

CHAPTER 2

Literature review

2.1 INTRODUCTION

Reviewing literature that is relevant to one's research is a critical step in the research, it is used in all the steps of the research process. Researchers cannot conduct their study in an intellectual vacuum, but it is undertaken within the context of an existing knowledge base (LoBiondo-Wood & Haber 1998:94).

Burns and Grove (2001:107) cite Becker (1986) in stating that, when research is conducted, researchers depend on their predecessors, they do not sit down and invent it from scratch. Research would not be possible, if one could not rely on previous methods, results and ideas. Few people will be interested in results that do not demonstrate a relationship with previous results and findings.

LoBiondo-Wood and Haber (1998:94) define a literature review as a systematic and a critical review of the most important published scholarly literature on a particular topic. To be able to critically review literature, the end product should state the current knowledge about the topic, point out both consistencies and contradictions in the literature, and provide possible explanations for inconsistencies.

The review should be objective, studies should not be excluded because they do not agree with the research topic, or conflict with one's personal views (Polit & Hungler 1999:98-99.)

A further suggestion is made by Polit and Hungler (1999:82-83) that the breadth and the depth of the literature review depend on several factors like the knowledge of the researcher about the topic under

study. A common misconception is to relate the number of references as determining the quality of the research, but the relevancy of the literature does the trick, rather than the number.

2.2 PURPOSES OF THE LITERATURE REVIEW

Reviewing literature helps the researcher to

- become familiarised with practical and theoretical issues relating to the problem
- generate ideas and focus on a research topic
- develop appropriate research questions
- confirm what is already known about the topic
- compare findings with earlier research done on the topic

The first time researcher is able to point out useful research strategies, specific procedures, measuring instruments and statistical analyses that might be productive in pursuing the research problem (Polit & Hungler 1999:79-80.)

Burns and Grove (2001:118-125) suggest that reviewing relevant literature aids the researcher to

- develop creative ideas whilst going through other researchers' work as recorded in the available literature
- cluster and interrelate ideas from several sources
- determine the current knowledge about the topic through obtaining meaning from other sources and connecting them to the proposed study

2.3 LITERATURE REVIEWED

In this study literature has been reviewed based on the research problem and the research questions. Emphasis has been given to contraceptive challenges that exist even before a woman initiates the use of contraceptives. These challenges include sexuality education received during teenage years, gender, religion, cultural values and norms, socio-economic status, politics and the women's educational status.

Literature on contraceptive challenges that exist during the use of contraceptives has also been reviewed, including counselling received about the use of contraceptives, unavailability of certain contraceptive methods, attitudes and perceptions pertaining to various contraceptive methods, the attitude of the contraceptive providers, side-effects experienced, lack of adequate and up to date contraceptive knowledge by providers, shortage of personnel, lack of relevant contraceptive resources and equipment and knowledge about various available contraceptive methods.

As such TOP has been discussed under the following topics, the history of abortion in the RSA, characteristics of women who undergo TOPs, reasons attributed to TOPs, the effects of TOP, counselling on TOP, the partners' support during TOP, pro-life arguments and pro choice arguments.

2.4 CONTRACEPTIVE CHALLENGES

Using contraceptives is neither a simple nor a straightforward process. It is complicated and is accompanied by many challenges that hamper its effective implementation and sustained usage. Effective management of these challenges could enhance contraceptive use.

Belfied (1998:26) stated that to be an effective and efficient contraceptive provider, one needs to know why and how people make contraceptive choices. To minimise unintended pregnancies will depend on the user's maximum satisfaction and confidence with the method, and the method's effectiveness. To develop a method that is perfect is next to impossible, because that method has to be 100,0% safe,

effective, without side-effects, non-intercourse related, reversible and cheap. To admit that no contraceptive method is suitable for everyone poses a big challenge to contraceptive providers.

Speizer, Hotchkiss, Magnani, Hubbard and Nelson (2000:13) stated that it is uncommon for contraceptives to be without challenges, whether they are facility, policy, provider or legislation related. South Africa is a country with limited resources and facilities, so the effective use of contraceptives has a potential to improve not only the lives of the men, women and children involved, but also those of their families and the communities. The primary reason for having sex is not always procreation (Visser 2000:18).

According to the DOH (2001:7-9), there are various factors that influence contraceptive usage, the socio-economic status, knowledge about contraceptives, attitudes about issues related to contraceptives, residential area, educational status, counselling received on contraceptives, the attitudes of the contraceptive providers, and cultural values, norms and beliefs.

Orem's General Theory of Nursing was used to correlate contraceptive challenges experienced before a woman initiates the use of contraceptives and those that are experienced during the use of contraceptives. These theoretical applications were discussed in section 1.6 of this dissertation.

2.5 CONTRACEPTIVE CHALLENGES THAT EXIST BEFORE CONTRACEPTIVES CAN BE INITIATED

2.5.1 Sexuality education

Sexuality education is not an event but it is a process that continues throughout the person's life. Sex information should include relevant knowledge about anatomy, physiology, sexual behaviour, STDs, sexual development, conception and contraception.

This information should be able to build the person's character, self-esteem, ethical and moral behaviour, ego strength, sense of personal worth and the capacity for independent decision-making. Sexuality education that focuses on reducing teenage pregnancies emphasises only the physical aspects of sexuality. The psychological, social, spiritual and emotional aspects of sexuality tend to be neglected with such an approach. This approach might focus on how to engage in sexual encounters and not get pregnant. Sexuality education should prepare teenagers to meaningfully incorporate the concept of sex within the rest of their lives.

Sexuality education cannot be provided effectively by one person or institution. It is not an event where all can be said within a few hours, at home or at school nor by watching a video or film.

The institutions of family, school, church, club and media should join efforts if sexuality education is to be successful. Parents play an important role as they are supposed to lay the foundation upon which the rest is to be built. The parents' background information, level of education and their personal experiences pose obstacles to effective sexuality education (Bam 1994:16–28).

Mayekiso and Twaise (1992:21-23) stipulated the following reasons that could be associated with poor sex education by parents:

- Embarrassment to discuss sex with the children because of the parents' own beliefs that sex involves the duty to procreate and that sex purely for pleasure is wrong.
- Lack of necessary skills and information needed to empower children for responsible sexuality.
- The inability to realise that even though adolescents are biologically capable of being sexually active, they might be emotionally unprepared to act responsibly.
- The parents' attitudes of not being approachable to discuss sex-related issues.

Parental involvement in their children's sex education is influenced by the parents' educational status, background history, socio-economic factors, religion and cultural background.

Although it is recommended that every institution takes part in sexuality education (Bam 1994:26), this does not seem to occur in real life situations in the RSA. In their study of parent's involvement in imparting sexuality knowledge to adolescents, Mayekiso and Twaise (1992:20-30) found that in the Transkei region of the RSA, 45,0% of adolescents gained sexual knowledge from their peer group, 14,2% from their parents, 16,7% from school teachers and 18,5% from family members other than parents and 4,8% from the media. In Garankuwa (RSA) Ehlers et al (2000:46) found that 40,52% of the adolescent mothers received sex education from parents or other family members, 24,32% from friends and 25,23% from teachers and 5,4% from nurses. Similarly teenage mothers in the Transkei region of the RSA reportedly received sex education from their parents (1,4%), teachers (16,7%) and from the church (14,0%).

Lewis and Salo (1996:59-63) studied birth control; contraceptives and women's rights in Cape Town (RSA). Out of their sample, only 25,0% reportedly had sex education while at school, only after they were sexuality active. Some of these women heard about sex education for the first time during their antenatal clinic visits.

According to Williams and Mavundla (1999:58), out of 42 teenage mothers, 59,0% had received sex education while 31,0% did not. However, 42,0% of these teen mothers did not receive any education about contraceptive issues.

In imparting sexuality education, factors that influence timing of the first intercourse should be considered. Gueye, Castle and Konate (2001:56) stated that research in Africa revealed that sexual activities currently take place in different social circumstances, than what used to happen in the past. Urbanisation, modernisation, education and exposure to Western media caused declines in traditional values, particularly the issues of virginity and marriage were rapidly changing. The concepts of sexual pleasure, taboos, rites and cleansing procedures were often associated with particular cultural rituals such as circumcision and initiation, but even these were changing in parts of Africa.

In their study Gueye et al (2001:58) found that boys' and girls' reasons for consenting to sex were different. Girls from urban areas cited love and those from rural areas cited promises for marriage as reasons for engaging in sexual intercourse. Boys from both rural and urban areas cited curiosity and peer pressure as reasons. The use of contraceptives was associated with being satisfied with the timing of the first intercourse.

In Chile, researchers reportedly found the following factors to be influencing the timing of the first intercourse (Murray, Zabin, Teledo-Dreves & Luengo-Charath 1998:151):

- liberal attitudes towards sex
- teenagers who thought that their peers were sexually active
- teenagers who rarely attended religious services
- teenagers who used alcohol, tobacco and/or marijuana
- teenagers with lower school grades
- the absence of the father

Mwaba (2000:34) found that both teenage boys and girls in the RSA stated the following as factors leading to pregnancies among teenagers:

- peer pressure (66,0%)
- participants' refusal to use condoms (65,0%)
- having sex without considering pregnancy (57,0%)
- fear to use contraceptives (5,0%)
- distrusting contraceptives (49,0%)
- girls wanting to prove their fertility (23,0%)
- fearing parents' reactions towards their use of contraceptives (49,0%)

Factors that were found to be associated with ineffective contraceptive use by Makhetha (1996:30) were:

- Age: the younger the teenager, the less chances there were that she could use a contraceptive.
- Religion: higher religiosity made teenagers less likely to indulge in pre marital sex.
- Socio-economic factors: teenagers from lower socio-economic status tended to be more inconsistent contraceptive users.
- Psychological characteristics of fatalistic attitudes like low esteem, a sense of powerlessness characterised low contraceptive use.
- Lack of knowledge and attitudes about reproduction, availability and accessibility of contraceptive services disabled teenagers from accessing and using these services.

A positive attitude from a parent or adult is required in order to be effective sexuality educators. Teenagers indicated that adults consider sex to be their "own thing", discouraging teenagers from engaging in sexual encounters. Teenagers reportedly think adults talk too much (Mfono 1998:180-190).

If all institutions within the society could engage in meaningful sexuality education, this could help teenagers to become informed and to initiate contraceptive use when required. According to Orem's General Theory of Nursing (George 2002:127), this will qualify them to belong to the self-care construct where an individual initiates and practises activities on her own.

2.5.2 Gender

Gender refers to the economic, social and cultural attributes and opportunities associated with being female or male. It encompasses a set of qualities and behaviours expected by society from females and males. In most societies being a woman or a man means not only having different biological

characteristics but also facing different expectations about appearance, qualities, behaviour and work appropriate to being male or female (Foy et al 2001:76.)

Nelson (1997:52) sees clinics as being stigmatised, they belong to women, not to men who are mostly seen at clinics after sport injuries. Men should be targeted and taught about contraceptives where they are seen the most. Teaching men about contraceptives could save the women arguments when condoms are to be used. Men could help with remembering information when emergency contraceptives are to be used.

Erasmus and Bekker (1996:38) stated that in nurturing their egos, and in combatting their wives' potential unfaithfulness, African men prefer to have their wives "permanently pregnant". If no children can be procreated in a marriage, it is a woman's fault, leaving the women feeling unhappy, guilty and depressed. In fear that contraceptives could lead to infertility, some women might fail to use contraceptives, because in many African cultures a man is never regarded as being infertile (Ehlers 1999:50), unless he is impotent.

Mfono (1998:180) highlighted that the teenage boys in her study in the Gauteng Province (RSA), did not use any form of protection against pregnancy. They assumed that the girls would use protection, as they regarded it as being the girls' responsibilities to be protected.

Traditionally men are regarded as providers and heads of their families, even after all the socio-economic changes, whereby women were forced to seek jobs and to become providers too, they are still not provided equal rights (Pretorius 1994:19). In many traditional societies African women hold inferior positions compared to those of men. Women are taught to be subservient to their husbands, men in general and specifically to their husbands' family members, especially their mothers-in-law (Troskie & Raliphada-Mulaudzi 1999:43).

Counselling women about the use of contraceptives might be worthless because women might not have any decision-making powers when it comes to procreation and sexuality issues. In African cultures this decision can lie with the husband, mother in law or the extended family (Ehlers 1999:82).

Matladi (1998:26) further highlighted this issue by stipulating that preoccupation with educating women ignores the social significance of men and their role within the family, workplace, community and government. Men should be viewed as partners and potential clients with their own sexual and reproductive needs, as they hold a dominant role in decision-making, regarding fertility and sexual relations and many other issues that shape gender relations and directly affect women. If men were included in contraceptive education efforts this could improve communication within relationships and foster respect and shared responsibilities pertaining to the reproductive health processes.

Because of gender issues women might sometimes be unable to initiate the use of contraceptives to prevent unwanted pregnancies, which is what Orem (George 2002:127) calls the self-care construct. Gender makes men to be regarded as never infertile, married women (but not married men) commit adultery, women can work and be providers for their families but they are still regarded as being subordinate to men. Reproductive decisions lie with men or with the woman's in laws. If contraceptives are allowed, it is the woman's (not the man's) responsibility to be protected against pregnancy.

2.5.3 Socio-economic status

Ehlers (1999:54) highlighted the effect socio-economic status has on the use of contraceptives. She stated that the low socio-economic status of African women puts them in a situation where they are dependent on their husbands for financial support. They, therefore, cannot independently decide on the number of children required in their families, the use of contraceptives, the husbands' use of condoms, nor about the husbands' polygamous marriages and/or extramarital affairs.

Women's low socio-economic status puts them in a submissive role, where they lack self-confidence, assertiveness and self-value. Husbands might have to grant their wives permission to use

contraceptives. The higher the woman's socio-economic status, the more assertive she becomes, and the more she can enjoy her reproductive rights. Women who are not earning an income, or who earn smaller incomes falling below the breadline, will always depend on their husbands for support, therefore forfeiting the right to decide about the reproductive issues generally, and the use of contraceptives specifically (Troskie & Raliphada-Mulaudzi 1999:46).

If a woman has a low socio economic status then she cannot belong to the self-care construct in terms of Orem's theory (George 2002:127-129). This means she cannot initiate contraceptive use on her own, but she requires someone to engage in a relationship with her, and support her to be able to take the decision. Extrapolating this theoretical assumption, it could be argued that unless significant other persons in the woman's life (such as her husband, partner or mother-in-law) support her decision to use contraceptives, she might not be able to sustain its use.

2.5.4 Religion

Ehlers (1999:54) indicated that religion could sometimes hamper the effective use of contraceptives. Islamic women tend to let men decide on the number of children required. (Such women are unlikely to use contraceptives.) The Roman Catholic Church is opposed to many birth control methods, favouring the rhythm method which is unreliable. This could be problematic in the African situation, characterised by low socio-economic status of women, men's dominant culture and the fact that most of these men are migrant labourers. Bankole et al (1998:127) stated that because religious values oppose contraceptives, women tend to use methods with high failure rates such as the rhythm method.

On the contrary, Makhetha (1996:29) in his study of factors associated with contraceptive use by adolescents, mentioned that high religiosity made adolescents less likely to engage in premarital sexual relations. Murray et al (1998:140) stated that the teenagers who attended religious services regularly delayed the timing of the first sexual encounters.

According to Orem's self-care deficit construct (George 2002:129), the nurse must decide who needs health care when the nurse engages in a relationship with individuals, society and communities to help them meet their health care needs, including women's needs to use contraceptives to avoid unplanned pregnancies.

2.5.5 Level of education

Over the years researchers have tried to find factors that are related to the non-use of contraceptives. Never having been to school remains a strong predictor of non-contraceptive use. In the interviews of 883 women in Mexico, 49,0% of the illiterate women were found to have never used contraceptives, compared to 31,0% who did have either primary or secondary education who were using contraceptives (Nazar-Beutelspacher, Molina-Rosales, Salvatierra-Izaba, Zapata-Mertolo & Hepanin 1999:132-138).

Unless a woman has achieved a grade 9 level of education, it is unlikely to have had any impact on her fertility behaviour. In a study in the Transkei (SA), 67,0% of educated women were using contraceptives compared to 16,0% of the uneducated women (Chimere-Dan 1996:8).

Several other studies demonstrated that the lower the level of education the woman has, the less likely she is to use contraceptives. The incidence of unwanted pregnancies is high amongst the less educated women (Fikree, Khan, Kadir, Sajan & Rahbav 2001:135; UN 1993:59).

According to Troskie and Raliphada-Mulaudzi (1999:41), if a woman is uneducated then she cannot enjoy her reproductive rights. Women with higher education are able to comprehend information about contraceptive methods, they are therefore more aware of their human rights including their reproductive rights.

Ehlers (1999:48) stated that if a woman is uneducated she is unlikely to find a worthwhile job, so her hope for survival is to find a husband who will support her. She then performs her household duties, whilst the man decides on the size of the family and whether she can use contraceptives or not. Education helps women to access and use the clinics properly.

With regard to Orem's General Theory of Nursing (George 2002:127-130) educated women can initiate the use of contraceptives, constituting the self-care construct, but uneducated women's inability to access contraceptives belongs to the self-care deficit construct. The approach in helping both these groups of women differs. Women who are educated can be helped through the supportive – educative system, whilst illiterate women could require wholly compensatory actions from contraceptive providers.

2.5.6 Culture, norms and values

Culture is defined as a complex whole, which includes knowledge, beliefs, art, morals, law, customs and habits, acquired by man as a member of the society. Culture represents the way of perceiving, behaving, and evaluating one's world, it is a blueprint that is used for determining one's values, beliefs and practices (Andrews & Boyle 1995:8). Norms are said to be the roles by which human behaviour is governed, they provide direction for living according to values (Andrews & Boyle 1995:10).

Values are personal perceptions of what is good or useful, they differentiate what is desirable from what is undesirable. Values are the universal features of culture (Andrews & Boyle 1995:10). Humans do not exist without culture, nor without values.

Contraceptive providers are expected to know the effect cultural differences could have on the use, preferences, attitudes and beliefs concerning contraceptives. They are expected to know the cultural beliefs of the people they serve, as well as their own cultural beliefs that might influence preferences for a particular method or prescription. It is also important to know the level of affiliation of an individual to

his cultural beliefs, which might influence childbearing behaviours (Noone 2000:339), and thus also contraceptive usage/non-usage.

In many African cultures prospective husbands pay "lobola" (bridal prize) in the form of money, or a particular number of cattle to the bride's family. Men, because they have paid lobola, could regard their wives as possessions that they have bought. Women end up not being able to decide on the number of children desired nor about use of contraceptives. In some circumstances the men can claim back his lobola if a wife fails to bear children (Ehlers 1999:54).

Pretorius (1996:25) explained some disadvantages South African women face. They are expected to keep up with marital infidelity, emanating from the culture of polygamous marriage. Black South African men believe they have insatiable sexual needs. If a woman cannot bear children in a marriage her husband can easily engage in extramarital affairs and bear children outside marriage, and/or marry additional wives.

Erasmus and Bekker (1996:43) stated that South African black women are expected to use their reproductive ability in order to be accepted by their in-laws and other members of the community. If contraceptives are perceived as rendering women infertile, this poses a serious challenge to effective contraceptive usage. Females are not regarded as real women until they are mothers. Children symbolise a man's wealth and his future insurance. Manliness is mainly judged by the number of children fathered by the man.

In polygamous marriages, the wife with most children is likely to be the husband's favourite wife. Women in this kind of a marriage are not likely to use contraceptives, if they are competing to be the husbands favourite wife with the largest number of children. Sometimes women are required to prove their fertility even before the payment of lobola, because children in many African cultures are very important, they give value, meaning, dignity and status to the couple. In these instances even

adolescents might not be willing to use contraceptives since they know the values, culture and beliefs about children in their societies (Ehlers 1999:54).

These cultural beliefs could imply that culture poses a barrier to the use of contraceptives even before a woman can initiate the use of contraceptives. Such women cannot, according to Orem's General Theory of Nursing (George 2002:127-129), belong to the self-care construct, which means they cannot independently initiate the use of contraceptives. If indeed contraceptives are being used, they require what Orem calls the wholly compensatory nursing system.

2.5.7 Politics

In Africa politics are male dominated. This leads to a scenario where men are decision-makers in issues like immunisation, ante natal clinics and family planning programmes. Men end up deciding whether these services are available, accessible and acceptable in certain areas. This situation severely affects rural women who are not organised enough nor adequately educated to exert pressure on their governments (Ehlers 1999:48) nor on their male dominated social structures.

In the RSA during the apartheid era, when the Nationalist government was the ruling party, family planning was introduced racially. That government feared that the black populations were growing so large that they could undermine the white supremacy. The Apartheid government promoted the use of contraceptives among black and coloured women. All these efforts were aimed at reducing the growth of the black population, hence family planning became associated with the racist policies of the Apartheid government (Guttmacher, Kapadia, Naude & De Pinho 1998:191).

Klugman (1990:270) further highlighted the history of politics and contraceptives in the RSA. She stated that the previous government viewed the growth of the black population as a "Swart gevaar" (Black danger). When contraceptives were introduced for black women, black South African men frowned upon the idea. These men perceived the situation as being a threat to both their control over women

and their right to have the number of children they wanted. Professionals like Sister Bernard Ncube who was the president of the federation of Transvaal Women defined contraceptives as “a safe way to murder a nation”. There were reports that women were given injectable contraceptives without their consent or sterilised post caesarian section without their knowledge. One trade union exposed a procedure in a factory where women were asked to sign a contract granting the employer the right to dismiss them if they fell pregnant within one year of being employed (Klugman 1990:266.)

Family planning providers were trained within the framework of an over populated paradigm. The contraceptive provider was primarily not concerned with personal needs expressed by individual women, rather they were motivated to lower population growth rates. The physical, psychological and emotional aspects of the well being of women were not necessarily considered in these drives to reduce the impact of the perceived future over-population of the RSA (Klugman 1990:266-268). These factors created challenges for contraceptive providers. It is possible that black South Africans still perceive contraception to be a means of lowering their population growth rates.

In the male dominant African culture children symbolise a man’s wealth for future insurance (Erasmus & Bekker 1996:38). If these men believed that contraceptives aimed at lowering the black population’s numbers, then politics could serve as a barrier even before contraceptive use could be initiated by many women in the RSA.

2.6 CONTRACEPTIVE CHALLENGES THAT CAN BE EXPERIENCED DURING CONTRACEPTIVE USE

2.6.1 Counselling on contraceptives

The DOH (2001:19) in its objective for promoting high quality contraceptive services, mentioned that counselling has to take place in a private and comfortable environment, and that confidentiality has to be maintained. Following counseling, the client should be satisfied with the contraceptive method she

has chosen. She must know how to use the method, the anticipated side-effects, what to do if she experiences problems and when follow up is needed.

Effective counselling requires that the provider is empathetic, respectful, non-judgemental towards all clients, regardless of the clients' age, sex, race, religion, culture, disability and/or social status. The provider should be able to listen to the clients' needs, establish open interactive communication, and use appropriate language and materials. She must assist the client to choose an appropriate contraceptive method, that suits the client's personal circumstances, a method that is medically safe and takes into account the risk of exposure to STIs and HIV. She must help the client to understand how the chosen method works (DOH 2001:20).

This is what is recommended by the national contraceptive policy guidelines, but practically counselling remains a challenge and sometimes poses a barrier to effective contraceptive use.

Reproductive health services have been heavily criticised for ignoring genuine concerns about women and about the side-effects women might experience. Providers are said to be selective in providing contraceptives, and they might fail to provide accurate and relevant information (Leon, Monge, Zumarán, García & Ríos 2001:28-33; UN 1993:56-57).

A situational analysis done in 12 African countries indicated that the percentages of clients who received information on how to use a method, and each method's possible side-effects, varied greatly. It was estimated to be 5,0% in Tanzania, 22,0% in Burkina Faso, 64,0% in Kenya, 68,0% in Botswana and as high as 75,0% in Uganda and Zimbabwe (Leon et al 2001:32).

A "user's perspective" could only be adopted if women are included as policy-makers. A need was also identified for the development of an improved method for the examination of traditional methods and programmes that will attract men as contraceptive clients (UN 1993:60-67).

Kim, Kols and Mucheke (1998:4-11) conducted audiotaped counselling sessions in Kenya. Their results demonstrated that only 7,0% of providers discussed clients' child-bearing intentions, 27,0% discussed switching methods. Issues that were least discussed included clients' reproductive intentions, prior knowledge about family planning, contraceptive preferences, personal circumstances and health risks. Whilst women were given the right to choose a method, these women were never given the opportunity to weigh the pros and cons of each method nor to weigh alternatives.

In Khayelitsha, in the RSA, women reported that poor information was provided about contraceptives. They lacked choices of methods and support when they complained about any side-effects. Klugman (1990:262) stated that nurses and doctors carried an aura of authority about them, which makes women extremely vulnerable and unable to question decisions made by these professionals.

Other studies in the RSA reported that women were given contraceptives without explanations, and without any choice of specific methods. No information was given about any method's anticipated side-effects (Lewis & Salo 1996:64; Troskie & Raliphada-Mulaudzi 1999:44).

Contraceptive providers cited time constraints as barriers to effective counselling. A situational analysis was done on a sample of 114 cases in Kenya. Results showed that relevancy of information given to clients was increased by 43,0% when the session's length was extended from 2 to 8 minutes. When the session was extended beyond 14 minutes that conferred little advantage in terms of more effective counselling for the women (Leon et al 2001:32).

According to Kim, Putjuk, Basuki and Kols (2000:11), contraceptive providers require ongoing training on counselling skills, but ongoing in-service training on counselling skills is not enough. It needs to be followed by effective reinforcement to ensure that skills learned are put into practice in the providers' daily activities. This was demonstrated by 171 contraceptive providers from Indonesian clinics, who were trained how to conduct client centered counselling. One group received reinforcement in the form of peer review and self-assessment; the other group did not. The group, which did not receive

reinforcement, lowered their standard of counselling over time. The group that received reinforcement demonstrated continued improvements. Their counselling sessions were twice as much, their number of questions increased from 1.6 to 3.3 and they offered more information than members from the group which received no reinforcement.

It is only during counselling that a contraceptive provider can be able to determine all the contraceptive challenges that a woman brings along with her to the service. The provider should determine what is the distance that the client walks to the clinic, what is the client's socio-economic status, religion, culture and level of education.

The contraceptive provider can then base her counselling on the constructs of Orem's General Theory of Nursing (George 2002:128-132). She determines which women require explanations about basic reproductive anatomy, physiology, the method's action, and anticipated side-effects. These women will require counselling complying with Orem's compensatory system. The provider will also use her skills to determine which women need partly compensatory nursing intervention and those that need only educative supportive nursing interventions, in Orem's terminology.

If the nursing systems, as portrayed by Orem's General Theory of Nursing are followed, this could save the provider time, which is of importance if there is an increased workload. In such instances, the nurse will provide counselling according to the patient's needs, instead of giving the same education to all clients.

2.6.2 The attitude of the contraceptive provider

The contraceptive provider can serve as a barrier to effective contraceptive use, especially if the guidelines that are laid down by the National Contraceptive Policy Guidelines are not followed. Initiation of hormonal contraceptives should not be restricted to a period when a woman is menstruating. Until a reliable pregnancy test is available; women's history given should be taken as sufficient and accurate to

exclude pregnancy, because hormonal contraceptives will not abort an established pregnancy (DOH 2001:21-22).

Klugman (1990:267) stated that as much as women in the RSA have access to contraceptive methods, accessibility is largely dependent on the attitude of the personnel providing the contraceptives. When Lewis and Salo (1996:59) conducted a study in Cape Town in the RSA, women said that the staff at the family planning clinic "treated them like a piece of meat".

In Bangladesh, poor communication skills between the contraceptive providers and the clients were observed. There were hierarchical modes of communication, clients were seen behaving subserviently, and not asking questions. Statements like: "When I gave you pills I told you that you might feel dizzy, now why are you here complaining and disturbing my work", were recorded. "The IUCD cannot be removed until its time is complete, take your medicine and go, don't crowd me" was not an uncommon remark in this situation (Schuler & Hossain 1998:170-175).

Negative attitudes of contraceptive providers could leave the client without relevant information of how the specific method functions. A hostile attitude will also prevent clients from reporting problems experienced with the method being used (Troskie & Raliphada-Mulaudzi 1999:45.) Under such circumstances the client is likely to stop using the contraceptive, making its commencement a futile effort amounting to a waste of time and money, rather than to address the problem(s) with the help of contraceptive providers.

There are frequent reports from contraceptive clients about the negative attitudes and rudeness of the service providers. Service providers in general are also regarded as not being youth friendly (DOH 2001:10).

In the Limpopo Province of the RSA, teenagers reportedly regarded nurses in the reproductive health services as being rude, short tempered and arrogant. They reported that nurses were scolding them. Instead of providing relevant health education, nurses lectured adolescents about being too young for

having sex and that they should stop going around with old men. Some teenagers were reportedly refused contraceptives just because they did not use the clinic nearest to them, or because they previously used contraceptives from a general practitioner, or because they did not have parental consent. Being scolded provoked emotions of shame, unhappiness and fear resulting in discontinuing contraceptive use and clinic attendances (Wood, Maepa & Jewkes 1999:26).

2.6.3 Lack of relevant and up to date contraceptive knowledge by the provider

Contraceptive providers are expected to be informed in order to provide an up to date standard of contraceptive services. The DOH (2001:10) acknowledged that in the RSA, the work performance of many contraceptive providers is inadequate. This is attributed to the lack of comprehensive reproductive health care curricula and coordinated in service training programmes in all nine provinces. There is also a lack of a supervisory system throughout the country.

Ehlers (2003:22) reported that a 15-year-old and an 18-year-old adolescent mothers were chased away from clinics, for they were regarded as being too young to be using contraceptives. A child who is 14 years or older is allowed to seek medical intervention without parental concern (SA 1983:223), including the use of contraceptives.

In the Limpopo Province in the RSA, Troskie and Raliphada-Mulaudzi (1999:42) discovered that most women knew about available contraceptive methods, but they did not know about cervical caps, diaphragms or spermicides. Even nurses who participated in the study did not have this information. If nurses didn't know about these contraceptive methods, then there was no way in which nurses could teach patients/clients about these methods.

In some other countries in Africa, providers were found to be barriers to effective contraceptive use. They were overspecialising in the eligibility to contraceptive use by age, marital status or the provider's bias. In some areas women had to be married in order to obtain contraceptives. Sometimes a particular number of children was required, even for the insertion of IUCDs. Other providers required that women must have at least four children prior to fitting IUCDs, because the cervix might presumably be too tight, making insertion of IUCDs difficult if the woman has fewer than four children. However, IUCDs can be inserted successfully even if the woman never had a child. These are some of the situations that make one to wonder about the background knowledge of the contraceptive providers (Morrison 2000:192).

Providers' biases might include irrational reasoning like reproductive organs that are too immature for the use of contraceptives at the age of 20, or hormonal contraceptives being regarded as dangerous for women younger than 30 years (Morrison 2000:188-192; Speizer et al 2000:13-20; Stanback & Twun-Baah 2001:38-41).

2.6.4 Shortages of facilities, equipment and staff

For contraceptives to be effectively provided there is a need for appropriate facilities and reliable supplies of contraceptives. Providers' information and training should be continuously updated during in-service education sessions (DOH 2001:14).

Although the National Contraceptive Policy Guidelines recommend that women should not have to wait for long periods at contraceptive clinics, practically the situation differs. In one study in Cape Town in the RSA, women reportedly had to wait for many hours because of inadequately staffed services and inefficient overworked staff. The clients reported that this was disrupting their lives and it was tiresome (Lewis & Salo 1996:59). Working women cannot afford to lose hours every month to obtain their contraceptives. Unless this situation improves, many working women might discontinue using contraceptives because of this access barrier at the point of service delivery.

Chimere-Dan (1996:7) stated that in Khayelitsha in the RSA the contraceptive services were characterised by shortage of doctors, poor services, poor working conditions, low staff morale and services that were not client friendly.

In an informal settlement in the Gauteng Province of the RSA satisfaction about family planning services was investigated. The respondents were least satisfied with the availability of the contraceptive methods and the waiting time (Westaway, Viljoen & Chabalala 1998:36).

Due to lack of space in the Limpopo Province of the RSA more than one woman were observed entering one cubicle simultaneously for receiving contraceptive methods (Troskie & Raliphada-Mulaudzi 1999:44–47).

2.6.5 Side-effects

Much as contraceptives are beneficial, they have side-effects. Each method has its own side-effects. It is only during effective counselling that each women can be told about anticipated side-effects of the method she has chosen, on how to deal with the side-effects and, on where help can be obtained if side-effects become unbearable.

Hormonal contraceptives could cause women to experience any of the following side-effects: amenorrhoea, headaches, backaches, nausea, tiredness, irritability, increased pigmentation, weight gain, menorrhagia, epistaxis, loss of libido, migraine, and hair loss (Lewis & Salo 1996:60; Mofokeng, Hoffman, Jacobs & Snow 1996:13; Wood et al 1999:26).

Women using IUCDs reported experiencing increased vaginal discharges, repeated vaginal infections, ectopic pregnancies and IUCD embedment into the uterine wall (Lewis & Salo 1996:61; Mofokeng et al 1996:13).

In a study conducted in 27 different countries Bankole et al (1998:127) found that women who requested TOPs, reported fears of side-effects and of sterility as reasons for discontinuing their use of contraceptives and thus for their unwanted pregnancies.

Contraceptive providers have to be conversant with all contraceptive methods, bearing in mind that there is no contraceptive without side-effects. Popis (1998:58) stipulated that if side-effects are to be minimised, the contraceptive providers should bear in mind that different groups of women require different contraceptive methods. For example, adolescents, older women, postnatal lactating,

postabortion and women with recurrent medical problems all require their unique situations to be considered in selecting an appropriate contraceptive method.

According to Wood et al (1999:26), contraceptive providers should be able to manage side-effects appropriately and change a method of contraceptive if needed. If side-effects are reported and no actions are taken, the contraceptive user might feel that she is not taken seriously, leading to discontinuation of contraceptive use.

According to Orem's General Theory of Nursing, in the self-care construct. (George 2002:228–230) the requisites in the health deviation self care construct, are to diagnose the condition, prescribe measures to treat the condition, carry out the prescribed treatment and alter one's lifestyle to promote personal development. In contraceptive provision, the provider is expected to positively react when a client reports side-effects. In following the requisites in the health deviation self care construct, she must be able to diagnose the cause of the side-effect, prescribe measures to address to the problem, encourage patient to carry out the prescribed measures and to alter their life-styles, promoting the clients' personal development.

An example can be a client reporting that an IUCD causes an offensive yellowish vaginal discharge which means she has contracted an infection. A speculum examination can be done to assess the woman, antibiotics can be prescribed to treat the infection, and the client can be encouraged to complete her treatment and to modify her life-style by using a condom each time she has sexual intercourse to avoid another episode of an infection.

2.6.6 Knowledge and utilisation of different contraceptive methods

Hormonal contraceptives, IUCDs, emergency contraceptives and barrier methods require specific knowledge to prevent unwanted pregnancies from occurring.

According to the DOH (2001:19), to have complete information on a contraceptive method, one must have knowledge on how to use a method, how to obtain supplies or to remove an IUCD. One must also know the common side-effects, and how to deal with the warning signs of complications and when to obtain help in case of emergencies.

2.6.6.1 Knowledge and utilisation of hormonal contraceptives

Choosing a contraceptive method, can only be based on an informed choice if a client was counselled privately and respectfully, in a non-judgemental manner, irrespective of the client's race, sex, religion, culture, disability or social status. The client should be helped to choose a method that best suits her personal circumstances, that is medically safe and takes into account the exposure to STI and HIV infections (DOH 2001:19).

Some women in the RSA were found lacking information about the methods they were using for contraception, and the methods that were available to them. Lewis and Salo (1996:59-68) in their study in Cape Town, investigating contraception and women's rights, found that 67,0% contraceptive users knew about less than half of the methods available at their services; and 65,0% had no understanding of how these methods worked. Many women claimed that the clinic provided them with a contraceptive method without explaining how it worked, or what side-effects might occur.

In the Limpopo Province of the RSA, Troskie and Raliphada-Mulaudzi (1999:41) studied rural women's reproductive rights. They reported that 83,0% of the women were using contraceptives without any knowledge of the method's action. Only 16,7% knew about the method's actions and possible side-effects.

The situation of women using contraceptives without knowledge of how a method works is not unique to the RSA. In Indonesia, which is said to have the largest contraceptive implants programme in the world, with an estimated 400 000 IUCD insertions per year, women reportedly participated in the programme out of the sense of duty. They did not know how the method worked. Women stated that each rod stood for one year (which was not true). They also knew that the rods could be removed after five years, but they did not know why (Hull 1998:178).

The DOH (2000:10) suggests that a client have to be helped to choose a method that best suits her circumstances. In the RSA it could be questioned whether the extensive use of injectable hormonal contraceptives is client or provider chosen. In a sample of 96 women in Khayelitsha in the RSA, Mofokeng et al (1996:14) studied women's perceptions and preferences for contraceptives. They reported that 90,0% of these women were using the injectables, only a few women used contraceptive pills.

According to Lewis and Salo (1996:59), in Cape Town, 58,0% of the women in their study used DPMA, and only 30,0% used pills. In a sample of 2 290 women in the Transkei region of the RSA, Mofokeng et al (1996:15) reported that 58,0% of the women were using injectables and 29,0% were using pills.

The DOH (1998a:20) came up with the results that paints the same picture, where injectables were the most frequently used method, 57,0% of SA women were using injectables and 38,0% pills. Chimere-Dan (1996:4) attributed the excessive use of injectables to the previous government of the RSA, because injectables required minimal education, little client involvement and fewer follow up services for the users. However, Ehlers et al (2000:51) reported that most adolescent mothers preferred contraceptive injections to any other contraceptive. The major reasons for this preference were that they only needed to visit a clinic once every three months, that they did not need to remember to take a pill on a daily basis and that neither their parents nor their sex partners knew that they were using contraceptives.

Much as knowledge is an important component for effective contraceptive use, it is also important to acknowledge that other factors play a part. It is not always as simple as it sounds, and knowledge does not necessarily imply equal usage.

In Thailand, when knowledge, attitudes and perceptions on contraceptives were studied (Morrison 2000:190-192), women demonstrated a high level of contraceptive knowledge. Out of a sample of 102 women who were interviewed, 86,0% knew about oral contraceptives, 86,0% about condoms, 88,0% about injectables but only 12,0% were using a modern contraceptive, irrespective of their stated wishes to delay or to stop future pregnancies.

This does not imply that if women in the RSA had the same amount of information they would also not use contraceptives, because these are two different countries with different, social, economic and other challenges. Ehlers et al (2000:52) reported that although adolescent mothers in the RSA knew about contraceptives, they failed to use these. However, most adolescent mothers used contraceptive injections after their babies were born to prevent further unwanted pregnancies.

The principle that knowledge does not equal use is not unique to a particular group of individuals. Teenagers and adolescents in the RSA were found in various studies to have knowledge of one or the other method to prevent pregnancy, but they did not use these methods. In a comparative study of pregnant urban and rural girls' knowledge on contraceptives, conducted in Mamelodi, Pretoria, almost all the pregnant teenage girls interviewed knew some contraceptive methods but they did not use these methods to avoid unwanted pregnancies (Setiloane 1990:44-48).

In the Cape Peninsula of the RSA missed opportunities for contraceptive counselling were investigated by Flisher, Roberts and Blignaut (1992:104-106). Out of the total sample of 225 young people, 73,0% had sexual experiences and 43,0% did not use any method to prevent pregnancy, irrespective of the knowledge they had about available contraceptives.

In the Umtata region of the RSA, parental involvement in imparting sexual knowledge to adolescents was investigated by Mayekiso and Twaie (1992:21-23). They reported that 55,0% of the adolescents claimed to be sexually active. Although 60,0% knew about contraception, only 12,3% used some form of contraception.

Ehlers et al (2000:43) investigated adolescents mothers' utilisation of reproductive health services in the Garankuwa area of the RSA. Although 60,0% of these adolescent mothers knew about contraceptives, only 43,0% used injectables, condoms or pills and only after their babies were born.

In various studies teenagers gave different reasons for the non-use of contraceptives, which included:

- Fear of parents finding out they were using contraceptives/being sexually active
- Ignorance about contraceptives
- Boyfriends did not approve
- Mothers did not approve
- Fear of infertility
- Fear of clinic nurses' attitudes towards sexually active adolescents
- They did not expect to become pregnant despite being sexually active and not using contraceptives (Buga, Amoko & Ncayiyana 1996:523-527; Ehlers et al 2000:43-53, Ehlers & Maja 2001:9-12; Mfono 1998:180-190)

Various strategies can be adopted for improving knowledge, attitudes and practices of contraceptives in the RSA. In Mali a community based distribution programme was instituted. This resulted in improvements in enhanced contraceptive knowledge, attitudes and practices (Katz, West, Doumbia & Kane 1998:104).

Other means to improve knowledge and to change attitudes about contraceptives could be through accessing social clubs. A situational analysis was done among 2 217 women aged 15-49 and 2 152

men aged 15-54 in Kenya. Women who were club members were 28 times more likely than non-members to know about modern contraceptives, 45,0% of the club members used contraceptives while 34,0% of the non-club members did not. Men who belonged to clubs were found to be 1,5 times more knowledgeable about modern contraceptives than non-club members; male club members were also 1,7 times more likely to approve the use of contraceptives than non-club members (Boulay & Valente 1999:112).

Media can help to disseminate information about contraceptives. This was demonstrated in Tanzania. A sample of 4 225 women participated in a study on the impact of mass media on a family planning campaign and on contraceptive behaviour. The more the types of media the woman had been exposed to, the more likely she was to use contraceptives. Even women, who could remember one type of media message, were found to be twice more likely to be users of contraceptives than women who could not remember any media message on contraceptive. Women who could remember media messages were also more likely to have discussed contraceptive use with their partners than their counterparts (Jato, Simbakalia, Tarasevich, Awasum, Kihinga & Ngirwamungu 1999:60-67).

In the light of the available constraints in the contraceptive health providers' daily duties, due to staff shortage, pamphlets posters and leaflets could come in handy as means of additional information dissemination, especially for clients who can read. When Mbananga (1999:42-47) studied the use of reproductive health information material in the rural clinics of the Umtata region of the RSA, the following was found:

- There was inappropriate display of posters due to lack of space and the design of waiting rooms.
- Health related posters were fighting for space with posters from water affairs, transport, welfare and agriculture.
- Health workers did not know where to order posters, neither did they have the time to enquire.
- Posters were mainly in English, which was not a local language.
- Language used on posters was too academic for the community to understand.

- Some posters did not appear to have any consideration for the norms and values of the people they intended to serve.
- Some cultures found it irregular and inconsiderate to display sexual organs.
- Posters were found to be prepared by one generation for another generation.
- The producers and suppliers of the posters displayed insensitivity to the needs of the rural people.

2.6.6.2 Knowledge and utilisation of IUCDs

The IUCD as a method of contraception is not widely used in the RSA. Smaller numbers of women were found to be using this method when compared to women who used injectable and oral hormonal contraceptives. Mayekiso and Twise (1992:22) found that out of 50 respondents in their sample only 6,0% knew about IUCDs. Very few women knew this method when Mofokeng et al (1996:14) investigated poor women's perceptions and preferences for contraceptive technologies. Only one woman was satisfied with her experience of using an IUCD.

Lewis and Salo (1996:62) conducted a study in the Cape Town region of the RSA. Only 5,0% of the women used an IUCD. In the Gauteng Province of the RSA Mfono (1998:187) stated that only two teenagers in their study used IUCDs for contraception.

2.6.6.3 Knowledge and utilisation of emergency contraceptives

In 1972 a breakthrough in the use of combined hormonal oral contraceptives was achieved by a Canadian physician Albert Yuzpe and his colleagues. He found that the administration of 100 mcg of oestrogen with 1,0 mg of progestin causes endometrial changes that are incompatible with implantation (Ellertson 1996:52).

Since then this method has been widely used and these doses are to be taken in equally divided doses within 72 hours of unprotected sex. There is medical consensus that this method has no contraindications, and that there is no link between this method and fetal malformation.

In the late 1970s the insertion of a copper releasing IUCD to induce unfavourable conditions for implantation was discovered. It is believed that the copper releasing IUCD appeared to be directly embryotoxic (Ellertson 1996:54).

Quinn 1999 (41-43) stated that before emergency contraceptives can be administered, good history taking is of paramount importance, and should include the following aspects:

- The date of the last menstrual period
- Whether the last menstrual period was lighter, shorter or different
- The usual duration of the individual's menstrual cycle
- When unprotected sex took place in relation to the menstrual cycle
- The number of hours since the first episode of unprotected sex
- Whether the client is using any antibiotics
- Tactful questioning to establish whether the episode of unprotected sex carried the risk of sexually transmitted infections

The following should be communicated to the women after emergency contraceptives had been administered:

- To report any unusual abdominal pains
- Report any light, heavy or missed period
- Any episode of unprotected sex in the same cycle
- The importance of using a reliable contraceptive method should be addressed

Emergency contraception is a method that has the potential to reduce the number of women undergoing back street abortions (and those requesting TOPs), if it is utilised correctly (Quinn 1999:42).

In Britain, Crosier (1996:87) conducted telephone interviews about emergency contraceptives. Women were asked to mention any emergency contraceptive method. Out of the 798 women who participated, only 9,0% mentioned the name of a morning after pill; only 36,0% could define it correctly; only 24,0% could mention the correct time to use emergency contraceptives; and only 12,0% reportedly used the emergency contraceptives in their life-time. This study revealed that younger women were more informed about emergency contraceptives than older women. The younger women mentioned leaflets, books, articles, television and radio as their sources of information.

A focus group interview was conducted with family planning providers in Vietnam, to learn about their knowledge and attitudes about emergency contraceptives. Although the participants knew something about emergency contraceptives some of their information was incorrect. Surprisingly some participants believed in vaginal douching, doubling spermicidal jelly or using traditional remedies like drinking large quantities of coconut juice. Those who knew about oral contraceptives as emergency contraceptives, did not know which intervals between doses of the oral contraceptives to be adhered to for the desired results. Few knew about post coital insertion of a copper containing IUCD and its side-effects. Most of the participants overestimated the incidence and the severity of the side-effects (Ngoc, Ellertson, Surasrang & Loc 1997:68-72).

In Brazil (Galvao, Diaz, Diaz, Osis, Clark & Ellertson 1999:171) a survey was conducted on a nationally representative sample of 579 obstetricians/gynaecologists. Although 98,0% knew about emergency contraceptives, 14,0% believed this method to be illegal (which was untrue), and 30,0% believed that the method was an abortifacient. Of the 6,0% who reportedly prescribed this method, only 15,0% could correctly list the name of the pill prescribed, the dosage and the timing of the first dose.

Facilitating access to emergency contraceptives could imply fewer unintended pregnancies. Instead of obtaining emergency contraceptives from clinics, doctors or pharmacies, they can be made available in other places such as shops. This was demonstrated by a study conducted in the United Kingdom (UK), where 553 women were given replaceable emergency contraceptive pills to take home and to use when necessary. In a control group 530 women were informed that they could obtain emergency contraceptive pills from doctors, when the need arose. The frequency of use of emergency contraceptives and the incidence of pregnancy were checked a year later. In the treatment group 47,0% of the women used the method once, and 98,0% used it correctly. In the control group 27,0% of the women used the method once. Unintended pregnancies occurred in 18,0% of the treatment group and 25,0% in the control group (Glasier & Baird 1998:1-4). If emergency contraceptives could be well-known and utilised effectively, it could bring down the number of unwanted pregnancies and requests for TOPs.

In the Garankuwa area of the RSA, Ehlers et al (2000:47) found that 67,56% of the adolescent mothers did not know about the availability of emergency contraceptives, only 37,83% knew about its existence. Of the 37,83% only 13,5% knew that contraceptive pills could be used as emergency contraceptives and only one respondent could name such a product, indicating adolescent mothers' lack of knowledge about emergency contraceptives.

The RSA, as a country, could enhance its contraceptive services by implementing some recommendations based on international and national research reports, including that:

- Both the users and the providers need to be well informed about EC.
- EC is effectively used in countries where it is integrated into the general practice of family planning education and information services.

2.6.6.4 Knowledge and utilisation of male condoms

Peltzer (2001:53-57) investigated the knowledge and sexual practices, with reference to correct condom use, amongst the first year university students in the Limpopo Province of the RSA. More male students had more information about male condoms than female students. Although 57,0% of the students knew about condoms before their first sexual encounter, only 20,0% used condoms. A total of 56,0% were ignorant about the correct moment to put on a condom, 55,0% on when to take the condom off and 28,0% on whether a condom should be rolled up before being put onto the penis or not. As many as 92,0% never used a condom, 34,5% always used condoms, 19,8% used condoms regularly and 8,5% used condoms irregularly during the three months preceding their participation in this survey.

When asked to mention methods that could prevent pregnancy, adolescent mothers, mentioned condoms as one means, even though they did not use it (Ehlers et al 2000:47; Ehlers & Maja 2001:11).

In the Transkei region of the RSA, 62,1% of the sexually active boys reportedly used condoms (Bugu et al 1996:524). Differences were observed in condom usage in different racial groups in the Cape Peninsula of the RSA, when the risk behaviours of high school students were studied. Condoms were reportedly used in 22,5% of the Afrikaans speaking boys; 57,1% of boys who spoke both English and Afrikaans at home; 63,0% of the English speaking boys and 23,6% of the Xhosa speaking boys (Flisher, Ziervogel, Chalton, Leger & Robertson 1993: 495–497).

Attitudes and beliefs about condoms were investigated by Nichola (1998:892). In a total sample of 1986 first year black students, (59,0% were female and 44,0% male) in a South African university, 39,8% used condoms with every sexual encounter; 40,9% of the respondents provided condoms to their sex partners; 57,2% suggested condoms and 46,5% actually used condoms at their most recent sexual encounters.

In Zimbabwe multivariate logistic analysis regression models were used to evaluate condom usage in marital and non-marital relationships. The data showed that single sexually active males were more likely to use condoms than married sexually active males. Males with secondary and higher education were ten times more likely to use condoms than males without these educational qualifications (Adetunji 2000:196).

Almost the same characteristics in condom usage were obtained by Agha (1998:37) in Zimbabwe. Females were found to be more likely to use condoms if they were unmarried. Condom usage in men was associated with accessibility, having an education beyond secondary level and being younger than 30 years of age. Programmes which targeted men for condom use were reportedly more likely to be successful than those that aimed at developing women's skills in negotiating condom usage.

2.6.6.5 Knowledge and utilisation of female condoms

A female condom is said to be the first officially recognised women controlled means of protection against STIs, HIV and pregnancy. This has provided an alternative to the previously male dominated situation. The population has been slow to experiment with female condoms. This could be attributed to several factors like the lack of familiarity with the female condom, the size of the device, the number of instructions on how to use the device and its cost (Klein, Eber, Crosby, Welka & Hoffman 1999:114).

According to Foy et al (2001:2), female condoms are not readily available in the RSA. This method is not available in the public sector, it is being piloted at selected sites, and is only readily available in the private sector. Most of the literature obtained about female condoms are based on studies done in the USA.

Soet, Dilorio and Dudley (1998:19) found that intrapersonal and interpersonal factors influenced the use of female condoms. In their study of 2 044 female university students in the USA, self-efficiency and self-evaluative outcomes were significant intrapersonal predictions of women's condom usage. Intrapersonal predictions did not play a major role in influencing condom usage. Interpersonal

predictors, for example anticipated negative reactions of the partner, played a most significant role in determining women's use of the female condom. Again in this study, women with high self-efficiency were found to be more likely to use a condom. These authors suggest that interventions that are aimed at promoting female condoms usage, should recognise that cognitive factors play an important role in influencing condom usage, like self-efficiency and beliefs about using a condom. Women's HIV status also influenced condom usage. More women who were HIV negative believed that condom usage could impact negatively on their relationships than women who were HIV positive.

A convenient sample of 1 268 women was investigated for consistent condom usage in Philadelphia in the USA. Women who desired babies were less likely to be consistent condom users than those who did not desire babies. Women who reported partners' support for contraceptive use, showed higher levels of consistent condom use than women whose partners did not support the use of contraceptives (Klein et al 1999:97-114).

2.6.6.6 Knowledge and utilisation of natural family planning methods

Natural family planning (NFP) methods are the less known and the less practiced methods of family planning. Only a few studies mentioned NFP as contraceptive methods. In a study by Mofokeng et al (1996:15), only one woman mentioned having used a safe period. In a study by Erasmus and Bekker (1996:41) in the Transkei region of the RSA, lactation amenorrhoea (LAM) and coitus interruptus were mentioned as some of the methods used to prevent pregnancies. Vernon (1996:29) stated that the rhythm method is the least known and the least practiced method of contraception.

Factors that are associated with the use of NFP include:

- Lack of knowledge about modern methods of contraception
- Fear of perceived side-effects of modern contraceptives
- Cultural constraints

- Lack of accessibility and cost of modern contraceptives
- Religion also plays a part, especially the Catholic Church that encourages the rhythm method, but discourages modern contraceptive methods (Hubacher, Suazo, Terrell & Pinel 1996:163-168)

2.6.6.7 Knowledge and utilisation of voluntary surgical contraception

Voluntary surgical contraception (VSC) is a method of contraception that has been available for decades, and it is widely used worldwide with the exception of African countries (Kincaid, Merritt, Nickerson, Buffington, De Castro & De Castro 1996:169). In 1998 the demographic health survey of the RSA found that few women aged 15–49 knew about VSC and only 12,0% used this method. Male sterilisation was mainly undergone by white South African men (DOH 1998a:20).

Of all the contraceptive methods that were mentioned or known by adolescents in several studies conducted in the RSA, VSC was never mentioned (Buga et al 1996:523-527; Ehlers et al 2000:43-53; Ehlers & Maja 2001:12; Flisher et al 1992:104-106). However, this might be attributed to the fact that VSC is usually a permanent method and that adolescents would probably plan to have children at some future stage of their lives, making VSC no option for them during their adolescence.

This could be associated with the point that this particular method cannot be easily communicated to this age group, because of the VSC's characteristics, of being permanent and irreversible.

Vernon (1999:26) did a data review in three Latin American countries. He found that men who underwent vasectomy were characterised by:

- High levels of education
- Small families
- Living in large cities
- Being married

- Their wives' influence on the decision for vasectomy
- High quality accessible health care services
- Their wives who did not consider female sterilisation to be a viable option

In the RSA, VSC is minimally used as a method of contraception (DOH 1998a:20). A Kenyan non-governmental organisation (NGO) conducted a mass media vasectomy promotion campaign. Innovative communication skills were utilised including: on-site training for service providers, periodic television talk shows, newspaper advertisements with coupons directing men to family planning sites, newspaper articles, film clips, booklets, posters, leaflets and flyers. This resulted in an increase of 125,0% in the number of vasectomies performed after six months (Kincaid et al 1996:169).

In Brazil a mass media vasectomy promotion campaign aimed to eliminate public misconceptions about the operation, its effects on sexual functioning and its long-term health effects. This information targeted men aged 25–49 years. “The slogan was vasectomy is an act of love”. This campaign resulted in increases of 108,0%, 59,0% and 82,0% in different areas of Brazil (Kincaid et al 1996:171).

2.6.6.8 Knowledge and utilisation of traditional methods of contraception

Traditional methods of contraception are described by Agadjanian (1999:7) as a diverse range of substances and devices, provided by a third person, mostly traditional healers. These methods are not industrially manufactured and their physiology and effectiveness have not been scientifically tested nor reported.

Agadjanian (1999:7) is of the opinion that full interpretation of contraceptive needs, problems and prospects, cannot be achieved without understanding its idiosyncrasies and women's social and cultural characteristics and resources. The use of traditional contraceptive methods is mostly associated with women with lower educational standards, and those who do not have easy access to modern contraceptives, more especially women from rural areas.

In the RSA, Erasmus and Bekker (1996:43) identified several traditional contraceptive methods that women use to prevent pregnancies, including:

- A woman sits in a bath full of water, with a pocket knife closed after sexual intercourse, under these circumstances she regards her cervix to be closed and therefore incapable of becoming pregnant.
- A woman will sit on an overturned bucket placed over a placenta after birth, and she is regarded as not being capable of becoming pregnant whilst she breastfeeds.
- Menstruation (or a soiled sanitary pad) is put in a bottle and buried in soil, if a woman wants to conceive she must first dig the bottle up.
- A mixture of cowdung and vinegar is rubbed inside the vagina to prevent conception before intercourse; this is believed to destroy sperms cells.
- A woman should turn on her abdomen shortly after sex and urinate.
- Women should take a laxative shortly after intercourse.

2.6.7 Attitudes and perceptions on different contraceptive methods

2.6.7.1 Attitudes and perceptions on hormonal contraceptives

Statt (1993:96) defines perception as a process by which the brain receives the flow of information about the environment from the sense organs, and uses this raw material to help the organism to make sense of that environment, in this case to make sense of contraceptives.

An attitude is said to be a stable, long lasting, learned predisposition to respond to certain things in certain ways (Statt 1993:11).

The way different individuals perceive contraceptives could cause long lasting ways of responding to a particular method. They then develop attitudes on the particular method; their attitude can have an

influence on how other people respond to a method of contraception. If bad attitudes are developed about a particular method, that becomes a challenge to effective contraceptive use.

Women in Khayelitsha in the RSA perceived contraceptives as helping with the spacing of their children and of improving the quality of life of both children and parents. They also perceived contraceptives as providing teenagers with an opportunity to finish schooling without having to face unwanted pregnancies. Nuristerate was perceived to be a method that was too weak for someone who already had a child. Oral contraceptives were reportedly not readily prescribed by health care workers who regarded this method to be unsafe, since women forget to take their pills on a daily basis (Mofokeng et al 1996:17).

Morrison (2000:187) reported about the knowledge, attitudes and perceptions concerning contraceptives in Thailand. These women feared contraceptives, because contraceptives were perceived to be causing weight gain, excessive vaginal bleeding and illness. When Thai men were asked about their perceptions of contraceptives, they stated that contraceptives lead to vaginal infections.

Otoide, Oronsage and Okonofua (2001:71–81) found that Nigerian women perceived contraceptives as leading to infertility, injectables as leading to “frequent dosing off” and causing frequent periods. In the Limpopo Province in the RSA, that society did not approve of women using contraceptives (Troskie & Raliphada-Mulaudzi 1999:41-47).

Contraceptives were regarded as making women weak and destroying men’s libido. The pill was regarded as an unsafe method since women forget it and end up with unwanted pregnancies. The injectables were perceived to be a better method as this did not require constant vigilance. In the Garankuwa area of the RSA some adolescent mothers perceived hormonal contraceptives to be causing infertility and vaginal discharges (Ehlers & Maja 2001:12). In the Gauteng Province of the RSA, teenagers viewed hormonal contraceptives as leading to weight gain and losing muscle tone

(Mfono 1998:185). In Jamaica when young adolescents were interviewed, sexually active boys and girls perceived the usage of contraceptives to be associated with persons who had more than one partner and who indulged in sex more frequently (Eggleston, Jackson & Hardee 1999:78).

2.6.7.2 Attitudes and perceptions on intra-uterine devices

Women, who used IUCDs perceived them to be unsafe, resulting in unplanned pregnancies. Women who had never used the method, displayed negative attitudes and perceived this method as being capable of penetrating the womb, disappearing into the abdomen, ending up in the heart and causing death (Mofokeng et al 1996:14-16). In Cape Town, Lewis and Salo (1996:62) found that women perceived IUCDs as leading to infections and causing ectopic pregnancies and infertility.

In a focus group conducted with adolescents in Nigeria, IUCDs were perceived to be a dangerous method, that can go "missing" in the body, requiring an operation to be removed and a method that could lead to sterility (Otoide et al 2001:79).

2.6.7.3 Attitudes and perceptions about emergency contraceptives

Various authors perceived levonorgestrel as being a better method for emergency contraception than the combination (oestrogen and progesterone) pills. They agreed that fewer side-effects were experienced, with fewer incidences of unintended pregnancies. In a double blind randomised trial of 1998 women in 21 countries, women who requested TOPs were given "pills". One group received the levonorgestrel pill and the other group received the combined pill. Levonorgestrel was better tolerated and was more effective than the combined pill. The pregnancy rates were reportedly 1,1% versus 3,2%. Nausea and vomiting were more common in the combined pill group than in the levonorgestrel group (WHO 1998a:428-433.)

Olenick (1999:53–54) studied 1 957 women recruited from 21 cities around the world. These women had engaged in one instance of unprotected sex and were randomly assigned to the levonorgestrel regime and the Yuzpe method. More women experienced side-effects and the incidence of pregnancy was higher in the Yuzpe method than in the levonorgestrel method, with the rate of pregnancy being 21,0% versus 4,0%, nausea was 51,0% versus 23,0%, vomiting was 19,0% versus 6,0%, dizziness was 17,0% versus 11,0% and fatigue was 29,0% versus 17,0%.

Webb (1997:243) perceived the insertion of the copper bearing IUCD as a more advantageous emergency contraceptive method than the administration of contraceptive pills. He stated that the advantages included a very low failure rate of 0,1%. The IUCD can be inserted up to five days after the incidence of unprotected sex compared to pills that should be taken within 72 hours. If a woman is happy with the IUCD it can be kept in situ and continue to provide protection against unwanted pregnancies for a number of years.

In the Garankuwa area of the RSA, adolescent mothers who knew about emergency contraceptives failed to use them because of fears that EC could cause the baby to be malformed (Ehlers & Maja 2001:11.)

2.6.7.4 Attitudes and perceptions on male condoms

Teenage and adolescent boys might hold different ideas about condoms than older men, influencing their attitudes towards condom usage.

In a study conducted among university students in the RSA, condoms were perceived as being too expensive to buy, as making sex less pleasurable, and that too many condoms would be required for all the sexual encounters. These students stated that condoms made partners feel untrusted. They maintained that real men do not use condoms, and condoms cause vaginal injuries (Nicholas 1998:893).

In a different study conducted in the Limpopo Province of the RSA, condoms were perceived to be associated with positive HIV status. Students admitted not to be using condoms as they were not HIV positive and regarded themselves as being safe from contracting STDs including HIV (Peltzer 2001:55).

A descriptive study of 95 patients recruited from STD clinics, 98 from universities and 95 from the public was conducted in the RSA. Many respondents disliked condoms, 45,0% from STD clinics 65,0% from universities and 69,0% from the general public. Condoms were perceived as portraying a lack of trust in a relationship, as being unnatural and uncomfortable. When questioned about the risk of HIV infections, these men preferred women to use vaginal microcides to prevent cross infection rather than using male condoms (Ramjee, Gouws, Andrews, Myer & Weber 2001:164).

In Khayelitsha in the RSA, women regarded condoms as a method that was difficult to use, since it required men's cooperation. Most women stated that men refused to use condoms (Mofokeng et al 1996:12).

In Nigeria when teenagers were interviewed about contraceptive methods, some were reportedly afraid of condom usage, as it was regarded to be an unsafe method. Moreover, these teenagers believed condoms could break away and go to the stomach and cause difficulty in breathing (Amazigo, Silva, Kaufman & Obikeze 1997:28-33).

In Jamaica, of the young adolescents who admitted to being sexually active, most used condoms, but some had to hide their condoms from their friends not to be regarded as "chickens" (Eggleston et al 1999:82).

2.6.7.5 Attitudes about and perceptions of female condoms

In San Francisco in the USA, a convenient sample of 92 women were trained how to use female condoms. They were given female condoms to use over a period of three months. In depth interviews were conducted at the end of this period (Choi, Roberts, Gomez & Grinstead 1999:68).

The women who developed positive attitudes towards female condoms reported the following perceptions:

- It is less messy.
- It increases sexual pleasure.
- It was an empowering tool for women who were no longer expected to depend on men for protection against STI and HIV infection.
- It promoted communication amongst partners to revisit the issue of HIV/AIDS and protection.

Those who developed negative attitudes about female condoms reported the following perceptions:

- The shape and size of the device was unfeminine.
- The device was regarded as being too big, slimy and weird.
- The part of the device which was hanging outside the vagina caused embarrassment for these women.
- It diminished spontaneity of sex.
- It interfered with foreplay, for example if oral sex came to mind, this was prevented by the vaginal lubrication caused by the female condom.
- Most women experienced difficulty with inserting the device.
- Some women were uncomfortable with its insertion, especially those who had never previously felt the inside of the vagina.
- It was too bulky to carry around.
- Insertions prior to sex diminished the mood.

In Washington DC in the USA, women who were crack users and those who injected drugs were introduced to female condoms, and taught how to negotiate condom use. Those who developed positive attitudes about the device perceived it as being

- more reliable and contributing to sexual pleasure
- advantageous since it could be inserted up to eight hours prior to sex
- drug users who were also commercial sex workers could use it without the client being aware of its use
- it did not break or tear like male condoms
- it felt smooth as if you were not using anything at all
- the idea of trying something new was “kinky”
- partner helped with its insertion which increased the eroticism and sexual pleasure (Choi et al 1999:66-68)

Those whose male partners developed positive attitudes reported that their male partners found the female condoms

- less constricting and more comfortable to the male partner
- did not grab pubic hair like male condoms did
- produced increased sexual pleasure with liberal lubrication
- caused warming qualities of polystherane material which they liked (Choi et al 1999:70)

Those females who did not like the female condoms perceived it as

- being difficult to insert it the full length of the vagina
- it had a tendency to bundle up
- having too much plastic and they could feel the extra bulk inside their bodies
- feeling funny (Choi et al 1999:70)

The male partners who negatively reacted to the device perceive of it to be

- diminishing sexual pleasure
- having a funny taste
- feeling the rubber ring inside (Choi et al 1999:71)

From these perceptions it is apparent that women viewed the device differently from men. Those women who perceived the device positively, could help overcome challenges experienced by women who disliked the device.

Women who find it difficult to insert the female condom, can involve their male partners in doing so. Those who find inserting the female condom to be diminishing sexual pleasure can be advised to insert the device up to eight hours before the sexual act. Commercial sex workers can be saved the ordeal of having to plead with men to use male condoms.

2.6.7.6 Attitudes and perceptions about voluntary surgical contraception

These methods are permanent and irreversible. Clients should not be misled on the basis that tubes can be repaired, because repairing tubes is very expensive and it is not always successful (Foy et al 2001:3). Clients' wishes and fears should be respected at all times. Voluntary surgical contraception should be recommended if the family is complete or if a woman should not become pregnant for specific health reasons. However, the final decision should be made by the person and her/his partner, not by health care providers.

2.6.8 Termination of pregnancy

2.6.8.1 The state of abortions in various countries

TOP is defined as separation and expulsion by medical or surgical means of the contents of the uterus of a pregnant woman (South Africa 1996a:4).

Whether termination of pregnancy is legal or not, that has not stopped women worldwide to terminate unwanted pregnancies. The numbers and rates of termination was estimated in 57 countries using different sources of information; to be 26 million legal TOPs and 20 million illegal TOPs performed worldwide in a year. The TOP rate is said to be 35 per 1 000 women aged 15–44. The termination rates are reportedly no lower in countries where termination of pregnancy is illegal (Henshaw, Singh & Haas 1999:530-538).

According to Amazigo et al (1997:31) in Nigeria, in a study of 140 women with gynaecological conditions, 59 had complications following back street abortions, 53,0% were aged between 14 and 17 years and 37,0% had undergone previous abortions. Out of 127 adolescents in the gynaecology wards of three hospitals in Nigeria, 99,0% were admitted with complications of induced TOPs. Of these adolescents 36,0% had pregnancies prior to their current pregnancies

In the RSA Guttmacher et al (1998:192) estimated the number of clandestine TOPs to range from 120 000 to 250 000 for the period from 1975 to 1996. These authors felt that this could be an underestimation seeing that not all women who attempted TOPs reached hospitals. Calculations of the costs incurred by clandestine abortions should consider that 50,0% of gynaecological admissions in the RSA wards, constituted incomplete and/or septic TOPs. These patients required long hospital stays, extensive surgery, anaesthesia, blood transfusions and medications (Guttmacher et al 1998:194).

2.6.8.2 The state of abortions in the Republic of South Africa

TOPs in the RSA were illegal under the Abortion and Sterilisation Act (no 2 of 1975), unless severely stringent conditions could be met. This made it impossible for the majority of South African women to access legal TOP services. This Act did not make any provisions as to what gestational period was

liable for TOP. No provisions were made for women to request a TOP if they did not want to carry the pregnancy to term. The women's social circumstances were not considered when they requested TOP services (De Pinho & Hoffman 1998:22-28)

Since 1 February 1997 women in the RSA can undergo safe hygienic, accessible and legal TOPs under the CTOP Act (no 92 of 1996). The success of achieving these objectives is dependent upon the following three factors:

- The provision of accessible, effective and acceptable services.
- Health service providers who are familiar with the details of the law.
- Women choosing to undergo TOPs should be familiar with their rights (De Pinho & Hoffman 1998:27)

2.6.8.3 Characteristics of women who undergo termination of pregnancies

Bankole et al (1998:127) used various statistics from 56 countries to estimate the percentage and distribution of abortions by selected characteristics of women. This study demonstrated that women aged 40 years and older obtained fewer abortions than younger women. In some countries adolescents accounted for higher proportions of TOPs than older women.

Engelbrecht et al (2000:12) in their study of women who underwent TOPs in the Gauteng Province of the RSA, found that half of their respondents were students. In Nigeria, Amazigo et al (1997:29) studied complications resulting from clandestine TOPs, and reported that 53,0% of the women in their sample were adolescents between the ages of 14 and 17 years.

These studies demonstrated that younger women are more likely to seek TOPs than older women. Unmarried women are more likely to seek TOPs than married women (Bankole et al 1998:152). With

regard to religion, a study in USA revealed that Moslem women (17 per 1 000) were found to have lower TOP rate, when compared to Christian women (39 per 1 000). Racially TOPs were reportedly 56 per 1 000 of the black women and 17 per 1 000 of white women in the RSA. Women in urban areas were more likely to seek TOPs than women in rural areas (Bankole et al 1998:127) in the RSA.

2.6.8.4 Reasons for the termination of pregnancies

In different countries TOPs are performed under different circumstances. Most women stated the following reasons for undergoing TOPs:

- Socio-economic concerns.
- The desire to postpone or stop childbearing.
- Relationship problems with partner or husband.
- Personal problems.
- Lack of support from partner.
- Desire to provide education for the existing children (Bankole et al 1998:152; Engelbrecht et al 2000:12-14; Suffla 1997:216-218).

In depth interviews were conducted with black, coloured and Indian women who underwent clandestine TOPs in the RSA. These women over and above the already mentioned reasons for TOP had the following to say about contraceptives:

- They were ignorant about contraceptives.
- Contraceptives were incorrectly used, for example taking a pill only when the partner was coming.
- Contraceptives resulted in undesirable side-effects like loss of libido and weight gain.
- They also feared sterility.
- Others stated that their partners initiated sex too early and forcefully in a relationship before contraceptive use could be commenced (Maforah et al 1997:79-82).

Stotland (1997:677) stated that women also underwent TOPs for psychosocial reasons such as

- ongoing psychiatric illness
- social chaos
- abandonment
- ongoing domestic violence
- rape
- incest
- contraceptive failure

2.6.8.5 Effects of termination of pregnancy

There is no painless way to deal with the issue of TOP. Ambivalence is a norm when a TOP decision is to be taken. Conflict is always present and it becomes worse once the decision to undergo TOP is delayed, as attachment to the foetus increases. The response to TOP is largely dependent on the woman's psychological state and social environment (Suffla 1997:215).

Mpshe, Gmeiner and Van Wyk (2002:68) stated that the total well-being of women is affected by the decision to undergo a TOP or to carry the pregnancy till full term. Such a woman experiences emotional turmoil and physical distress in deciding whether to terminate the pregnancy or not.

Physical effects

Physically these women experience pain irrespective of the circumstances, whether a doctor, a nurse or an unregistered person performs TOP procedure (Engelbrecht et al 2000:11; Myburgh, Poggenpoel & Britz 1998:14; Suffla 1997:219).

One woman, who underwent a clandestine TOP, stated that she thought she was going to die, due to the severity of the pain. Having a sharp instrument inserted through her cervix; the pulling, tugging and pushing caused severe lower abdominal pain (Suffla 1997:220-221).

Other physical effects are bleeding and dizziness resulting from the loss of blood and the drugs used for the procedure. Fatigue is also experienced. These experiences vary according to the competence of the person performing the procedure, the availability of drugs and the gestation period of the woman (Myburgh et al 1998:14; Suffla 1997:219).

Emotional effects

Emotionally these women experience a state of emotional turmoil, a mixture of emotions. They can immediately experience relief when they can go on with their lives. Guilt follows for ending a potential human life. Feeling of sadness and loss occur even though they decided to undergo the TOPs themselves, just like ending a troublesome marriage could lead to a sense of loss (Myburgh et al 1998:17).

A feeling of maturation, whereby a woman experiences that she has come out of a situation of passivity to active responsibility and planning mastery of her destination. Anger is also experienced which can either be directed at herself, the partner, or at the whole situation,. She also experiences regret (Myburgh et al 1998:16; Stotland 1997:679; Suffla1997:221).

Psychological effects

Due to the mixture of emotions that the post TOP woman can experience she might end up being unhappy and depressed, becoming ashamed of herself. Psychological defense mechanisms might be used in order to deal with the situation, including denial, rationalisation, intellectualisation, suppression and regression (Myburgh et al 1998:16-18; Mpshe et al 2002:70-76).

Spiritual effects

Most women have standards based on their religious beliefs. Having undergone a TOP, they might experience spiritual pain due to religious convictions. One woman said she could not go to church for some time after undergoing a TOP (Myburgh et al 1998:14; Suffla 1997:220).

Social effects

Many women undergo TOPs secretly. Due to the nature of the procedure, she might not discuss this situation with anyone, not even with people close to her, such as her mother, sister, brother or partner. Hence women who undergo TOPs might experience social isolation and loneliness.

Some women reported feeling alone even in the presence of others. They felt lonely even if they had discussed the situation with somebody else, because the other person might not understand their experiences. Other women preferred to cope alone with their feelings about TOPs, because keeping this secret helped them to minimise unsupportive and conflicting responses from significant other persons in their lives (Myburgh et al 1998:18, Suffla 1997:216-218).

2.6.8.6 Counselling

Counselling is of the utmost importance to women who undergo TOPs. The CTOP Act (no 92 of 1996) provides women the right to non-mandatory and non-directive counselling, before and after the procedure. This is done to help the women to cope better with the situation (SA 1996b:4).

Ngwena (1998:62-63) highlighted that TOP is accompanied by stigmatisation, either from peers, family or even from health care workers. He stated that counselling should be based on the principle of

autonomy and the belief that these women have a sound mind and are capable of self determination. Counselling should be free from the counsellor's personal values.

TOP is a moral and emotional issue. In counselling all the required information should be given to the women, for her to be able to make an informed choice. Each woman should know exactly what the procedure entails, the risk she is taking and the after effects. The more informed the woman is, the less traumatic the procedure becomes (Callaghan 1997:9; Myburgh et al 1998:17).

Effective counselling requires empathy, respect for human rights and unconditional acceptance of the person. Pre counselling could be made shorter and provide information about the procedure, the physical, psychological, spiritual and social effects of TOP. Postoperative counselling should be extensive. It should allow the woman to verbalise her feelings about the procedure. Communication skills should be used to help each woman to deal with her TOP experiences (Botes 2000:27; Myburgh et al 1998:19).

2.6.8.7 The partners' support

Suffla (1997:218) stated that women's coping behaviour is linked to the presence or absence of social support from the partner. Men who cope poorly with TOP could become burdens to women who are already attempting to cope with their decisions.

The male partner's coping strategy affects a woman's adjustment to the TOP. Most of the time emphasis on experiences and coping is given to women, leaving the male partner out. Society has a tendency to stereotype men as tough, objective, stoic and emotionally inexpressive. Men end up masking and denying their emotions, in order to conform to their prescribed roles. These repressed feeling could end up manifesting in undesirable ways (Myburgh, Gmeimer & Van Wyk 2001:38).

Male partners' most experiences could include anger, fear, guilt, helplessness, sadness and regret. It is important that men find ways to deal with these feelings. If men are available in the women's lives and they are being supportive of the TOP decision, it is important to help these men to deal with their feelings too. Psychiatric nurses could help these men to cope. This is important because these men are a support system for the women who have undergone TOPs (Myburgh et al 2001:38-39).

2.6.8.8 Challenges for implementating the Choice on Termination of Pregnancy Act

However difficult the decision to undergo a TOP might be " ... it does provide a moment of power, a window of relief in an impossible situation in a woman's life" (Birenbaum 1998:491).

Although the CTOP Act (no 92 of 1996) provides South African women the legal right to undergo safe TOPs in health care institutions, not all women who desire TOP services, manage to access these. Guttmacher et al (1998:194) stated that because of the shortages of staff and long waiting lists, women continue to be turned away for being too far advanced in their pregnancies. This is irrespective of the fact that these women were booked early. The lack of state funded TOP centres, and the negative attitude of health care workers continue to make it difficult for many women to access TOP services.

According to Engelbrecht et al (2000:11), providers of TOP services do complain about the lack of emotional and psychological support provided to them. These providers face problems due to shortages of TOP services, inadequate infrastructure, and the shortages of staff and facilities. Much as health care providers have the right to refuse to participate in the performance of the procedure, they should ensure that this does not end up as a medico legal hazard. Some providers refuse to deal with cases presenting with incomplete TOPs (Walker 1996:49).

When Walker (1996:43-63) interviewed primary health care community nurses working in clinics in the Soweto area of the RSA, 70,0% of these nurses unequivocally and unambiguously rejected TOPs. Their opposition was expressed as anger, hostility and judgmental attitudes towards women who underwent TOPs. These nurses regarded TOPs to be unacceptable and unjustifiable under any

circumstances. These nurses described women who underwent TOPs as careless, unthinking, irresponsible, promiscuous, lacking self-control and having no excuse for not using contraceptives. Nurses who objected to TOPs were observed to be warm and friendly towards other patients, but they displayed cold indifferent attitudes when dealing with women who requested TOPs (Walker 1996:62).

In an exploratory descriptive study, Botes (2000:28-30) interviewed 1 200 nurses and conducted 22 focus groups, to evaluate the critical thinking of nurses in relation to the concept of TOP. These nurses were not considering alternative consequences to TOPs. They found it irritating to talk about TOPs which they viewed to be murder, sinful and criminal. Most of these nurses' responses were emotionally charged and they could not provide any rationale for their perspectives. TOPs were viewed as being disgraceful, amounting to a waste of taxpayers' money and constituting unfair and selfish acts.

Botes (2000:28-29) quoted the American Philosophical Association in describing a critical thinker. A critical thinker is described as a person who is

- habitually inquisitive, well informed
- trustful of reason
- open minded and flexible
- fair minded in evaluation
- honest in feeling personal bias
- prudent in mankind judgement
- willing to consider
- clear about issues
- orderly in complex matters
- diligent in seeking relevant information
- reasonable in selecting criteria
- persistent in seeking results which are precise considering the subject and circumstances of the enquiry

A study conducted by Guttmacher et al (1998:192-193) demonstrated that not all nurses were negative towards women who underwent TOPs. Some of the nurses verbalised having undergone TOPs themselves, so helping patients who had to undergo TOPs helped the nurses to deal with their own personal trauma. However, these nurses had to maintain secretiveness in order to protect themselves against victimisation and stigmatisation from their nursing colleagues. They voiced a need for cognitive, emotional and spiritual support to deal with the situation in which they found themselves.

2.6.8.9 Pro-termination of pregnancy arguments

Pro-TOP, or pro-abortion, or pro-choice activists believe it is each woman's right to decide whether to carry a pregnancy to term or not.

Naude, London and Guttmacher (1999:117-118) differentiated between nurses' legal and ethical obligations. Refusing to perform or to counsel women for TOP might be legally right but ethically wrong. Health care workers are bound by the principles of autonomy, beneficence and justice. In honouring autonomy women should be given the right to choose. Dismissing a woman before even consulting her denies her human dignity, freedom and the ability to make an informed choice. Ethical justice involves fairness, equity and impartiality.

Birenbaum (1998:485-499) argued that women should not be vocationally, economically or socially punished for their reproductive roles. Women have a right to control their biological destinies. A responsible society, when supporting women to carry their pregnancies to term, should provide these women with adequate antenatal care (ANC), and guarantee these women's jobs post maternity leave and restructure the work place to accommodate child care at the women's places of work.

TOPs should not be looked at as an isolated event, or a dilemma but should be viewed within the totality of circumstances leading to pregnancy. In the RSA, TOPs should be looked at in relation to

women's social, economic and gender status. When women are forced to carry pregnancies to term, they might be exploited reproductively (Birenbaum 1998:486-490).

The anti-choice or pro-life lobbyists who maintain that pregnant women should carry their pregnancies full term might fail to recognise a gender power imbalance. In the RSA, many women cannot choose whether to have sex or not, nor to use contraceptives. Women in the RSA are sometimes denied the use of contraceptives by their husbands (and sometimes by their families-in-law). Forcing women to carry pregnancies to term is like punishing them for contraceptive ignorance or failure, whether as a result of subordination to men or to poverty, or for demographics that make contraceptives inaccessible to them. Men do not suffer any biological or social consequences of contraceptive failures, nor any possible side-effects of contraceptives (Birenbaum 1998:489-494).

According to Maforah et al (1997:79-80), being negative towards women who undergo TOPs fails to recognise that some of these women had been raped. The child conceived would be a constant reminder of the event of the rape throughout the woman's life.

2.7 SUMMARY

Chapter 2 outlined challenges to effective contraceptives use. Several other factors were highlighted, which could impact on contraceptive behaviours of women in the RSA.

A discussion about knowledge, attitudes and perceptions about contraceptives and the challenges posed to effective contraceptive use indicated that the mere fact that contraceptives are freely available in the RSA, does not imply that women will use them effectively.

The concept of TOP and its effects on women's well being has also been addressed. Remaining barriers to contraceptive use could help to decrease the numbers of women requesting TOPs in the RSA.

The purpose of this research was to identify specific reasons why women failed to use contraceptives and ended up undergoing TOPs. If these reasons could be known, then more accessible contraceptive services could be planned and implemented in the RSA, leading to decreased numbers of requests for TOP services. This should not only enhance the quality of women's lives, but also reduce health care costs by providing fewer TOPs annually.

In chapter 3 the research methodology which was adopted to identify reasons why women who requested TOP services failed to use contraceptives effectively, will be discussed.