and occupational health care settings.
- Values clarification workshops should be conducted on a regular basis to ensure that health care providers who might have missed the initial workshops, have the opportunity to attend and also update those who attend.
- The feasibility of an education programme for significant others of young women and men should be investigated. Such a programme should be included as part of a community development programme, or an adult education or literacy programme.

It is recommended that policy makers do the following:

- provide policy guidelines to health care providers, including nurses working at family planning and TOP units about providing contraceptives, emergency contraceptives and TOP services to all clients, including adolescents. The issue of parental consent needs to be clearly dealt with as well as guidelines on adolescent ages and

the types of contraceptives to be offered.

- Investigate whether private pharmacists and medical practitioners do provide contraceptives and emergency contraceptives to all women who request them.
- Revise and modify policy guidelines, including stipulating clearly conditions under which contraceptives, emergency contraceptives and TOP services should be supplied to clients.
- Provide clinics exclusively for adolescents, wherever possible, so that they need not fear encountering their mothers, teachers and aunts at these clinics.
- Make female condoms available as a matter of urgency in state health care centres to allow women to exercise their rights in additional self-protection against unwanted pregnancies. Leaflets containing directions about the correct use of condoms should be included in the condom packs clearly stated in English and one language spoken predominantly in a specific health care centre's area.

#### **7.5 CONCLUSION**

Based on the foregoing summary and discussion of the research findings, the following conclusions in line with the relevant assumptions underlying and objectives guiding the study (see sections 1.4 and 1.5) could be drawn.

Both female and male, adolescents were not using contraceptives effectively as slightly less than half the total number already had between one and three children. Adolescents were aware of this

problem and argued that they would not have more than three children. All the respondents considered two or three children to be an affordable number.

All categories of respondents had some information about contraceptives which were available at health care centres. Contraceptives, such as Norplant and female condoms, were unknown to the majority of clients as they were unavailable from health care centres. This finding was confirmed by nurses, who also lacked information about unavailable contraceptives.

Mothers and the media played a major role in disseminating information about contraceptives as opposed to fathers and brothers who never talked about contraceptives to clients. Only a few clients received contraceptive information from nurses.

Males (adults and adolescents) lacked the skills to use condoms, which they attributed to the failure of nurses to provide contraceptive information. They believed that they could benefit if nurses could explain the details of condom use.

The respondents had positive, negative or ambivalent perceptions about different contraceptives, depending on how much they knew about or had experienced in the use of such contraceptive methods. IUCDs were perceived negatively and, as such, used by small number of clients while injections were preferred by adults and adolescents.

Side-effects were perceived positively and negatively by the adult and adolescent females. Adults were concerned about irregular menstruation, which they feared and related to cancer of the cervix, and adolescents were concerned about weight gain and amenorrhoea.

Traditional contraceptives were used by a minority of clients, mainly females (adults and adolescents). Men did not believe in traditional contraceptive methods and would not recommend their partners using these methods.

Emergency contraception was largely unknown to clients and nurses. Nurses expressed negative perceptions about emergency contraceptives, and as a result, they were reluctant to mention or recommend it to clients, claiming that clients would use emergency contraception irresponsibly, instead of using contraceptives consistently.

Both clients and nurses generally viewed CTOP to be a better option than emergency contraception. Clients had unfounded myths about emergency contraception claiming that they did not know anything about this contraceptive method and that it might cause foetal malformations in future. Nurses did not want to share information about emergency contraception with clients.

Clients were aware of legalised CTOP but did not have details such as which health care centres were designated to conduct the procedure, when to seek CTOP help and whom to contact in the event of having unwanted pregnancies.

Nurses experienced various obstacles in providing quality care to CTOP clients mainly because human and material resources were lacking, they felt undermined by colleagues who were judgemental and the community which threatened them and their families.

The findings of this study indicate the need for sexuality education, including information about contraceptives and their effective use. This education should start as early as 10 years and parents, teachers and

the media could play a major role in joining hands with health care providers to prevent unwanted pregnancies.

Authorities and policy-makers are challenged to make contraceptives such as female condoms, available free of charge, increase the accessibility of contraceptives to all, including remote areas, and provide the means to revive school health services. A lesson could be learnt from countries like the Netherlands, Vietnam, Bangladesh and Cuba in an effort to implement the small family norm.

In order to enhance the effectiveness of contraceptive practices/services in Northern Tswane the health care authorities should ensure that

- all clinics have adequate supplies of contraceptives
- clinic hours and days are extended so that working persons and students can attend over weekends and after 16:00 on weekdays
- all nurses receive in-service education on
  - different types of oral contraceptives
  - inserting IUCDs
  - CTOP legislation and services
  - emergency contraceptives and the relevant policies
  - supplying contraceptives to adolescents (emphasising the health risks involved when injecting double doses of Nur Isterate and the pregnancy risks involved when injecting half doses of Depo Provera).

The basic freedom of the world is a woman's freedom and no woman can be free until she can choose whether she will or will not be a mother. According to Margaret Sanger, a founder member of the Planned Parenthood Federation (Heber & George 1999:86), *Women enchainied cannot choose but give a measure of that bondage to their sons and daughters.*

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## **Annexure 1**

**Request for permission  
to conduct research**

Department of Advanced  
Nursing Sciences  
UNISA  
January 2001

Health Care Centres  
Tswane North Metropolitan  
Gauteng Province

Dear Sir/Madam

**Permission to Conduct Research-Contraceptive Practices, in Northern Tshwane, Gauteng Province**

I hereby request permission to conduct research at your Health Care Centre.

The title for the research is "**Contraceptive Practices, in Northern Tshwane, Gauteng Province**" under the leadership and guidance of Dr VJ Ehlers and Prof. LJ King from the Department of Advanced Nursing Sciences, UNISA.

The objectives of this study are to identify, determine and describe contraceptive practices of women and men in Northern Tshwane. For these objectives to be achieved, it is necessary to collect data from females and males presenting for contraceptives at health care centres. Nurses involved with providing contraceptives and CTOP services to clients will also be requested to participate in the study.

Permission to conduct the study has been approved by the Ethics committee at UNISA.

Your response to this request will be appreciated.

Yours faithfully



**TM Maja**  
**(D Litt et Phil student)**

## **Annexure 2**

**Letters granting permission  
to conduct research**



1

Tel: (012) 521 8152  
Fax: (012) 549 3016  
E-mail: francisr@npmss.org

CTMM: SOCIAL DEVELOPMENT  
DIVISION: HEALTH SERVICES  
P O Box 58393  
KAREN PARK  
0118

Our ref: 6 17/1/2

Your ref:

Enquiries: MF Roodt

Date: 30 August 2001

TO: Ms TMM Maja

### PERMISSION TO CONDUCT RESEARCH

Permission is hereby granted for conduction of interviews with clients at Rosslyn Clinic.  
Arrangements are to be made with the Facility Manager Mrs S vd Walt; tel 521 8136.

Yours sincerely



MF Roodt

Acting Area Coordinator : NPMSS



Tel: (012) 529 - 3201  
Fax: (012) 560-0094  
Cell: 083-631-3637  
e-mail: supergar@iafrica.com

Office of the Chief Superintendent  
Ga-Rankuwa Hospital  
Private Bag X422  
PRETORIA, 0001

10 January 2000

Ms TM Maja  
Technikon Northern Gauteng  
Soshanguve

**RESEARCH ON CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE,  
GAUTENG PROVINCE**

Permission is hereby granted for you to conduct your research in this hospital. Please will you contact the Matron in charge of the area when you come and discuss your requirements with her.

Best Wishes.

A handwritten signature in black ink, appearing to read "RJ Brokmann".

Dr RJ Brokmann  
Chief Medical Superintendent  
/maja



**NORTH WEST PROVINCE  
DEPARTMENT OF HEALTH  
ODI DISTRICT HOSPITAL  
GENERAL MANAGER: MR. M.M.P. MONALE**



Enq: Reginah  
Private Bag X 509  
MABOPANE  
0190



Tel: (012)7022279  
Fax: (012) 702 1610  
E-mail: mmakhudu@nwpg.org.za

04/03/200

**TO: Mrs. Maja T.M.M**

**FROM: Mrs. Ramahlo  
Nursing Service Manager**

**MESSAGE:**

Your request to complete your research on Reproductive Health Services in this hospital has been approved by management.

You are requested to provide management with your report as expected.

Kindly phone to indicate your commencement date.

Thank you.

**RAMAHLO S. M.(MRS)**

**FOR: GENERAL MANAGER**

*Ramahlo*

**Vision:**

To be recognised as the leading model district in providing a comprehensive Primary Health Care Service to our community.

## **Annexure 3**

**Female structured interview schedule**

**CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE, GAUTENG  
PROVINCE**

**FOR OFFICE  
USE ONLY**

**STRUCTURED INTERVIEW NUMBER**

**1**

**STRUCTURED INTERVIEW FOR FEMALES**

**NB! PLEASE MARK THE APPROPRIATE BLOCK WITH AN "X".**

**SECTION A: BIOGRAPHICAL INFORMATION OF PARTICIPANTS**

1. Indicate your age in years at last birthday

1	2	3	4	5
Younger than 15	16-20	21-30	31-40	Older than 40

**2**

2. Marital Status

1	2	3	4	5
Single	Married	Separated /Divorced	Widowed	Cohabiting

**3**

3. What is your present residential area?

1	2	3	4	5
City	Suburb	Rural Area	Informal Settlement	Township

**4**

4. Indicate the highest school standard you have passed

1	2	3	4	5	6
No Schooling	Below Std 2	Below St 5	Below St 8	Below St 10	Matric

**5**

5. Indicate if you have tertiary education qualifications

1	2
Yes	No

**6**

6. If the answer to question 5 is YES, please list the qualification(s) and the institution where you've obtained the qualification, eg. M.Sc. UNISA

**7**

**FOR OFFICE  
USE ONLY**

7. What is your home language?

1	Sotho
2	Tswana
3	Ndebele
4	Venda
5	Tsonga
6	Xhosa
7	Zulu
8	Swazi
9	English
10	Afrikaans
11	Other, Specify

8-9

8. Indicate your religion

1	Anglican
2	Catholic
3	Methodist
4	Lutheran
5	Presbyterian
6	ZCC
7	Apostolic
8	Jehova's Witness
9	Other, Specify

10

9. Indicate Your Employment Status

1	2	3
Employed	Unemployed	Scholar/student

11

10. Indicate your personal income per month

1	2	3	4	5
Nil	R100- R500	R501- R1000	R1001- R2000	More than R2000

12

Other, please specify .....

13

11. Indicate all family members sharing the home with you

1	2	3	4	5	6
Father	Mother	Partner	Brothers	Sisters	Children

14

12. Please write down the total number of people living in your home

15

**SECTION B: CONTRACEPTIVE USE AND NON-USE****FOR OFFICE  
USE ONLY**

13. How many children do you have?

1	2	3	4	5	6
0	1	2	3	4	5

16

State number if more than five children \_\_\_\_\_

14. How many children would you like to have?

1	2	3	4	5	6
0	1	2	3	4	more than 4

17

15. State the reasons for the number of children you've indicated in question 14.

---



---



---

18

16. Do you have any knowledge about contraceptives?

1	2
Yes	No

19

17. If YES to Question 16, what information do you have?

---



---



---

20

18. Who informed you about the contraceptives you've mentioned in question 16?

1	2	3	4	5	6	7
Mother	Father	Brother	Sister	Friends	Teacher	Media

21

Please specify other sources of information \_\_\_\_\_

19. Have you ever used any contraceptive method?

1	2
Yes	No

22

**FOR OFFICE  
USE ONLY**

20. If YES to Question 19, which contraceptive method(s) have you used?

1	Pill
2	Injection
3	Intra-uterine device
4	Condoms
5	Diaphragm
6	Hormonal implant
7	Other, please specify

23

21. If you indicated NO to Question 19, please state your reasons for not using contraceptives.
- 
- 
- 

24

26

22. Do you have any personal preference of specific contraceptives?

1	2
Yes	No

25

23. If YES to Question 22, which contraceptive method(s) do you prefer?
- 

26

24. State reasons for your preference of contraceptive method(s) indicated in Question 23.
- 
- 
- 

27

26

25. Do you have any knowledge of female condoms?

1	2
Yes	No

28

26. Have you always received condoms when asking for them at health services?

1	2
Yes	No

29

27. If NO to question 26, what were the reason(s) for not getting condoms from health services?

---



---



---

30

28. What do you think of female sterilization?

---



---

31

29. What do you think of male sterilization?

---



---

32

30. What do you think of intra-uterine contraceptive devices (IUCDs)?

---



---

33

31. What do you think of oral contraceptives?

---



---

34

32. What do you think of side effects of contraceptives?

---



---

35

33. Have you been to any traditional healer for contraceptives?

1	2
Yes	No

36

34. If YES to Question 33, what contraceptive method(s) was/were prescribed?

---



---

37

35. Did you use the prescribed contraceptive method?

1	2
Yes	No

38

36. State reasons for your answer provided to question 35.

---



---



---

39

37. Do you know of any emergency contraceptives which can prevent pregnancy taking place after unprotected sex?

1	2
Yes	No

40

38. If YES to Question 37, which emergency contraceptives do you know?

---



---

41

39. What other information do you have about emergency contraceptives?

---



---

42

40. Would you use emergency contraceptives to prevent getting pregnant after unprotected sex?

1	2
Yes	No

43

41. Give reasons for your answer provided to question 40.

---



---

44

42. Do you know about termination of pregnancy (TOP) services which are legal?

45

1	2
Yes	No

43. If YES to Question 42, what information do you have about legal termination of pregnancy?

---



---

46

44. Would you utilize termination of pregnancy services if you get pregnant after unprotected sex?

47

1	2
Yes	No

45. State reasons for your answer provided to Question 44.

---



---

48

46. Do you think you need permission from your partner to terminate a pregnancy?

1	2
Yes	No

49

47. Give reasons for your answer provided to question 46

---



---

50

48. What do you think of termination of pregnancy used after unwanted pregnancy?

---



---

51

49. Which contraceptive method(s) are you presently using?

---



---



---

52

50. Are you using contraceptives constantly and accurately?

1	2
Yes	No

53

51. Please state reasons for your answer provided in question 50.

---



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54

52. How long does it take you to get to the nearest hospital or clinic for contraceptives?

1	2	3	4	5
Less than 15 minutes	15-30 minutes	30-45 minutes	45-60 minutes	1hour or more

55

53. What are/were the attitudes of staff when you asked for contraceptives?  
(You may tick more than one block)

1	2	3	4	5	6
Helpful	Gave health education	Advised about safe sex	Was rude	She gave me no information	She was polite

56

Other, please specify.

---

---

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54. Please make any suggestions for improving contraceptive practices and utilization of contraceptive services.
- 
- 
- 

57

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY

## **Annexure 4**

**Male structured interview schedule**

# CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE, GAUTENG PROVINCE

FOR OFFICE USE ONLY

## STRUCTURED INTERVIEW NUMBER

1

## STRUCTURED INTERVIEW FOR MALE CLIENTS

NB! PLEASE MARK THE APPROPRIATE BLOCK WITH AN "X".

## SECTION A: BIOGRAPHICAL INFORMATION OF PARTICIPANTS

1. Indicate your age in years at last birthday

1	2	3	4	5
Younger than 15	16-20	21-30	31-40	Older than 40

2

2. Marital Status

1	2	3	4	5
Single	Married	Separated /Divorced	Widowed	Cohabiting

3

3. What is your present residential area?

1	2	3	4	5
City	Suburb	Rural Area	Informal Settlement	Township

4

4. Indicate the highest school standard you have passed

1	2	3	4	5	6
No Schooling	Below Std 2	Below St 5	Below St 8	Below St 10	Matric

5

5. Indicate if you have tertiary education qualifications

1	2
Yes	No

6

6. If the answer to question 5 is YES, please list the qualification(s) and the institution where you've obtained the qualification, eg. M.Sc. UNISA

7

**FOR OFFICE  
USE ONLY**

7. What is your home language?

1	Sotho
2	Tswana
3	Ndebele
4	Venda
5	Tsonga
6	Xhosa
7	Zulu
8	Swazi
9	English
10	Afrikaans
11	Other, Specify

8-9

8. Indicate your religion

1	Anglican
2	Catholic
3	Methodist
4	Lutheran
5	Presbyterian
6	ZCC
7	Apostolic
8	Jehova's Witness
9	Other, Specify

10

9. Indicate Your Employment Status

1	2	3
Employed	Unemployed	Scholar/student

11

10. Indicate your personal income per month

1	2	3	4	5
Nil	R100- R500	R501- R1000	R1001- R2000	More than R2000

12

Other, please specify .....

13

11. Indicate all family members sharing the home with you

1	2	3	4	5	6
Father	Mother	Partner	Brothers	Sisters	Children

14

12. Please write down the total number of people living in your home

15

**SECTION B: CONTRACEPTIVE USE AND NON-USE****FOR OFFICE  
USE ONLY**

13. How many children do you have?

1	2	3	4	5	6
0	1	2	3	4	5

16

State number if more than five children \_\_\_\_\_

14. How many children would you like to have?

1	2	3	4	5	6
0	1	2	3	4	more than 4

17

15. State the reasons for the number of children you've indicated in question 14.

---



---



---

18

16. Do you have any knowledge about contraceptives?

1	2
Yes	No

19

17. If YES to Question 16, what information do you have?

---



---



---

20

18. Who informed you about the contraceptives you've mentioned in question 16?

1	2	3	4	5	6	7
Mother	Father	Brother	Sister	Friends	Teacher	Media

21

Please specify other sources of information \_\_\_\_\_

19. Have you ever used any contraceptive method?

1	2
Yes	No

22

**FOR OFFICE  
USE ONLY**

20. If YES to Question 19, which contraceptive method(s) have you used?  
(You may mark more than one block)

1	Condoms
2	Coitus interruptus/withdrawal
3	Sterilization
4	Other methods, please specify

23

21. If you indicated NO to Question 19, state your reasons for not using contraceptives.

---



---



---

24

22. Do you have any personal preference of specific contraceptives?

1	2
Yes	No

25

23. If YES to Question 22, which contraceptive method(s) do you prefer?

---



---



---

26

24. State reasons for your preference of method(s) indicated in Question 23.

---



---



---

27

25. What do you think about male sterilization?

---



---



---

28

26. What do you think about female sterilization?

---



---



---

29

27. Have you been to any traditional healer for contraceptives?

1	2
Yes	No

30

28. If YES to Question 27, what contraceptive method was prescribed?

---



---



---

31

29. Would you use any of these traditional contraceptive methods?

1	2
Yes	No

32

30. State reasons for your answer indicated in question 29.

---



---



---

33

31. Do you know of any emergency contraceptives which can prevent pregnancy taking place after unprotected sex?

1	2
Yes	No

34

32. If YES to Question 31, which emergency contraceptive(s) do you know?

---



---

35

33. What other information do you have about emergency contraceptives?

---



---

36

34. Would you encourage your sexual partner to use emergency contraceptives to prevent her from getting pregnant after unprotected sex?

1	2
Yes	No

37

35. Please give reasons for your answer provided to question 34.

---



---

36. Do you know about termination of pregnancy (TOP) services which are legal?

1	2
Yes	No

38

37. If YES to Question 36, what information do you have about legal termination of pregnancy?
- 
- 
- 

39

38. Would you encourage your sex partner to obtain termination of pregnancy should she become pregnant?

1	2
Yes	No

40

39. Please state reasons for your answer provided to Question 38.
- 

41

40. Do you think your sex partner has the right to obtain termination of pregnancy without your permission?

1	2
Yes	No

42

41. Give reasons for your answer provided to question 40.
- 
- 
- 

43

42. Which contraceptive method(s) is your sex partner presently using?

1	Pill
2	Intra-uterine contraceptive device
3	Condoms
4	Injection
5	Norplant
6	Other methods, please specify

44

43. Why did she choose the method she's presently using?
- 
- 

45

44. Do you use a condom every time when you have sex?

1	2	3	4
Yes	No	Sometimes	Only when having sex with casual partner

46

45. Please give reasons for your answer to question 44.

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47

46. Have you always received condoms when asking for them at health services?

1	2
Yes	No

48

47. If NO to question 46, what are the reasons for not getting condoms?

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49

48. How long does it take you to get to the nearest hospital or clinic for contraceptives?

1	2	3	4	5
Less than 15 minutes	15-30 minutes	30-45 minutes	45-60 minutes	1-2 hours

50

49. What are/were the attitudes of staff when asking for condoms?

1	2	3	4	5	6
Helpful	Gave health education	She was rude	She was polite	She gave me no information	She gave me sex education

51

50. Do you know about side effects of using condoms?

1	2
Yes	No

52

51. If YES to question 50, please list the side-effects you know about condoms?

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53

52. Please make any suggestions for improving contraceptive practices and utilization of contraceptive services.

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54

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY

## **Annexure 5**

**Introductory letter**

Enquiries

: TMM Maja

22 May 2001

UNISA  
DEPARTMENT OF  
ADVANCED  
NURSING SCIENCES  
PRETORIA  
0001

Dear Participant,

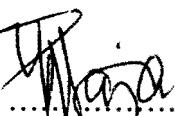
**CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE OF GAUTENG PROVINCE**

I am presently engaged in a research project entitled: "Contraceptive Practices in Northern Tshwane, Gauteng Province", as a prerequisite for my Doctoral study. The study is done under the supervision and guidance of Dr. VJ Ehlers and Prof. LJ King from the department of Advanced Nursing Sciences, UNISA.

The objective of this study is to identify, determine and describe contraceptive practices in Northern Tshwane.

Please answer questions as objectively as possible. Your name will not appear in any of the documents and your confidentiality will be maintained. Your expert input in this research will be highly appreciated.

Thank you



TMM Maja

(D Litt et Phil student UNISA)

## **Annexure 6**

### **Focus Group Interview Guide**

## **CONTRACEPTIVE PRACTICES IN NORTHERN TSHWANE, GAUTENG PROVINCE**

### **FOCUS GROUP INTERVIEW GUIDE**

**(1) *Which modern contraceptives do you supply to clients seeking contraceptives?***

- What information do you give to clients regarding the use of modern contraceptives?
- Which barriers to you experience regarding modern contraceptives?

**(2) *Which traditional contraceptives are used by clients coming to your health care centre?***

- How effective are these contraceptives methods?
- What guidance do you give to clients using traditional contraceptives?
- What barriers do you experience with clients regarding traditional contraceptives?

**(3) *Which emergency contraceptives do you supply to clients at your health care centres?***

- What are your perceptions regarding the use of emergency contraceptives?
- What guidance do you give to clients regarding the use of emergency contraceptives?

- Do you think any person who needs emergency contraceptives needs contraceptives?

(4) ***Can clients obtain CTOP services at your health care centres?***

- What information do you give to clients regarding CTOP?
- What are your perceptions of clients who choose to terminate a pregnancy?
- Under what conditions do you advice clients to seek CTOP?
- What barriers do you experience when dealing with CTOP clients?
- What is the policy regarding the supply of contraceptives to adolescents at your health care centres?

## **Annexure 7**

**Summary of contraceptive methods**

## Contraceptive methods

## ANNEXURE 7

CONTRACEPTIVE METHODS	PRESCRIPTION METHODS				
	THE PILL (ORAL)	DEPO-PROVERA NUR-ISTERATE (INJECTION)	NORPLANT (IMPLANT)	IUCD (INTRA-UTERINE CONTRACEPTIVE DEVICE)	DIAPHRAGM (WITH CREAM/JELLY)
EFFECTIVENESS	97-99%	99-100%	99-100%	97-99%	82-94%
Description	Hormone pill available in two types: oestrogen/progestin combination or progestin-only mini pill	Injection of progestin given in the arm or buttock	Soft thin capsules filled with the hormone progestin, placed under the skin of the woman's upper arm	A small plastic device, may contain copper or hormones, placed inside the uterus	A shallow rubber placed over the cervix – the cervical cap is a smaller type of diaphragm
Method of action	<ul style="list-style-type: none"> <li>• Inhibits ovulation</li> <li>• Changes uterine lining</li> <li>• Thickens cervical mucous</li> </ul>			May affect sperm, egg, implantation in uterine lining	The cup blocks sperm and the cream/jelly kills sperms
Benefits	<ul style="list-style-type: none"> <li>• Highly effective, safe and convenient</li> <li>• Protective against certain reproductive cancers and diseases</li> <li>• Sometimes helps to decrease menstrual cramps and pain</li> </ul>		<ul style="list-style-type: none"> <li>• Effective, safe and convenient</li> <li>• IUCDs containing hormones decrease menstrual blood loss and reduce pain</li> </ul>	<ul style="list-style-type: none"> <li>• Can reduce the spread of STD</li> <li>• Can be inserted up to six hours before the sex act</li> </ul>	
	<ul style="list-style-type: none"> <li>• Combination pill helps regulate menstrual change</li> <li>• Lightens menstrual flow</li> </ul>	<p>Can be used by breast feeding mother when milk is established</p>	Maintains contraceptive privacy	Contraceptive effect quickly reversible after removal	Can be used by breast feeding mother
Availability	Prescribed by health care professional and obtainable from clinic/pharmacist	Prescribed and injected by health care professionals in a clinic or hospital	Inserted and removed by a health care professional in a clinic or hospital		
Side-effects	The pill can cause irregular bleeding or no bleeding	Can cause irregular bleeding or no bleeding		<ul style="list-style-type: none"> <li>• Heavier menstrual flow and cramps</li> <li>• Side-effects usually lessen after first few months</li> </ul>	<ul style="list-style-type: none"> <li>• Mild allergic reactions occasionally occur</li> <li>• Some women are prone to bladder infections</li> </ul>

Source: Olmsted County Public Health Services (2001)

CONTRACEPTIVE METHODS	OVER THE COUNTER METHODS			NATURAL METHOD	PERMANENT
	VAGINAL SPERMICIDE	FEMALE CONDOM	MALE CONDOM	NATURAL FAMILY PLANNING/FERTILITY AWARENESS	STERILISATION
EFFECTIVENESS	79-97%	79-95%	88-98%	80-98%	99-100%
Description	Many forms: foam, cream, jelly, suppository tablets, gel and film	A soft, loose fitting plastic pouch placed inside the vagina and partly covers the outside area	A thin rubber or latex sheath placed over the man's penis during sexual intercourse	A woman keeps track of changes in basal temperature, cervical position and/or mucous to estimate when an egg is ready to be fertilised	Vasectomy (male) and tubal ligation (female) are permanent procedures in which the ducts carrying sperm are tied and cut - this keeps the sperm from uniting with an egg
Method of action	Contains sperm-killing ingredients and provides some STD protection	<ul style="list-style-type: none"> <li>• Catches the sperm and stops it from entering the vagina</li> <li>• Spermicide kills sperm</li> </ul>		-	-
Benefits	<ul style="list-style-type: none"> <li>• Quick protection, easy to use</li> <li>• Can be used as a back-up option to other contraceptive methods</li> <li>• Can reduce the spread of STDs/HIV infection</li> <li>• Can be used by breastfeeding mothers</li> <li>• Condoms may be used after childbirth when comfort level has been established</li> </ul>		<ul style="list-style-type: none"> <li>• Helps woman learn about her body</li> <li>• allows couple to become aware of their combined fertility potential</li> <li>• Can be used after delivery and by breastfeeding mother</li> <li>• Acceptable to some who might oppose other methods based on religious beliefs</li> </ul>	<ul style="list-style-type: none"> <li>• Most effective birth control method</li> <li>• Low rate of complications</li> <li>• Tubal ligation may be done immediately after delivery and does not affect breastmilk or mother's ability to breastfeed</li> </ul>	
Availability	<ul style="list-style-type: none"> <li>• Available at pharmacies and clinics, except for the female condom which is only available at pharmacies</li> <li>• Mail condoms are available at some public restrooms</li> </ul>		Users should be trained by a qualified counsellor or health care professional to learn proper use	The operation must be performed by a doctor in a hospital or clinic	
Side-effects	<ul style="list-style-type: none"> <li>• Mild allergic reactions to rubber, cream or jelly occasionally occur</li> </ul>		<ul style="list-style-type: none"> <li>• May lessen the spontaneity of sex</li> <li>• Natural family planning – less effective in practice</li> <li>• May not reduce fear of unwanted pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Tubal ligation surgery is more complicated than vasectomy</li> <li>• Recovery can be a few hours or a few days</li> </ul>	

Source: Olmsted County Public Health Services (2001)

# Shocking abortion figures

80 873 under-18 girls ended pregnancies

By JIMMY SEEPE

SO MANY abortions are being performed at hospitals and clinics across South Africa – between 2 500 and 3 000 every month – that the health department is worried some facilities may not be able to cope.

The department has voiced concern that the high demand for abortion could overburden some facilities charged with doing abortions.

The figures relate only to abortions done at state hospitals and clinics, and exclude those done at private facilities like the Marie Stopes clinics, a major provider of abortions, and other private clinics.

The latest official figures reveal a worrying trend – far more girls below the age of 18 are having legal abortions than women over 18.

Figures provided by the department show that by the end of January this year a total of 155 824 abortions had been performed in state hospitals and clinics since the law legalising abortion came into effect in February 1997.

Concern is now growing that the abortion figure could exceed 200 000 before the end of the year.

Girls under 18 accounted for a figure of 80 873 abortions, more than half the total since abortion was legalised. The latest figures have

once again divided those favouring abortion and those opposed to it.

Organisations working in the reproductive health sector hailed the latest figures as an important but unmeasurable victory for women to make informed choices about their reproductive health, while at the same time helping to reduce backstreet abortions which had killed hundreds of women.

Religious groups have expressed concern about the figures and said they showed sex education was seriously lacking in SA.

The health department said the figures were proof of their commitment to provide an abortion service to those who requested it within the

time frame specified in the Act.

More abortions were carried out in Gauteng (69 442) than in any other province since abortion was legalised. The Western Cape is second with 20 641 abortions.

Department spokesperson Siyani Marima was unable to say if the high incidence of HIV/AIDS was contributing to the high number of abortions being conducted.

Marima said since HIV testing is voluntary, most women did not have an HIV test before their pregnancies were terminated. The latest figures come amid persistent claims that, despite ready access to legal abortion, many women are still resorting to illegal abortions.

Health workers estimate that 80 000 illegal abortions may have been conducted this year alone.

A spokesperson for the Reproductive Health Clinic, Dr Tertia Cruywagen, said the availability of abortion has given women an opportunity to make informed decisions about their reproductive health.

Cruywagen rejected the notion that the availability of abortion has contributed to the degeneration of society and its morals.

She did, however, express concern that their office was still receiving a high number of reports of women having illegal abortions.

Cruywagen said she was concerned that doctors in private practice who did not have the necessary equipment to conduct the procedure were nevertheless luring unsuspecting women into abortions in their surgeries.

Some of the doctors involved in this practice are alleged to have conducted abortions after the stipulated 20-week limit (legally, an abortion may not be done if a woman has been pregnant for more than 20 weeks).

An SA Council of Churches priest, Bishop Patrick Matholomwe, reacted with shock to the figures and said they showed SA was failing to provide sex education.

## PROVINCIAL BREAKDOWN OF ABORTIONS

Gauteng	69 442	Northern Province	4 655
Mpumalanga	8 397	Western Cape	20 641
Free State	15 445	Eastern Cape	11 684
KwaZulu-Natal	18 058	North West	5 119
Northern Cape	2 183		