CHAPTER 1

Overview of the study

1.1 INTRODUCTION

Throughout recorded history women have resorted to abortions to terminate unwanted pregnancies despite legal and religious sanctions and personal risks involved. Termination of pregnancy (TOP) is universally practised and no other elective procedure has evoked political, moral and/or emotional debates similar to the heated debates surrounding TOP issues globally (Jali 2001:25; Suffla 1997:214).

Over the years abortion has been used as a means of birth control, and the Republic of South Africa (RSA) is no exception (Engelbrecht, Pelser, Ngwena & Van Rensburg 2000:5). People's perceptions on the termination of pregnancies differ, some are totally opposed to the procedure, and others accept it. When Walker (1996:42-57) observed and interviewed nurses in a Soweto clinic about their feelings towards abortion, the following statements were recorded.

- Women get unplanned pregnancies because they are careless
- If women do not want babies they must use contraceptives
- These days there is no room for unplanned pregnancies
- Women can prevent unplanned pregnancies through the use of family planning methods

These nurses went to the extent of labeling women who requested TOPs as killers, ignorant, irresponsible, unthinking and even promiscuous.

In the RSA under the previous Abortion and Sterilisation Act (no 2 of 1975) undergoing legal abortion was difficult, due to the strict grounds laid down by this Act. Legal abortions could only be procured where:

- The continued pregnancy endangered the life of the pregnant woman or constituted a serious risk to her physical health.
- The continued pregnancy constituted a serious risk for the child to suffer from a physical or a mental defect of such a nature as to be irreparably handicapped.
- There was a serious threat to the pregnant woman's mental health which constituted a danger of permanent damage to her mental health.
- Pregnancy was the result of unlawful sexual intercourse including rape, incest or intercourse with a mentally defective female, unable to appreciate the consequences of intercourse or bear parental responsibility (SA 1975:1-6).

The doctor who intended to perform the procedure had to apply for permission from the hospital's medical superintendent. There had to be certification from two other doctors, excluding the practitioner who was going to perform the procedure, that indeed the woman qualified for a legal abortion. In terms of the Act, one of these practitioners should have practiced for at least four years. Where abortion was granted on grounds of mental ill-health, one certifying practitioner had to be a psychiatrist employed by the state. In the case of rape or incest the one certifying practitioner had to be a district surgeon, and in addition the magistrate had to issue a certificate (SA 1975:1-6), granting permission for the abortion to be performed.

According to Ngwena (1998:39-40), this law granted women no legal right to abortion. The women had to approach medical practitioners, state officials and/or magistrates and request them to determine whether the Act's criteria had been fully met for procuring a legal abortion. This Act required no less than four doctors to comply with the requirements of granting legal permission for an abortion to be performed. The Act was very restrictive, but that did not prevent women form procuring abortions. It

only nurtured “back street abortions”, with an estimated 120 000 back street abortions being performed annually in the RSA (Suffla 1997:214). These abortions were procured illegally, sometimes under unhygienic conditions. This resulted in 33 000 surgical procedures to treat the complications of back street abortions. The mortality rate as a result of post abortion complications was estimated to be 425 women per annum in the RSA (Suffla 1997:214). The situation in the RSA could be regarded as being in accordance with the global situation. The WHO (2000:1) estimated that 30 million women worldwide used legal TOP services during 1995; but that an additional 20 million women ended their pregnancies outside their countries’ legal systems annually. These figures indicate that women do terminate unwanted pregnancies within or outside legal requirements throughout the world, including the RSA.

Based on the estimation of illegal abortions procured, women found themselves carrying unwanted and unplanned pregnancies to term. The question asked by Walker (1996:56) was: “*Why not use contraceptives to prevent an unwanted pregnancy?”* According to the Department of Health (DOH 2001:2), family planning services in the RSA commenced in the 1930s as “mother clinics”. During the late 1960s the government launched national family planning programmes, but these became formally established only during 1974. Free family planning services were made available to all women in the RSA. However, TOPs on demand remained illegal in the RSA until 1996 (Maja 2002:55-56). It has been estimated that approximately 100 000 women terminated first trimester pregnancies from 1996 to 1999 in the RSA (Kenny 2000:16).

Reportedly women in the RSA, underwent legal and illegal abortions irrespective of the freely available contraceptives. If contraceptives were free, why would women put their lives at risk to procure back street abortions under unhygienic conditions? What could cause women not to use contraceptives if they are available and free of charge?

Over the years in the RSA changes occurred in women’s sexual and reproductive health issues following the change in political power. Since becoming the ruling party in the RSA in 1994, the African National Congress (ANC) implemented several changes in the restructuring and delivery of health care

services. A national health plan was compiled which aimed at a complete transformation of the national health care delivery system and of all relevant institutions. This was to be achieved by the adoption of the primary health care (PHC) approach. The aim was to redress the harmful effects of apartheid health care services, and of a health care system characterised by fragmentation, inequality, and delivery of health care services along racial lines (ANC 1994:27–32).

In addressing the situation, several health policies, regulations and legislations were compiled. Policies that were identified as forming part of the health priorities were targeted at improving the health status of women in the RSA. *The Mother and Child Care Policy's,* objectives include to promote family planning through readily available educational services. Every woman in the RSA has the right to control her reproductive function through using reproductive and contraceptive services, geared towards the needs of all women throughout their lifespan (ANC 1994:46-54; 57-58).

Still in the process of improving women's health, especially their sexual and reproductive health, the Abortion and Sterilisation Act (no 2 of 1975) was repealed, because it was perceived as being restrictive and inaccessible (SA 1975:1-6). The decision to have children is regarded as being fundamental to each woman's physical, psychological and social health. Access to reproductive health care, including contraceptives, the choice on termination of pregnancy (CTOP) services, sexuality education and counselling services (SA 1996b:2), constitute part of this fundamental right of women in the RSA.

1.1.1 Policies and legislation impacting on reproductive health issues

According to the DOH (2001:12–17), a number of policies and legislation impact on sexual and reproductive health issues of the women in the RSA.

The Constitution of the Republic of South Africa

According to the Constitution of the RSA Act (no 108 of 1996)(SA 1996a:6-13), under the bill of rights, every South African has a right to access health care services, including reproductive health care. Everyone has an inherent dignity and the right to have this dignity respected and protected.

The Population Policy

The Population Policy aims to meet its objectives through a number of strategies, including strategies addressing reproductive health issues such as:

- Improving the quality, accessibility, availability and affordability of PHC services, including reproductive health and health promotion, to the entire population in order to reduce maternal mortalities and unwanted pregnancies.
- Promoting responsible and healthy reproductive sexual behaviour among adolescents and the youth, to reduce the incidence of high-risk teenage pregnancies, abortions and STDs including HIV and AIDS. This can be achieved through the provision of gender sensitive sexuality education and user friendly health care services.
- Promoting the equal participation of men and women including responsible parenthood, reproductive health, child rearing and household work (SA 1998a:25-26).

The Child Care Act (no 74 of 1983)

- According to the Child Care Act (no 74 of 1983, as amended), any person over the age of 14 years is competent to consent without the assistance of a guardian, to the performance of any medical treatment upon him/herself. In contraceptive provision this implies that any child aged 14 or older can receive contraceptives without the consent of parents/guardians.
- Any person over the age of 18 years is capable to consent without the assistance of a parent or guardian, that an operation be performed on him/her. With regard to the reproductive health issues this means that any person over the age of 18 years can consent to sterilisation without his/her parents' assistance (SA 1983:229).

Medicines and Related Substances Control Amendment Act (no 101 of 1965)

- The Medicine and Related Substances Control Amendment Act (no 101 of 1965) allows a pharmacist, a pharmacist intern or a pharmacist assistant acting under the personal supervision of a phamarcist, to sell schedule 1, 2, 3, 4, 5 and 6 substances, to any individual aged 14 or older who has a valid prescription from an authorised prescriber.

- In reference to contraceptives, which are schedule 4 drugs, a client may buy these contraceptives over the counter if she has a valid prescription from an authorised person.
- The Act allows any medicine or scheduled substance to be possessed by a medical practitioner, dentist, veterinarian or nurse for the purpose of administering it in accordance with his or her scope of practice. This means registered nurses are allowed to keep contraceptives and to prescribe them according to their scope of practice.

Youth and Adolescent Health Policy Guidelines

The Youth and Adolescent Health Policy Guidelines stipulate several youth and adolescent health care priorities, including sexual and reproductive health issues. The situational analysis on youth and adolescents' sexual and reproductive health issues, demonstrates the national average age of first intercourse to be 15 years for girls and 14 years for boys. Contraceptive prevalence, among the sexually active young people of the RSA, varies across reported studies from 25,0% to 75,0% with an average of about 60,0% (DOH 2001:36-42).

The intervention strategies of this policy include:

- Creating a safe and a supportive sexual and reproduction environment.

- Providing relevant and up to date information about sexual and reproductive health issues.
- Providing counselling services and peer counselling programmes.
- Improving access to health services for the youth and adolescents (DOH 2001:36-42).

Sterilisation Act (no 44 of 1998)

- According to the Sterilisation Act (no 44 of 1998), any person over the age of 18 years who is capable of consenting has a right to be sterilised.
- It is illegal to sterilise any person who is above 18 years, who is capable of consenting, without her permission.
- A person who is younger than 18 years can be sterilised only if

    - her physical health is threatened if she is not sterilised
    - a parent, spouse, guardian or curator consents to her sterilisation
    - a panel of experts convened in terms of this Act concurs that sterilisation should be performed
    - there should be no safe and effective method of contraception, other than sterilisation available to a specific person (SA 1998b:3)

The National Health Bill

- The National Health Bill prioritises maternal, child and women's health and it includes the following policy intentions:

    - Women and men should be provided with health care services that will allow 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 2000:30-36).

The Essential Drug List (EDL) for Primary Health Care

The Essential Drug List **(**EDL) for PHC stipulates that the drugs to be used for contraceptive purposes at PHC level include:

- Spermicidal jelly 0,1 g active ingredients/5g in 81 g tube with an applicator.
- The intra uterine device (IUCD) 250 short type for a uterus with sound length of 6 cm and 375 standard type for uterus with sound length of over 10 cm.
- Injectable contraceptives – the medroxyprogesterone acetate (MPA) 150 mg long acting and the norethisterone enanthate (NET-EN)
- Oral contraceptives:

  - Monophasic preparation of levonorgestrel 0,03 mg
  - Biphasic preparation of 11 tablets levonorgestrel 0,05 mg and ethinyl oestradiol 0,05 mg
  - Triphasic preparation of 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 (DOH 2001:30-36)

The Choice on Termination of Pregnancy (CTOP) Act (no 92 of 1996)

According to the CTOP Act (no 92 of 1996), circumstances under which pregnancy may be terminated include:

- Upon the request of a woman during the first 12 weeks of gestation

- From the 13th week up to and including the 20th week of gestation if a medical practitioner, after consultation with a pregnant woman, is of the opinion that:

  - The continued pregnancy will pose a risk of injury to the woman's physical or mental health.
  - There is a substantial risk that a fetus would suffer from severe physical and mental abnormality.
  - The pregnancy resulted from rape or incest.
  - The continued pregnancy would significantly affect the social or economic circumstances of a woman.

- After the 20th week of pregnancy if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy would

  - endanger the woman's life
  - result in severe malformation of the foetus
  - pose a risk of injury to the foetus (SA 1996b:4)

Since the CTOP Act (no 92 of 1996) was promulgated, many women used this opportunity. Since February 1997 to July 1998, an estimated 61 389 TOPs were done in the RSA (Reproductive Rights Alliance 1998:5–9) as reported by Ngwena (1998:38). The continued demand for CTOP services in the RSA cannot be explained because contraceptives are available free of charge. The Abortion and Sterilisation Act (no 2 of 1975) was regarded as being so restrictive that many women had to resort to "back street abortions" (Ngwena 1998:39). Since the CTOP Act (no 92 of 1996) has been implemented women should be able to access CTOP services. However, it cannot be explained why large numbers of South African women continue to resort to CTOP services when all women in the RSA have access to free contraceptive and emergency contraceptive services.

According to the DOH (2001:26), several factors influence contraceptive use, including knowledge about contraceptives, socio-economic development, urban and rural residence, women's educational

and economic status, cultural values, beliefs and norms. As Belfield (1998:32) stated, contraceptive providers need to understand how and why people make contraceptive choices, because minimising the likelihood of unintended pregnancies depends on each user's satisfaction and confidence. Effectiveness and continuation of contraceptive use is enhanced through the provision of a method that is truly the method of choice.

1.2 BACKGROUND TO THE STUDY

The structure of the RSA's government has one National government and nine provincial governments. Each province is then divided into districts. The aim is to decentralise management and the delivery of services in order to increase efficacy, local innovation, empowerment and accountability (ANC 1994:123).

Mpumalanga is one of the RSA's nine provinces. According to the Health Systems Trust (HST 1997:16–19), it is the seventh most populous province of the RSA. It is inhabited by approximately 7,0% of the country's people, which is about 2 900 000. It occupies 7,0% of the surface area (see annexure F).

Mpumalanga comprises a number of former "self governing states" and homelands, including the Kangwane homeland and the KwaNdebele homeland. It is divided into three districts: the Ehlanzeni, Emalahleni and Gert Sibande district (see annexure F).

Mpumalanga has 360 clinics providing PHC services, including the provision of contraceptives and referrals to relevant institutions for TOPs. Of these clinics, 134 are in the Gert Sibande District, which has a population of approximately 967 579 people of which 55,0% live in rural areas (HST 1997:19).

The clinics in the Gert Sibande District comprise mobile clinics, which are clinics on wheels that visit certain areas that do not have clinics at all, like rural areas. These mobile clinics visit certain points where people gather and the service is rendered inside the mobile clinic. Other clinics are fixed, which

are built clinics, serving a particular area of the community. They are mostly open from 07:00 to 16:00. The community health centres are the bigger clinics in the area, which remain open for twenty-four hours per day. All the other clinics refer patients to the community health centres, as they provide more diverse services than the other clinics (HST 1997:9–40).

All clinics in the Gert Sibande District provide contraceptive services. The number of people who used contraceptives in Mpumalanga and the number of condoms issued from 1999 to 2001 are portrayed in table 1.1.

Table 1.1 Contraceptive use in Mpumalanga

YEAR	NURISTERATE	DEPOPROVERA	ORAL PILLS	IUCD'S	CONDOMS ISSUED
1999	24 376	223 180	123 365	2 113	3 711 319
2000	27 601	235 292	106 532	1 404	4 019 621
2001	402 244	299 461	154 683	1 813	6 022 525

(Mpumalanga Department of Health 1999–2001)

These numbers demonstrate an annual increase in the use of injectable contraceptives and barrier methods, with fluctuating figures in the use of oral contraceptives, and a decline in the use of intra uterine contraceptive devices (IUCDs) from 1999 to 2000, but a slight increase during 2001.

These statistics generate a number of questions. Why are injectable contraceptives the most frequently used contraceptive method? Why are other methods of contraceptives not promoted, like emergency contraceptives (ECs) and IUCDs? Are these methods offered to clients? Are they being used? On the other hand women who have undergone TOPs according to the CTOP Act (no 2 of 1996) in the Mpumalanga Province (SA 1996b), demonstrated an annual increase as reflected in table 1.2.

Table 1.2 Termination of pregnancies in Mpumalanga

YEAR	NUMBER OF TERMINATION OF PREGNANCIES
1998	1 810
1999	2 513
2000	3 282
2001	3 518

(Mpumalanga Department of Health 1998–2001)

In the Gert Sibande District (Mpumalanga) women who underwent TOPs also showed annual increases from 1998 to 2001, as shown in table 1.3.

Table 1.3 Termination of pregnancies in the Gert Sibande District, Mpumalanga Province

YEAR	NUMBER OF TERMINATION OF PREGNANCIES
1998	668
1999	891
2000	929
2001	1 094

(Mpumalanga Department of Health 1998–2001)

This study attempted to identify contraceptive challenges resulting in the non-use of freely available contraceptives in the Gert Sibande District. Non-utilisation of contraceptives results in increased demands for CTOP services. Conversely, the effective utilisation of contraceptive services should decrease this demand for CTOP services in this district.

1.3 PURPOSE OF THE STUDY

The estimated numbers of women who underwent back street abortions and the increasing numbers of women who requested TOPs, suggest that even though contraceptives are free of charge in RSA in the public sector, there might be other barriers challenging effective contraceptive utilisation.

There are those challenges that women face even before they can initiate contraceptive use, and those that are experienced during the use of contraceptives. All of these challenges can negatively affect and sometimes impede the use of contraceptives (Maforah, Wood & Jewkes 1997:80-82; Troskie & Raliphada-Mulaudzi 1999:41).

Contraceptive challenges that are facing women even before contraceptives can be initiated include:

Knowledge, if a woman has to utilise contraceptives effectively, she needs basic knowledge about her reproductive anatomy, physiology, conception and contraceptives. This knowledge can best be imparted during sexuality education, a process through which all institutions of society should inform individuals about issues and responsibilities pertaining to procreation and sex. These social institutions include the family, church, school, media and social clubs (Bam 1994:16-28.)

The women's level of education, the less educated the woman is, the less likely she is to use contraceptives (Chimere-Dan 1996:4-9). In many African cultures if children cannot be procreated within a family, it is perceived to be the women's "fault", making the woman feel guilty and depressed (Ehlers 1999:50), and justifying her husband's/partner's actions in fathering children with other women. In fear that the use of contraceptives could cause infertility, women might stay away from the use of contraceptives (Bankole, Singh & Haas 1998:117). In this instance gender influences contraceptive use. Certain religions discourage women from using contraceptives, advocating natural family planning (NFP) methods, which have higher failure rates than modern contraceptives. For example, the Roman Catholic Church encourages people to use the rhythm method, implying abstinence during the woman's fertile days of each cycle (Bankole et al 1998:120). This method has a high failure rate and is not an effective family planning option. In addition to depending on abstinence during the fertile

days of the woman's menstrual cycle, it demands a detailed understanding of the menstrual cycle and process and meticulous calculations - something not achievable by uneducated women. In such cases women might be discouraged by religious obstacles even before they initiate contraceptive use. However, should women become pregnant and wish to access CTOP services, then their religious opposition seems to weaken. "The compulsion to terminate overrode not only their legal considerations, but religious ones as well. It is notable that women with strong religious affiliations (Catholic, Muslim and Hindu) were not deterred from seeking termination even though they acknowledged that abortion was highly disapproved of on conventional religious grounds" (Maforah et al 1997:79).

Men pay "lobola" (bridal prize) for their prospective brides according to most African cultures. *T*his implies that men buy and pay for their wives' reproductive capacities, and for the children the wife would bring into the husband's family and tribe. This situation takes away the right of many African women to make their independent reproductive decisions. She cannot decide on the number of children she wants, because her husband paid for that right by paying lobola (Ehlers 1999:50).

Inaccessibility of contraceptive services in rural areas can impede contraceptive use since urbanisation is associated with greater contraceptive accessibility (DOH 2001:8). In addition to more family planning clinics being available in urban areas, urban women might be able to access these services in more anonymous ways. It might be difficult for a rural woman to access contraceptives without meeting a relative or friend at the clinic who might inform her husband of her practice. Fear of disclosure might play an important part in failure to use contraceptives, especially in rural areas.

Knowledge, gender issues, socio-economic and educational status, culture and religion can pose challenges before women can use contraceptives and sometimes even during the use of contraceptives.

If a woman uses a contraceptive method to prevent an unwanted pregnancy, this does not mean all is well. There are a number of challenges that can negatively influence and cause discontinuation of the use of contraceptives.

Unavailability of certain contraceptive methods, higher provider workload, staff shortage, inadequate contraceptive training of the provider, lack of proper counselling about the method of choice, negative attitudes and rudeness of the providers, all can negatively impact on the effective use of contraceptives (DOH 2001:7–8). Much as contraceptives have benefits to all who use them, they still have side-effects. If women are not properly counselled on side-effects, and on what to do if side-effects are not bearable, then they cannot use contraceptives effectively (Lewis & Salo 1996:60).

The purpose of this study is to identify challenges before and during the use of contraceptives experienced by women who requested CTOP services in the Gert Sibande District during August and September 2003.

1.4 PROBLEM STATEMENT

Burns and Grove (2001:66) defined a research problem as a situation in need of a solution, improvement or alterations, a discrepancy between the way things are and the way they ought to be.

The grounds for legal termination of pregnancy have been liberalised according to the CTOP Act (no 92 of 1996). The number of women who used CTOP services in the Gert Sibande District continued to increase (Mpumalanga Department of Health 1998-2001).

Carrying unintended and unplanned pregnancies, undergoing TOP, the annual increase of women requesting TOP, in the face of free contraceptives, is a discrepancy between the way things are, and the way they ought to be. Women should be utilising contraceptives effectively to prevent unwanted

pregnancies. In order to improve contraceptive use, contraceptive challenges should be identified and addressed in specific areas of each district of each province of the RSA.

The research problem can be stated as:

What are the challenges impeding effective contraceptive use, as experienced by women who requested CTOP services in the Gert Sibande District during August and September 2003?

1.5 RESEARCH QUESTIONS

The research problem led to the following research questions:

How can the following factors hinder a woman from using contraceptives?

- Lack of or inadequate sexuality education during the teenage years
- Lack of appropriate contraceptive knowledge
- Attitudes and perceptions about contraceptives
- Low socio-economic and educational status of women
- Cultural values, beliefs and norms
- Gender
- Religion
- Inaccessibility of contraceptive services

What influences do the following factors have on the effective use of contraceptives?

- Unavailability of certain contraceptive methods
- Lack of contraceptive equipment and resources
- The attitudes of the contraceptive providers

- The side-effects experienced during the use of contraceptives
- Counselling received about the contraceptive method of choice
- Lack of accurate, up to date and relevant contraceptive knowledge by the providers
- Political issues
- Shortage of personnel and the high provider workload
- The measures that could be implemented to address some challenges to enhance contraceptive use

1.6 THEORETICAL FRAMEWORK

Orem's General Theory of Nursing has been selected as a theoretical framework within the parameters of which to contextualise and explain the phenomenon of women who failed to use contraceptives and thus requested CTOP services in the Gert Sibande District during August and September 2003. Orem's General Theory of Nursing was used in this study in order to identify relationships of the concepts of contraceptive challenges, providing a systematic view of this phenomena.

According to Orem (George 2002:124), nursing has its concern in the individual's needs. It exists in order to help the individual to meet the needs for self-care, for continuously providing and managing these needs in order to sustain life and health. Orem's General Theory of Nursing consists of three constructs, namely the self-care construct, the self-care deficit construct and the nursing systems construct.

1.6.1 The self-care construct

It is the performance of activities that an individual initiates and performs on his/her own in order to maintain life, health and well being. These actions are deliberate; they have pattern and sequence. Intellectual curiosity, instruction, supervision and experience aid the performance of these activities. When these actions are performed by an individual they lead to structural integrity, human functioning

and development (George 2002:128). In contraceptive use Orem's self-care construct can refer to a client, who because of her intellectual curiosity and the information she might have received about sexuality education (basic reproductive anatomy, conception and contraception) would then initiate using contraceptives. During her use of contraceptives the instructions received from contraceptive providers should help her to continue their use, contributing towards her integrity and development.
There are three categories of requisites of the self-care construct; namely the universal, development and health deviation requisites.

The universal self-care requisites encompass activities associated with life processes, and the maintenance of integrity of human structure and functioning. These activities are interrelated and interdependent for example air, food, water, elimination, activity, rest, social interaction and normalcy (George 2002:129).

In contraception these include activities that need to be performed in order for the method to function effectively. Without performance of these activities there is no protection against pregnancy. If for example oral contraceptives are used, performance of activities will require.

- the taking of the contraceptive pill daily irrespective of the frequency of sexual intercourse
- returning for supplies as scheduled
- taking extra protection when using broad spectrum antibiotics, such as abstinence or using condoms (Theron & Grobler 2000:35-46)

The development self-care requisites comprises maintenance of conditions to support life processes and human development (George 2002:128). In referring to contraceptive use these self-care requisites can refer to activities that will help to maintain and support continuous use of contraceptives by an individual, like attending the contraceptive clinic as scheduled, and asking assistance from the provider if side-effects are experienced.

The health deviations self-care requisites are activities that take place in case of an illness. They constitute seeking medical assistance, attending to the effects of human pathology, carrying out medically prescribed measures and altering one's life style to promote personal development (George 2002:128).

The health deviation requisites in contraceptive use will be activities that are carried out when problems arise from the method used, or when side-effects are experienced. For example, if a woman experiences recurrent profuse offensive yellow vaginal discharge when using an IUCD, this could indicate the presence of an infection requiring diagnosis and treatment. These health deviation requisites imply assessing the woman and prescribing relevant antibiotics. The provider should explain the importance of finishing the treatment, the need to alter her lifestyle in order to promote her well being by promoting personal hygiene, using condoms to prevent contracting further sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV) (Theron & Grobler 2000:85).

1.6.2 The self-care deficit construct

The self-care deficit construct determines when nursing care is needed and who needs it. Nursing care is said to be required when the ability to perform self-care requisites is absent or limited, or when special techniques and scientific knowledge are required to provide care (George 2002:129).

With regard to contraceptives, this construct can refer to the determination of when contraceptives are required and by whom. The DOH (2001:15) states that contraceptives should be provided to all who need them, including men, adolescents and people with disabilities and special needs. No client requesting contraception should be sent away without a suitable method of choice.

George (2002:127) stipulates the activities that can be followed in providing nursing care:

- Enter into and maintain nurse patient relationships with individuals, families and groups.

- Determine if and how patients are to be helped.
- Respond to patients' requests, desires, needs for further contacts and assistance.
- Prescribe, provide and regulate direct help to patients and their significant others.
- Coordinate and integrate nursing with the patients' daily living, and social and educational services needed or being provided.

The performance of the abovementioned activities in contraception means, the contraceptive provider has to enter into a relationship with clients, families and communities. Since she is rendering her service within the community, this could be achieved by being active in community projects, responding to invitations to community gatherings, going out to the community and offering contraceptive talks in schools, women's and men's clubs and in other community gatherings, and providing family workshops on the use of different contraceptives.

In so doing she can find out how contraceptives can be provided. During her talks she can respond to the clients' requests and provide the necessary information and assistance. By being part of community events, she is coordinating and integrating nursing with the clients' daily living, social and educational services.

1.6.3 Nursing system construct

According to George (2002:132), the nursing system construct is dependent on the patients' ability to perform self-care needs. Orem has developed three nursing systems, they are the wholly compensatory, partly compensatory and supportive education. The wholly compensatory nursing system is designed for patients who cannot perform activities to meet their needs, like a non-responsive patient who requires oxygen, elimination, body hygiene and exercises.

In relation to contraceptives, the nursing care constructs can be associated with the levels at which contraceptives are provided. Wholly compensatory will be the education and support provided to a client who has no basic education, no knowledge about contraceptives, no background information on

reproductive anatomy and physiology and comes from a poor socio-economic background. The contraceptive provider will have to supply all the required information, at the level that this client can understand, enabling her to utilise contraceptives effectively.

The partly compensatory nursing system can be related to care and support provided to clients who have some basic form of education, and who have some knowledge about contraceptives. The knowledge she has might not be sufficient, so the contraceptive provider might need to add further information and address some misconceptions to afford this client an opportunity to use contraceptives effectively.

The supportive educative system is a system where a person is able and can learn to perform the required self-care measure, like an adolescent with some knowledge about the female reproductive system. However, she might still need explanations as to why it is absolutely essential to take an oral contraceptive every single day, preferably at the same time every day.

The supportive education system can refer to the provision of support and care to clients who are educated, and have most information about their reproductive anatomy, physiology, conception and contraception. An example could be a student nurse in her third year of training, who has requested contraceptives. The support and education provided would be at her level of understanding and she should be given support that can allow her to continue effectively with contraceptive use.

1.7 SIGNIFICANCE OF THE STUDY

Burns and Grove (2001:85) stated that research is conducted in order to provide information that can lead to research based nursing care. If contraceptive challenges can be identified, faced by women before and during the use of contraceptives, this knowledge could help

- policy-makers in the Gert Sibande District, to clarify guidelines about the provision of contraceptives

- contraceptive providers to overcome challenges identified as hindering effective contraceptive use
- clients to be provided with better reproductive health services that are research based, and this could lead to a decrease in the number of women requesting TOP
- if the demand for CTOP services could be reduced, the finances saved thereby, could then be utilised to improve the reproductive health care services
- use information obtained to be shared with nurses during in-service education sessions on contraceptives in the Gert Sibande District

1.8 ASSUMPTIONS UNDERLYING THIS STUDY

Burns and Grove (2001:790) defined assumptions as statements "… taken for granted or considered true, even though they have not been scientifically tested". The following assumptions were accepted as being true, on which the research was based. Ineffective use of or failure to use contraceptives is influenced by

- a lack of knowledge about reproduction, conception and contraception
- lack of knowledge about different contraceptives (including their effects as well as their side-effects)
- ineffective counselling on contraceptives
- insufficient contraceptive knowledge by the providers
- poor socio-economic status
- lack of general education
- cultural values
- religious beliefs
- inaccessibility of contraceptive services, in terms of distance and working hours
- side-effects experienced during the use of contraceptives
- inadequate equipment and resources for providing contraceptive services

1.9 ETHICAL CONSIDERATIONS

According to Polit and Hungler (1999:130-138), observing certain principles helps the researcher to adhere to research ethics. Ways in which the principles of beneficence, respect for human dignity and justice were observed are discussed in chapter 3.

1.10 METHODOLOGY

It refers to the way the study has been conducted. More details about all these aspects are provided in chapter 3.

1.10.1 Research method

This is an exploratory descriptive study of the contraceptive challenges experienced by women who requested TOPs in the Gert Sibande District (Mpumalanga Province).

1.10.2 Population

The population comprised the South African women of all races, age groups, educational status, socio-economic status and religion who has requested TOP under the CTOP Act (no 2 of 1996) in the Gert Sibande District (Mpumalanga Province) during August and September 2003.

1.10.3 Sampling

A non-probability sampling method has been adopted; a convenience sample of 50 respondents was obtained (Polit & Hungler 1999:226).

Data were collected using structured interview schedules.

1.11 SCOPE AND LIMITATIONS OF THIS STUDY

According to Polit and Hungler (1999:138-139), care must be exercised if the researcher uses participants that are a vulnerable group. Patients in a hospital setting are regarded as a vulnerable group, because they depend on health care personnel and they may feel pressurised into participating or may believe that their treatment would be jeopardised by their failure to cooperate.

This study was conducted in the Mpumalanga Province – Gert Sibande District, in the Bethal Hospital. Explanations were given to each participant that her refusal to participate was not going to influence her treatment in any way whatsoever. The type of setting in which the study was conducted constiuted a limitation, because participants found it difficult to be completely relaxed in a hospital environment and being in hospital might have made them vulnerable.

Another limitation was the fact that these were pregnant women, who did not want to carry this pregnancy to term. They wanted TOPs. This required a careful approach, as these women wanted maximum privacy and confidentiality.

The emotional and psychological state in which these women were, was that of being distressed and anxious because of the nature of the procedure they were to undergo (TOP). They needed to be handled with care, to avoid stressing them further.

1.12 OBJECTIVES OF THE STUDY

Research objectives are clear, concise, declarative statements that are expressed in the present tense (Burns & Grove 2001:169). In this study the research objectives aimed to

- identify contraceptive challenges existing before contraceptive use can be initiated
- determine contraceptive challenges experienced during the use of contraceptives
- outline initiatives, which could address contraceptive challenges

1.13 OPERATIONAL DEFINITIONS USED IN THE RESEARCH REPORT

An operational definition is a strategy through which a set of characteristics essential to the connotative meaning of a concept is identified (Burns & Grove 2001:133). This is what helps the researcher to describe what is going to be studied and how it will be investigated.

Burns and Grove (2001:132) define a concept as a term that abstractly describes and names the object, thereby giving it a separate identity or meaning. The concepts in this study have been operationally defined as:

Abortion

According to the *Oxford Handy Dictionary* (1991:2), an abortion refers to the premature termination of a pregnancy; this could be due to the spontaneous or induced expulsion of the foetus from the uterus - usually during the first 28 weeks of pregnancy.

Contraception

It refers to the prevention of conception by either temporary or permanent means (Foy, Gabriel, Cindi & Dickson-Tetteth 2001:2).

Contraceptive method

Contraceptive methods include hormonal contraceptives (injections, pills and implants), barrier methods (male and female condoms and cervical caps), intra uterine contraceptive devices (IUCDs), emergency contraception (EC), voluntary surgical sterilisation (VSS), natural family planning (NFP) and traditional methods of family planning (Foy et al 2001:2).

Contraceptive challenges before contraceptive use

These are factors that exist in women's lives that negatively impact on or prevent them from using contraceptives, including culture, religion, educational and socio-economic status, accessibility to contraceptive services, gender issues and level of education.

Contraceptive challenges during contraceptive use

These are factors that negatively impact on the process of continuous effective contraceptive use. The non availability of certain contraceptive methods, counselling received about the method of choice, the attitude of the provider, lack of equipment and resources relevant to reproductive health, the side-effects, political issues, inadequate contraceptive knowledge of the providers and shortages of personnel, comprise contraceptive challenges during contraceptive use.

Women who requested termination of pregnancy services

This concept encompasses all women who requested TOP services according to provisions stipulated in the CTOP Act (no 92 of 1996) in the Gert Sibande District.

Future plans

Ways and means which will be used by women who requested TOPs to prevent future unwanted pregnancies, are collectively termed ‘future plans’ for the purpose of this dissertation.

Termination of pregnancy

This refers to ending a pregnancy by expelling (aborting) the fetus from the uterus. Ehlers, Maja, Sellers and Gololo (2000:48) emphasised that termination of pregnancy services provided in terms of the CTOP Act (no 92 of 1996), should include the counselling of women before and after the CTOP procedure(s), should be able to handle incomplete abortions, should provide contraceptive services after the TOP and should link TOP services to other related reproductive health services, including contraceptive services.

Unwanted pregnancy

"Unwanted pregnancy refers to a pregnancy that may not have been planned, and that may be unintentional and unwelcome by the pregnant woman. Such a pregnancy may occur as a result of contraceptive failure or nonuse of contraceptives" (Maja 2002:20-21).

1.14 ABBREVIATIONS USED THROUGHOUT THIS REPORT

AIDS	Acquired immune deficiency syndrome
CTOP	Choice on termination of pregnancy
DENOSA	Democratic Nursing Organisation of South Africa
DOH	Department of Health
EC	Emergency contraception
HIV	Human immunodeficiency virus
IUCD	Intra uterine contraceptive device
Mcg	Microgram
Mg	Milligram
MPA	Medroxyprogesterone acetate
NET-EN	Norethisterone enanthate
RRA	Reproductive Rights Alliance
RSA	Republic of South Africa
SA	South Africa
TOP	Termination of pregnancy
VSC	Voluntary surgical contraception
VSS	Voluntary surgical sterilisation
UK	United Kingdom
Unisa	University of South Africa
USA	United States of America

1.15 CONCLUSION

In the RSA, the CTOP Act (no 92 of 1996) provides liberal grounds for women to obtain CTOP services. From conception to 12 weeks of pregnancy, all a woman needs to do, is to ask for a CTOP. Large numbers of South African women used CTOP services, despite the presence of freely available contraceptives. The reason for the continued demand for CTOP services, despite freely available contraceptives and emergency contraceptives, is not known.

The question to be answered by this research project is: why will women resort to CTOPs, instead of preventing unwanted pregnancies by using freely available contraceptives? Preventing conception through using contraceptives might require overcoming a number of challenges; preventing women from starting to use contraceptives, or to discontinue such use after a period of time, or to use contraceptives incorrectly/ineffectively.

Chapter 1 introduced the topic and provided some background information about TOP services and about contraceptives. Chapter 2 will summarise the literature reviewed relevant to the termination of pregnancies and to barriers affecting the effective use of contraceptives in the RSA and in other countries.

1.16 ORGANISATION OF THIS REPORT

The dissertation comprises the following chapters.

Chapter 1 is an introductory chapter. The background of the study, the purpose, the research problem, research questions, theoretical framework, significance of the study, assumptions underlying

the study, ethical considerations, methodology, scope and limitations of the study, objectives and the definitions of the terms as well as abbreviations used throughout this dissertation are discussed.

Chapter 2 contains a discussion of the literature that has been reviewed, to support the existence of contraceptive challenges, the legislation that impacts on contraceptives in the RSA and in selected other countries and several topics relevant to TOPs and to contraceptive use or non-use.

Chapter 3 incorporates a description of the research methodology, the research design, population, sampling, methods of data collection, validity and reliability of the research instrument, and ethical considerations pertaining to this research project.

Chapter 4 comprises the analyses and discussions of the research results obtained from the data collected during structured interviews with women who requested TOP services in the Gert Sibande District of the Mpumalanga Province.

Chapter 5 provides conclusions and recommendations for further research and indicates the limitations impacting on the generalisation of the research results.