

CHAPTER 4

Analyses and discussion of the research results

4.1 INTRODUCTION

This was an exploratory descriptive study attempting to identify contraceptive challenges experienced by women who requested TOPs in terms of the provisions of the CTOP Act (no 92 of 1996) at the Bethal Hospital in Gert Sibande District (Mpumalanga Province), during September and October 2003. This chapter presents the analysis of the data obtained from 55 women who agreed to be interviewed during these two months. A structured interview schedule, designed to capture data relevant to contraceptive challenges encountered by these women, was used to collect the data, as described in chapter 3 of this dissertation. The data was summarised mainly by computing frequencies and percentages. The relationships between different concepts were also explored and are reported in this chapter, where appropriate.

The first section of the structured interview schedule attempted to obtain demographic information from the respondents in order to contextualise the information about contraceptive challenges against the background knowledge of who the respondents were. The contraceptive challenges which a woman might encounter prior to initiating contraceptive use, include lack of sexuality education, contraceptive knowledge, gender issues and the accessibility of contraceptive services/supplies. Contraceptive challenges that could be experienced during the use of contraceptives were also explored. These included the utilisation of contraceptives, counselling received about different contraceptive methods, attitudes towards and perceptions about contraceptives, the attitudes of the contraceptive providers and the lack of contraceptive resources and the shortage of contraceptive providers.

The relationships between the results obtained and the theoretical framework were also explored and will be discussed in relevant sections of this chapter. It should be noted that frequencies and percentages will be displayed as calculated by the Microsoft Excel program, implying that not all percentages total 100,0%, but sometimes 100,1% or 99,9%.

4.2 DEMOGRAPHIC DATA

Demographic issues which were addressed in the structured interview schedule included age, level of education, marital status, race, residential area, employment, income, religion and the number of children that the respondent had. Information about these aspects might be useful for interpreting the data about contraceptive challenges encountered by women who requested TOP services at the Bethal Hospital during September and October 2003.

4.2.1 Age

One item in the structured interview schedule (see annexure A) requested the respondents to indicate their ages at their previous birthdays. According to the statistics portrayed in table 4.1 as many as 60,0% (n = 33) of the women's ages ranged from 20 to 30 years of age, while only 7,2% (n = 4) were 41 years old or older.

Table 4.1 Age in years at previous birthday

AGE	FREQUENCY (n)	PERCENTAGE (%)
13-14 years	10	18,2
20-30 years	33	60,0
31-40 years	8	14,5
41 – 50 years	4	7,3
TOTAL	55	100,0

It should be noted that 18,2% (n=10) of the women were adolescents, being 19 years of age or younger, and probably still pursuing educational aims. Although TOPs would afford these young women opportunities to continue with their educational pursuits, the effective use of contraceptives to prevent unwanted and unplanned pregnancies would have been psychologically and physically less traumatic to these individuals, and more cost effective to the health care services. "Effective use of family planning techniques can definitely help girls and women plan when to have their children and plan their lives so that they are not destined to poverty and hopelessness" (Ehlers 1999:53).

Similar age distributions of women who underwent TOPs in the RSA, were reported by other researchers. A study conducted in the KwaZulu-Natal (KZN) Province of the RSA reported that teenagers comprised 17,8% of this sample, while 5,7% of the participants' ages ranged from 20 to 29 years, and 17,0% reported their ages to fall in the 30-35 year age group and only 8% were 40 years of age or older (Adanlawo & Moodley 1999:102).

Research done in the Free State Province of the RSA, indicated that 18,7% of the women who participated in this study were teenagers, 37,7% reported their ages to range from 19 to 25, and 41,3% indicated their ages to fall into the 26-40 year group while only 2,7% were 40 years of age or older (Engelbrecht et al 2000:14). These results from studies conducted in the RSA seem to be in line with the statistics from 56 different countries, as analysed and reported by Bankole et al (1998:117-127). The statistics from these 56 countries indicated that women aged 40 or older requested fewer TOPs than women from other age groups, while adolescents requested TOPs in all these countries.

4.2.2 Level of education

According to Chimere-Dan (1997:15-16) women need to have completed a minimum of 7 years' schooling successfully before contraceptives can be used effectively by them; with an impact on fertility behaviour.

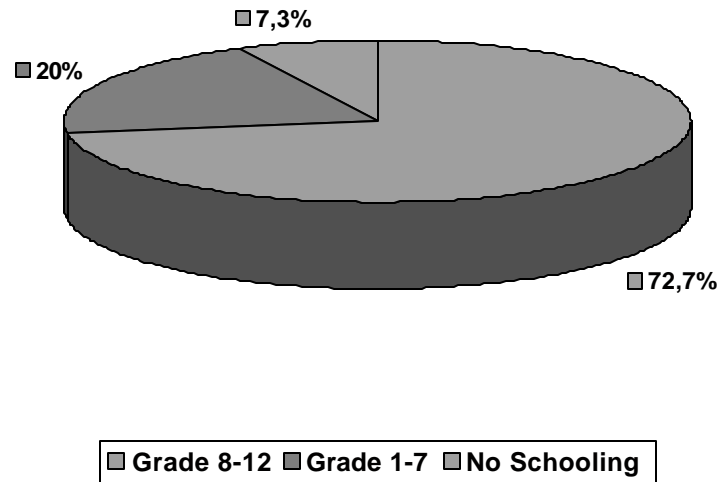


Figure 4.1

Participants' levels of education (n = 55)

As portrayed by figure 4.1 the majority of the women who underwent TOPs, namely 72,7% (n = 40), acquired secondary school education, 20,0% (n = 11) obtained primary school education and only 7,3% (n = 4) had no schooling at all. In terms of Chimere-Dan's (1997:15-16) assertion, those women who acquired secondary school education, should have been capable of utilising contraceptives effectively. However, they failed to do so as they ended up obtaining TOPs for unplanned and/or unwanted pregnancies which could have been prevented by using contraceptives effectively. Thus it could be surmised that these women might have encountered contraceptive challenges which they could not overcome successfully in spite of the relatively high levels of education acquired by most women who participated in this research project. (This deduction is strengthened by

the observation that 85,5% (n = 47) of these women used contraceptives at some stage during their lives - as reflected in figure 4.16 in this chapter).

4.2.3 Marital status

The husbands of married women could exercise considerable control over their use of contraceptives, especially in cultures where the husband has to pay a bridal prize ("lobola") in kind or in money to his wife's family. "Having paid for his wife, the husband is inclined to regard her as any other possession he bought and legally possesses. Consequently not only does the wife in such a traditional marriage have no status, but also no say concerning the number of children to be born" (Ehlers 1999:53).

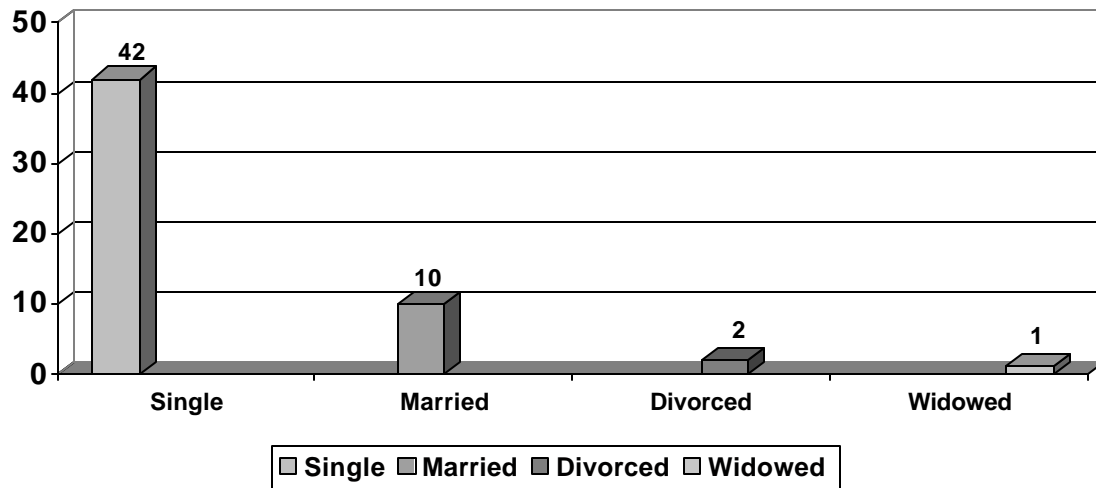


Figure 4.2

Respondents' marital status (n = 55)

As demonstrated by figure 4.2 the majority (76,3%; n = 42) of the respondents were single while only 18,2% (n = 10) were married, 3,6% (n = 2) were divorced and 1,8% woman (n = 1) was widowed.

Thus the expectation, based on the literature reviewed, that marriage partners' expectations that their wives should not use contraceptives in order to bear as many children as possible, was not supported by the research results obtained from the 55 structured interviews conducted with women who requested TOPs during this survey.

These results, portrayed by figure 4.2, appear to be consistent with those of other researchers who conducted similar projects in the RSA. These results seem to concur that single women would constitute the largest group seeking TOPs, followed by married women, and to a lesser extent by divorced and widowed women (Adanlawo & Moodley 1999:99; Bankole et al 1998:117-127; Engelbrecht et al 2000:8).

4.2.4 Race

Figure 4.3 indicates that the vast majority of women, namely 54 out of 55 (98,2%) who participated in this survey were Black women while only one woman (1,8%) was White.

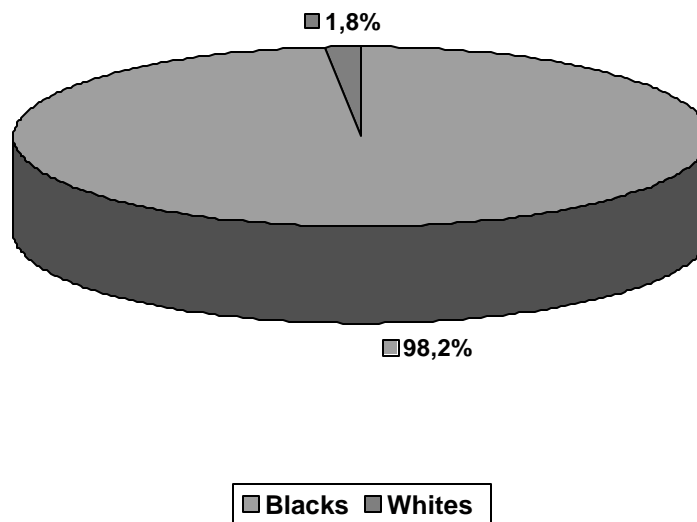


Figure 4.3**Participants' racial groups (n = 55)**

This finding is in accordance with the available statistics of Bethal Hospital (Bethal Hospital Statistics 1999-2000) which indicate that mostly Black women seek TOP services at this hospital.

4.2.5 Participants' residential areas

Most of the women who requested TOPs at the Bethal Hospital came from towns surrounding Bethal in the Gert Sibande District, amounting to 90,9% (n=50). None of these women came from cities elsewhere in the RSA, and only 9,1% (n=5) came from surrounding rural areas.

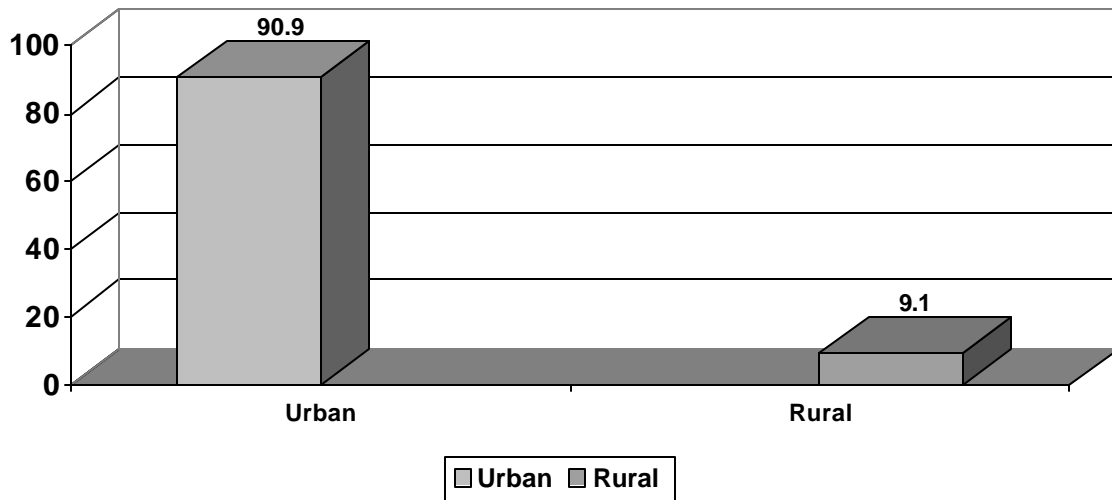


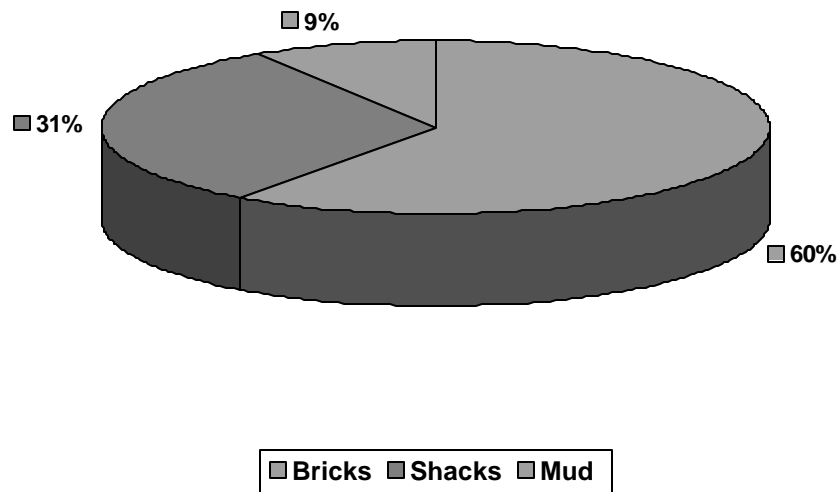
Figure 4.4

Participants' residential areas (n = 55)

This distribution of respondents' residential areas, reflected by figure 4.4, could indicate that women from surrounding towns might have accessed transport to the Bethal Hospital more readily than women from the rural areas (DOH 2001:14). However, this possibility could neither be supported nor refuted by the available statistics. No explanations were provided by the respondents to explain this apparent discrepancy between the utilisation of TOP services by women from surrounding towns compared to women from surrounding rural areas.

4.2.6 Type of housing

As indicated by figure 4.5 most respondents, namely 60,0% (n = 33), lived in houses constructed with



bricks, while 30,9% (n = 17) lived in shacks and only 9,1% (n = 5) lived in mud houses.

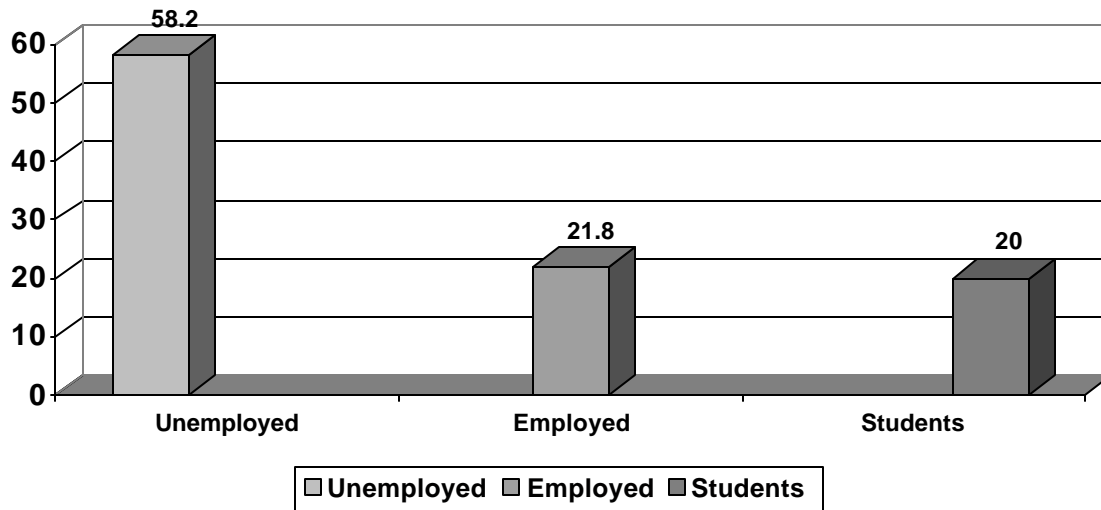
Figure 4.5
Type of housing (n = 55)

The distribution of the types of housing in which the respondents reportedly lived, as depicted in figure 4.5, appeared to support the statistics about the respondents' residential areas (see figure 4.4). This is the case because brick houses and shacks are mostly found in towns, while mud houses are mostly found in rural areas in the Gert Sibande District.

4.2.7 Employment history

Figure 4.6 demonstrates that 58,2% (n = 32) of these women were unemployed. Those who were employed constituted 12 women (or 21,8%) of whom 11 were students. The total number of women

who were not working (comprising those who were unemployed and those who were students) was 43 (78,2%). This result supports those of previous studies on women who underwent TOPs indicating that the majority of those women were unemployed (Adanlawo & Moodley 1999:99); Engelbrecht et al 2000:8). A contradiction is seen in terms of the number of students who underwent TOPs. In this study



the students constitutes 20,0% (n = 11) and in the other studies the students comprised approximately 50,0% of the sample (Adanlawo & Moodley 1999:99; Engelbrecht et al 2000:8).

Figure 4.6
Employment history (n = 55)

4.2.8 Income

Table 4.2 **Income**

INCOME	FREQUENCY (n)	PERCENTAGE (%)
Up to R500,00	5	33,4
Between R501,00 – R1 000,00	7	66,6

Of the 12 women who were employed 5 (33,4%) earned up to R500,00 and 7 (66,6%) reported their earnings to range from R501,00 to R1 000,00. Previous studies conducted in the RSA reported that

the majority of women who requested TOPs, did so for socio-economic reasons (Bankole et al 1998:117-127; Engelbrecht et al 2000:14; Maforah et al 1997:80; Suffla 1997:216-218). In this study the poor socio-economic status of women who requested TOPs was confirmed. As many as 78,2% (n = 43) of the women in this study were unemployed or students, and the 21,8% (n = 12) all earned less than R1 000,00 per month.

4.2.9 Religion

All the women who underwent TOPs in the Gert Sibande District during September and October 2003 were reportedly Christians. No other religion was mentioned. Bankole et al (1998:27-129) compared the religions of women who underwent TOPs. According to these authors, Christians were seen to be 39 per 1 000 and Moslems were 17 per 1 000. However, all the women who underwent TOPs at the Bethal Hospital during September and October 2003 were Christians. From the available statistics no explanation could be provided for this apparent discrepancy with previous research results.

4.2.10 Number of children

Table 4.3 **Number of children**

NUMBER OF CHILDREN	FREQUENCY (n)	PERCENTAGE (%)
None	15	27,3
One	12	21,8
Two	7	12,7
Three	12	21,8
Four	5	9,1
Six	3	5,5
Seven	1	1,8
TOTAL	55	100,0

As many as 27,3% (n = 15) of the women did not have any children, while these 15 women might have hesitated using contraceptives as their fertility had not yet been confirmed, the same argument cannot be upheld for the other 40 (72,7%) of the women who requested TOPs. However, women who desire to bear no further children have access to free contraceptives, emergency contraceptives and sterilisation services. It is not known why 38,2% (n = 21) of the women who had three or more children resorted to TOPs rather than to contraceptives, emergency contraceptives or sterilisations to prevent them from having more children. Seen against the joblessness and the poor socio-economic status of the majority of these women, their failure to use freely available, temporary, permanent or emergency contraceptives could indicate that they failed to access these free services. The major purpose of conducting this research was to identify challenges which women encountered in accessing and/or using contraceptives and to suggest ways of overcoming some of these challenges.

4.3 SECTION 2: SEXUALITY EDUCATION

4.3.1 Sexuality education received

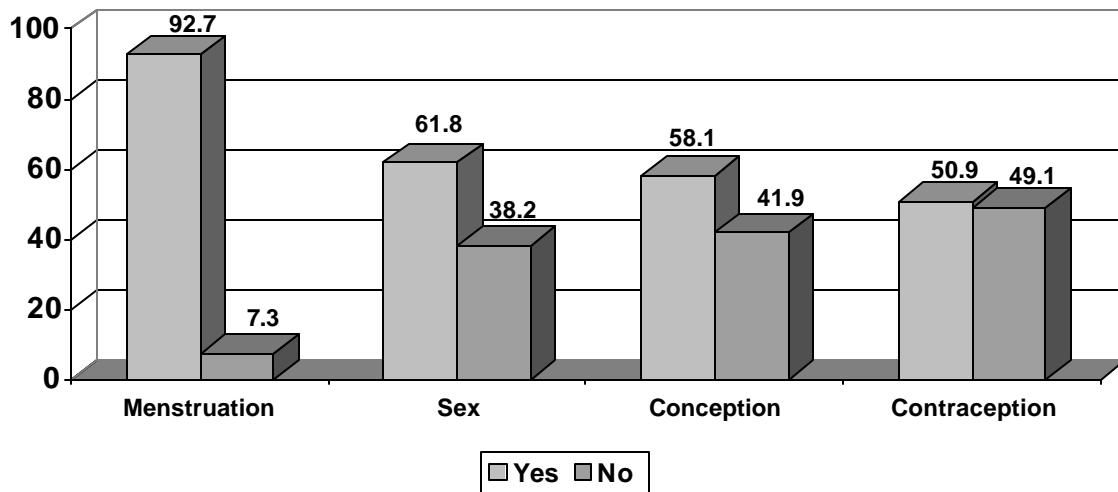


Figure 4.7

Sexuality education received (n = 55)

The main sexuality education received by women was on menstruation, by 92,7% (n = 51) and 7,3% (n = 4) did not receive this information. In reference to sex, 61,8% (n = 34) received information compared to 38,2% (n = 21) who did not, 58,1% (n = 32) received information on conception and only 41,9% (n = 23) did not. Those who have reportedly received information on contraception constituted 50,9% (n = 28) while 49,1% (n = 27) did not receive such information.

The majority of these women received one or the other form of education on sexuality. Attention should be drawn to the fact that these women were answering "yes" or "no" to this question. Therefore, these responses do not indicate the content of the education given. Bam (1994:16-20) stipulated that sexuality education is not an event but it is a process. Information given should constitute information on anatomy, physiology, sexual behaviour, STDs, sexual development, conception and contraception. This information should build the child's character, self-esteem, ethical and moral behaviour, a sense of personal worth and a capacity for independent decision-making.

4.3.2 Age at which sexuality education was given

Table 4.4 Age at which sexuality education was given

AGE	FREQUENCY (n)	PERCENTAGE (%)
No answer	13	23,6
10-14 years	16	29,1
15-17 years	22	40,0
18-19 years	4	7,3
TOTAL	55	100,0

According to table 4.4, 40,0% (n = 22) of these women received information when they were between the ages of 15 and 17 years, 29,1% (n = 16) received it when they were between 10 to 14 years and 7,3% (n = 4) received it when they were between the ages of 18-19 years.

4.3.3 Sources of sexuality education/information

Each respondent could report more than one source of information. Therefore the total number of responses exceeds the total number of respondents ($n = 55$). Nevertheless the percentage of each response was calculated based on 55 respondents.

Table 4.5 Sources of sexuality education/information

INFORMANT	FREQUENCY (n)	PERCENTAGE (%)
Mother	27	49,1
Father	2	3,6
Teacher	13	23,6
Nurse	11	20,0
Friend	9	16,4
Relative	9	16,4

The total number of informants who gave sexuality education exceeds the total number of women who received sexuality education, because some women stated more than one source. According to Bam (1994:23) parents are expected to lay the foundation for sexuality education, upon which all the other information could be built. Parents who gave sexuality education in this study constituted 52,7%, though fathers who contributed were only 3,6%. This result is similar to that obtained by Maja (2002:197) where information on sexuality education to adolescents was provided mainly by mothers (42,3%), no contraceptive information was received from the fathers, 8,6% of the information was from the adolescents' sisters, 23,9% was from the adolescents' friends, 10,8% was from the teachers and 39,1% was from the media.

4.3.4 Institutions that provided sexuality education

Each respondent could indicate more than one institution which provided sexuality education to her. Therefore the total number of respondents exceeds 55. However, the percentage of women who indicated any one institution as having provided sexuality education was calculated on the basis of n = 55.

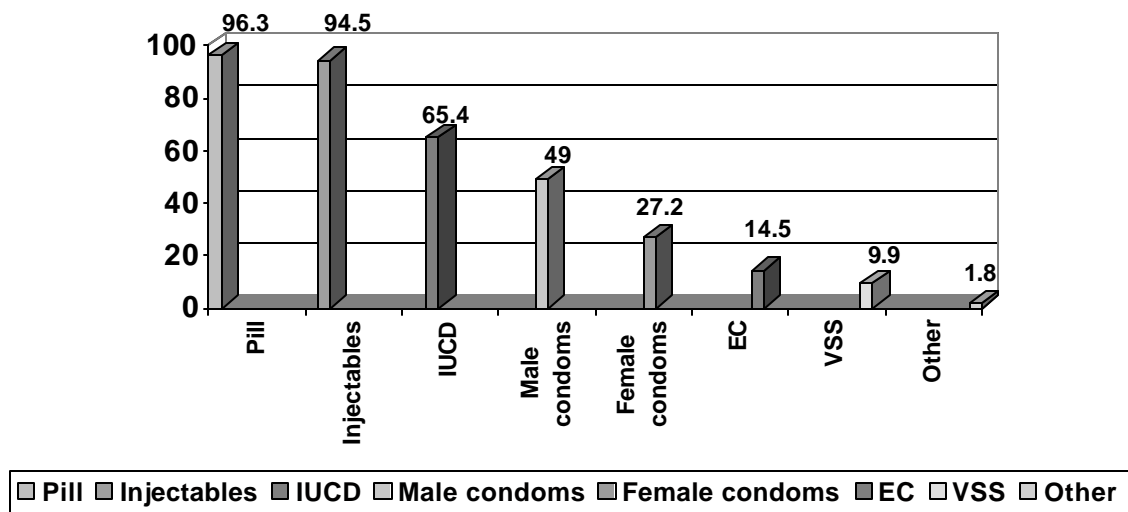
Table 4.6 Institutions that gave sexuality education

PLACE	FREQUENCY (n)	PERCENTAGE (%)
Home	38	69,1
School	13	23,6
Clinic	8	14,5
Church	1	1,8
Media	5	9,1
Other	8	14,5

Table 4.6 displays information that corresponds with information obtained from table 4.5. It indicates that 69,1% (n = 38) of the sexuality information was received at home which was either given by parents or mothers. The school gave 23,6% (n = 13) of the sexuality information, the media 9,1%, (n = 5) the church gave 1,8% (n = 1) and the other institutions gave 14,5% (n = 8).

4.4 CONTRACEPTIVE KNOWLEDGE

4.4.1 Contraceptive methods known

**Figure 4.8**

Contraceptive methods known (n = 55)

Women who requested TOPs at the Bethal Hospital knew about hormonal contraceptives. Injections were known by 96,3% (n = 53) of these women, pills by 94,5% (n = 52), followed by IUCDs (65,4%; n = 36), the male condom (49,0%; n = 27), the female condom (27,2%; n = 15), emergency contraceptives (14,5%), VSS (9,9%) and the "other" methods were mentioned by only 1,8% of these women. The level of knowledge especially about hormonal contraceptives was high, but it should always be remembered that knowledge does not equal usage. According to the DOH (2001:19) mentioning a method is not always sufficient to imply its use. A woman should be told about the method's function, anticipated side-effects, how to use the method effectively and what to do if side-effects are experienced. This allows a woman to make an informed choice. When Ehlers et al (2000:52) investigated adolescents mothers' usage of reproductive services, the adolescent mothers (60,0%) could mention pills, injectables and condoms. In the study by Ehlers and Maja (2001:10), 64,0% of the adolescent mothers could mention pills and injections. These were adolescent mothers who irrespective of knowing about contraceptive methods ended up being pregnant and being adolescent mothers.

4.4.2 Knowledge about emergency contraceptives

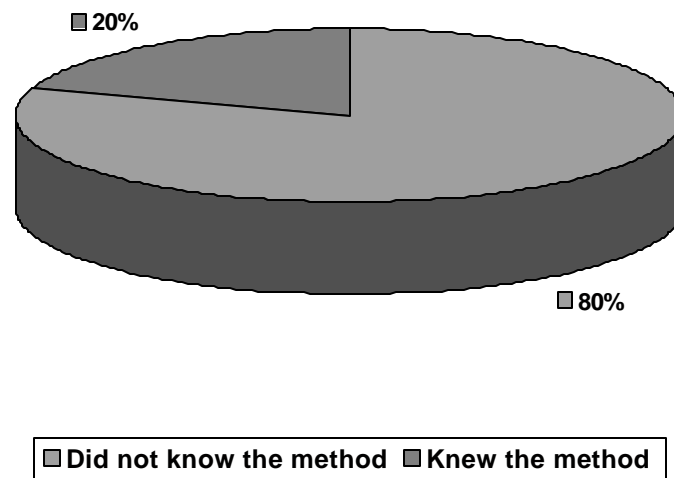


Figure 4.9

Knowledge about emergency contraceptives (n = 55)

As many as 80,0% (n = 44) of these women who requested TOPs in Gert Sibande District, reportedly did not know about emergency contraceptives, while only 20,0% (n = 11) knew about emergency contraceptives. Emergency contraceptives could reduce the number of unwanted pregnancies, if women could know about its existence, availability and action (Quinn 1999:42). This result supports that obtained in Tshwane in the RSA, where 67,5% of the adolescent mothers did not know about emergency contraceptives (Ehlers 2003:24).

4.4.3 Information about utilisation of emergency contraceptives

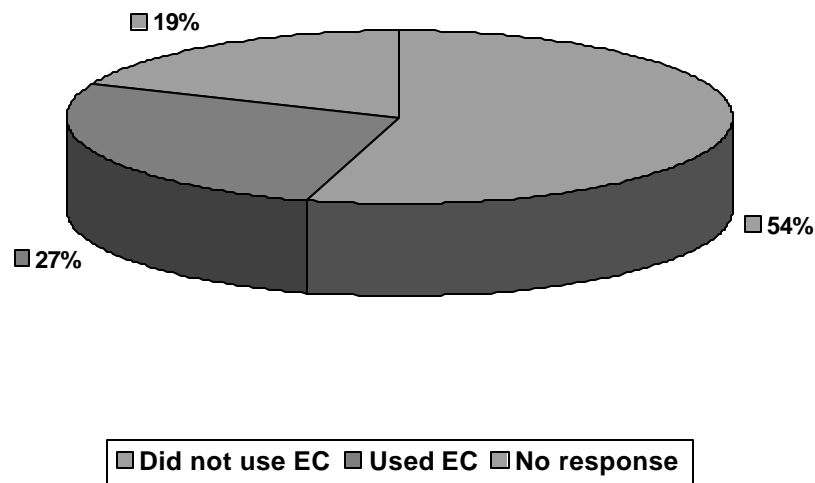


Figure 4.10

Information about utilisation of emergency contraceptives (n = 55)

Out of the 11 women who mentioned that they knew about emergency contraceptives, only 6 used this method after an episode of unprotected sex, 3 did not use the method and 2 provided unclear responses.

4.4.4 Knowledge that contraceptive pills could be used as emergency contraceptives

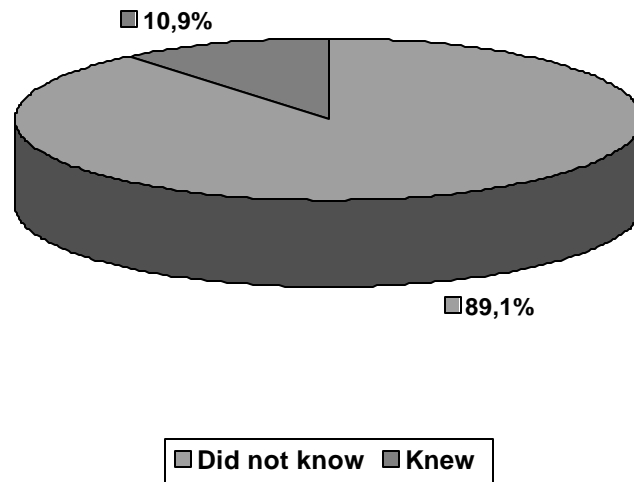


Figure 4.11

Knowledge that contraceptive pills could be used as emergency contraceptives (n = 55)

Figure 4.11 indicates that most of the women who requested TOPs in Bethal Hospital did not know that contraceptive pills could be used as emergency contraceptives. Only 10,9% (n = 6) knew about this method of emergency contraceptives. These results support those displayed in figure 4.9 where 80,0% (n = 44) of the women in this study did not know about emergency contraceptives.

4.4.5 Sources of information to help women to utilise emergency contraceptives

Table 4.7 Actions to help women to use emergency contraceptives

SOURCES OF INFORMATION	FREQUENCY (n)	PERCENTAGE (%)
Education	31	56,4
Posters	4	7,3
Radio	4	7,3
I don't know	3	5,5
I'm not sure	5	9,1
No response	8	14,4

TOTAL	47	100,0
-------	----	-------

In responding to the question of what could be done to help women to use emergency contraceptives, 56,4% (n = 31) said women should be educated, 7,3% (n = 4) said posters could be used to disseminate this information. Use of radio broadcasts was mentioned by another 7,3% (n = 4) women, 5,5% (n = 3) women did not know what could be done and 9,1% (n = 5) women were unsure of what could be done, while 14,4% (n = 8) provided no responses to this question.

4.5 GENDER ISSUES

4.5.1 Women's rights to decide about the use of contraceptives

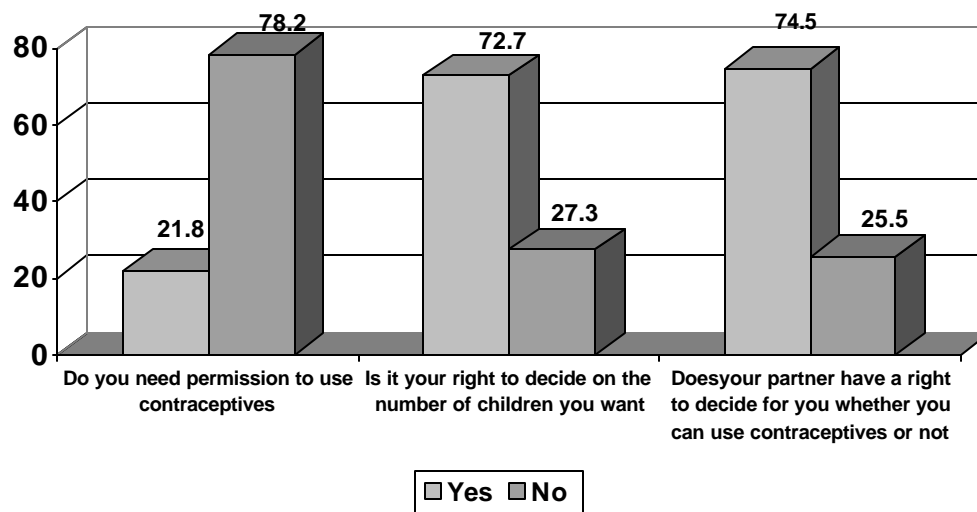


Figure 4.12

Women's rights to decide about the use of contraceptives (n = 55)

According to figure 4.12, 78,2% (n = 43) of these women did not require permission from anyone to use contraceptives, only 21,8% (n = 12) did. The majority (72,7%; n = 40) of the respondents believed it was their right to decide on the number of children they wanted, only 27,3% (n = 15) believed it was not their right. Most women (74,5%; n = 41) believed their partners had no right to decide whether they could use contraceptives or not, only 25,5% (n = 14) believed that their partners had any right

concerning their decisions to use or not to use contraceptives. These results should be viewed under the consideration that 76,4% (n = 42) of these women were single, only 18,2% (n = 10) were married (figure 4.2).

According to Ehlers (1999:48-55) payment of a bridal price or "lobola" causes African women to be regarded as a man's possession that is bought and paid for by a man in the same way that he buys and pays for other possessions. In some instances payment of "lobola" results in a woman losing her reproductive rights, the man decides on the number of children desired. This assumption was not supported by the 74,5% (n = 41) women in this survey who decided that their partners had no right to decide whether or not they could use contraceptives. However, as only a minority 18,2% (n = 10) of women were married, it is unlikely that their partners had indeed paid any labola.

4.5.2 Responsible person who had to provide permission for the use of contraceptives

Table 4.8 Responsible person who had to provide permission for the use of contraceptives

RESPONSIBLE PERSON	FREQUENCY (n)	PERCENTAGE (%)
Mom	4	33,3
Husband	2	16,7
Boyfriend	6	50,0
TOTAL	12	100,0

Much as the number of women who required permission from somebody else to use contraceptives was minimal (21,8%; n = 12), it was interesting though that 50,0% (n = 6) of these women required permission from their boyfriends and 16,7% (n = 2) from their husbands. These results support Nelson's (1997:52) statement that African women are sometimes required to prove their fertility even

before the payment of the "lobola" because children in an African culture are important, they provide value, meaning, dignity and status to the couple.

4.6 ACCESSIBILITY OF CONTRACEPTIVE SERVICES

4.6.1 Access to a contraceptive service centre

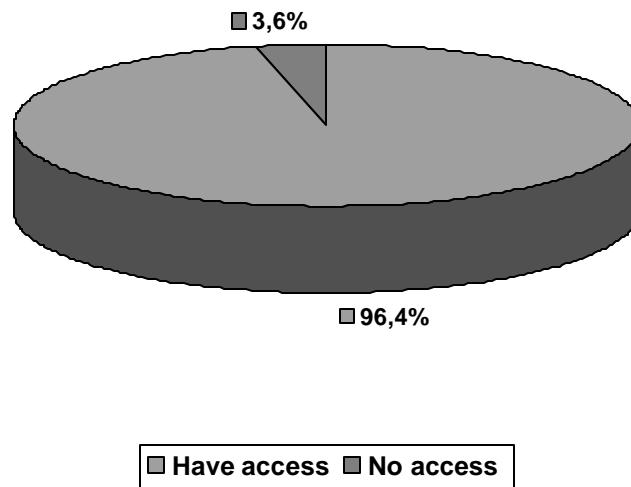


Figure 4.13

Access to a contraceptive service centre (n = 55)

Figure 4.13 indicates that the majority of these women (96,4%; n = 53) had access to contraceptive services, only 3,6% (n = 2) did not have access.

4.6.2 Type of contraceptive services available

Table 4.9 Type of contraceptive services available

AVAILABLE SERVICE	FREQUENCY (n)	PERCENTAGE (%)
Fixed clinic	36	65,5
Mobile clinic	8	14,5
Hospital	9	16,3
Doctor	1	1,8
Chemist	1	1,8
TOTAL	55	99,9

Table 4.9 indicates that most of these women 65,5% (n = 36) could access contraceptive services at permanent (fixed) clinics, followed by the number of women who could access contraceptives at hospitals 16,3% (n = 9), then mobile clinics could be accessed by 14,5% (n = 8) and the least used services were the chemist and the doctor. These results are linked with those displayed in figure 4.4, where 90,9% of these women were said to be from surrounding towns, whilst only 9,1% came from farms in the surrounding rural areas. Hospitals and clinics are easily accessible to people who reside in town and mobile clinics usually visit people in the rural areas (HST 1997:39).

The findings that extremely small numbers of women obtained contraceptives from chemists or doctors, correlate the earlier findings that most women came from low socio-economic backgrounds and very few earned sustainable wages. Thus socio-economic factors would make it difficult for these women to access contraceptives at chemists or doctors where they would have to pay for their services and supplies.

4.6.3 Distance travelled to contraceptive services

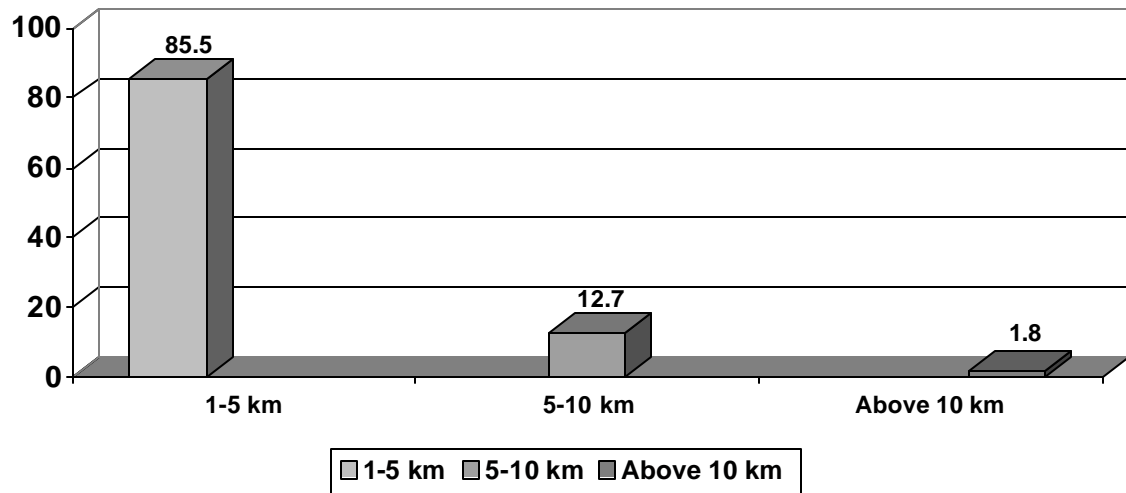


Figure 4.14

Distance travelled to contraceptive services (n = 55)

The estimated kilometres that were travelled to reach contraceptive services ranged from 1 to 5 kilometres by 85,5% (n = 47), between 5 to 10 kilometres by 12,7% (n = 7) women, and above 10 km was estimated to be travelled by 1,8% women. According to these results most women could access contraceptive services. These results tally with the results obtained by Adanlawo and Moodley (1999:100) of a study of the social profile of women who underwent TOPs. Those women also had easy access to contraceptive services. Maja (2002:215) found that travelling time to contraceptive services was between 1 and 15 minutes by 43,8% women, and between 15 and 30 minutes by 27,5% female respondents who used contraceptive services in the Northern Tshwane area of the Gauteng Province.

4.6.4 Times contraceptive services were available

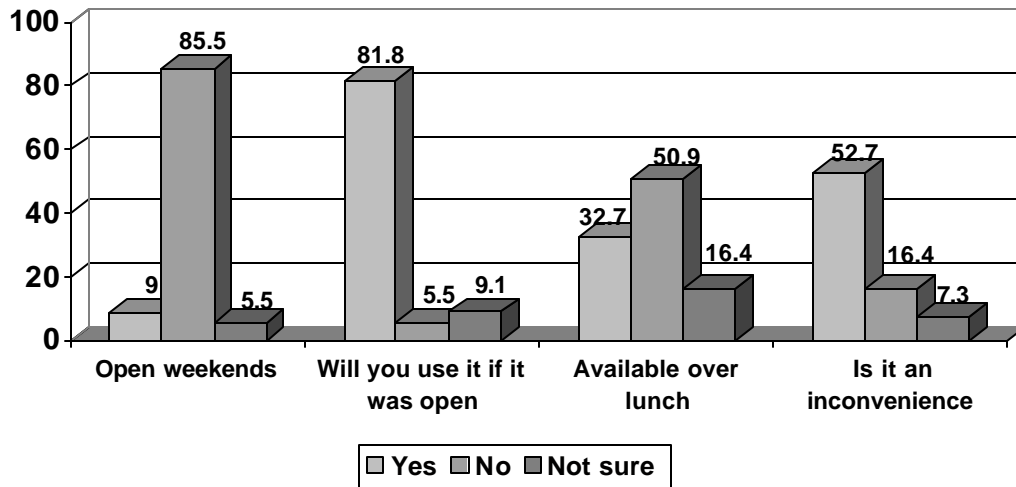


Figure 4.15

Times contraceptive services were available (n = 55)

According to figure 4.15 most of these women did not have access to the contraceptive services over weekends 85,5% (n = 47). Most of these women were willing to use contraceptive services if it was available over weekends 81,8% (n = 45), 5,5% (n = 3) were not willing to use it and 9,1% (n = 5) were unsure whether they would use it. These results appear to be inconsistent with those obtained in the Gauteng Province (Ehlers et al 2000:50) whereby 63,06% of the adolescent mothers would have preferred to attend contraceptive services over the weekend, whilst 23,5% would not have preferred to attend these clinics over weekends.

Many of these women did not have access to contraceptive services over lunch periods 50,9% (n = 28), 32,7% (n = 18) had access and 16,4% (n = 9) were unsure. A greater number 52,7% (n = 29) felt that non-availability of contraceptive services over lunch periods was an inconvenience, 16,4% (n = 9) said it was not an inconvenience and 7,3% (n = 4) were unsure.

4.6.5 Number of days per week contraceptive services were available

Table 4.10 Number of days per week contraceptive services were available

DAYS PER WEEK	FREQUENCY (n)	PERCENTAGE (%)
1 day	30	54,5
2 days	5	9,1
3 days	2	3,6
5 days	7	12,7
Whole week	3	5,5
Not sure	8	14,5
TOTAL	55	99,9

It was only one day a week that most of these women could access contraceptive services in their area 54,5% (n = 30), while 9,1%(n = 5) of these women could access it two days per week, 3,6% (n = 2) could access it three days a week, 12,7% (n = 7) women could access it five days a week. Contraceptive services could be accessed the whole week by only 5,5% (n = 3) while 14,5% (n = 8) women did not know how many days a week their contraceptive service was available.

4.7 SECTION 3: UTILISATION OF CONTRACEPTIVES

4.7.1 Previous utilisation of contraceptives

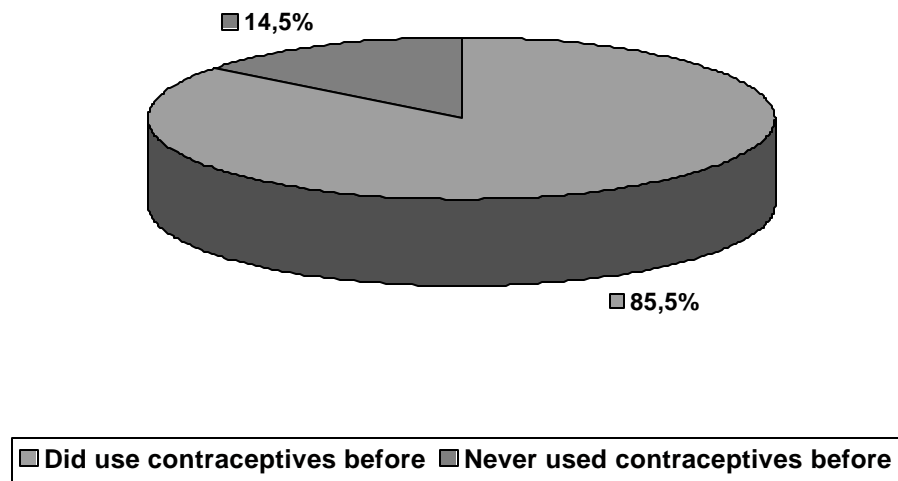


Figure 4.16

Previous utilisation of contraceptives (n = 55)

Although these women came in to request TOP of the present pregnancy, 85,5% (n = 47) used some form of contraception previously, 14,5% (n = 8) never used contraceptives. These results support those of Adanlawo and Moodley (1999:101) where 75,0% of the women who came in for TOPs did use contraceptives prior to their latest pregnancies and 25,0% did not. These results further complement the results in figure 4.8, where 96,3% of these women knew about injectables, 94,5% (n = 53) knew about pills, 65,4% (n = 36) knew about IUCDs, 49,0% (n = 27) knew about male condoms, and only 27,2% (n = 15) knew about female condoms.

4.7.2 Method used

Table 4.11 Method used

METHOD USED	FREQUENCY (n)	PERCENTAGE (%)
Pill	23	41,8
Injectables	32	58,2
IUCD	2	3,6
Male condom	8	14,5
Female condom	1	1,8
Emergence contraceptives	3	5,5

The numbers in table 4.11 exceeds the total number of the sample, because some women used more than one method. The majority of these women 58,2% (n = 32) used injections, followed by 41,8% (n = 23) who used pills, then the male condoms by 14,5% (n = 8) women, then emergency contraceptives by 5,5% (n = 3) women, IUCD by 3,6% (n = 2) women and lastly female condoms by 1,8% (n = 1) woman.

Hormonal contraceptives seem to be the mostly used method of contraception, injections being the most favoured followed by pills. This was observed in various studies conducted in the RSA. In the Transkei region of the RSA, Mofokeng et al (1996:50) found that 90,0% of the women in their study were using injectables. Lewis and Salo (1996:59-60) in their study in Cape Town, found that 58,0% of the women were using DPMA, 30,0% using pills and only 5,0% using IUCDs. De Vos (2001:20) found that in general South African women were mostly using injectables (57,05%), while 38,0% was using pills. In Thswane, Maja (2002:199) said 64,4% of women in her sample were using the injectables, 35,6% pills, 8,4% IUCDs, 8,0% condoms and only 2,7% used other methods.

4.7.3 Number of years each method was used

Table 4.12 Number of years each method was used

NUMBER OF YEARS	INJECTABLES		PILL		MALE CONDOMS		IUCD	
	f	%	F	%	f	%	f	%
Less than 1 year	2	6,2	4	17,3	1	12,5	-	-
1 year and above	3	9,3	3	13,5	-	-	-	-
2 years and above	5	15,6	4	17,3	2	25,0	2	50,0
3 years and above	6	18,7	4	17,3	-	-	-	-
4 years and above	3	9,3	1	4,3	2	25,0	-	-
5 years and above	5	15,9	2	8,6	1	12,5	-	-
More than 6 years	8	25,0	5	21,7	2	25,0	1	50,0
TOTAL	32	100,0	23	100,0	8	100,0	2	100,0

A number of these women used each method for more than 6 years, the injectables was used for more than 6 years by 25,0% (n = 8) women followed by 3 years and more by 18,7% (n = 6) women. The pill was used for more than 6 years by 21,7% (n = 3) women, followed by those who used it for more than 3 years, 17,3% (n = 4) women. The male condom was used for more than 6 years by 25,0% women (n = 2) and IUCD was used for more than 6 years by 50,0% (n = 1) woman.

4.7.4 Problems experienced by women who used contraceptives

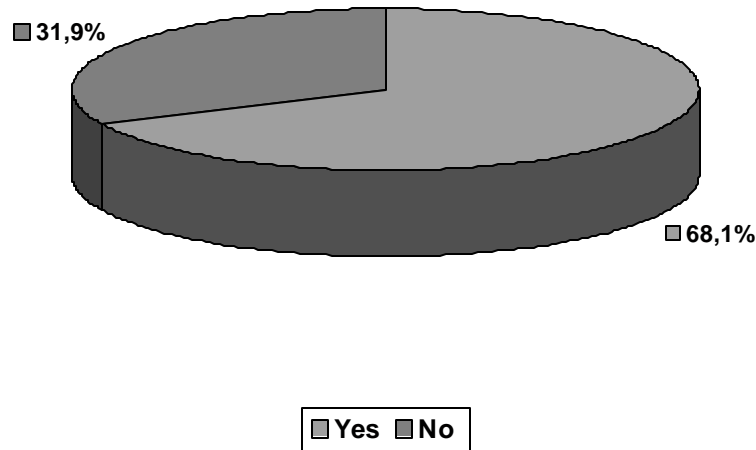


Figure 4.17

Problems experienced by women who used contraceptives (n = 47)

Figure 4.17 demonstrates that out of the 47 women who used contraceptives and replied to this question, 68,1% (n = 32) women experienced problems with the contraceptives they used, or 31,9% (n = 15) did not experience problems.

4.7.5 Problems experienced with specific contraceptives

- **Injectables**

The problems experienced by these women included amenorrhea and menorrhagia, loss of libido, headaches and dizziness. Some misconceptions reported included that injectable contraceptives led to yellowish offensive vaginal discharges and to the swelling of the whole body.

- **Pills**

Those women who used contraceptive pills, reported forgetting to take a pill regularly. They also reported nausea, vomiting, headaches and dizziness.

- **Male condoms**

Women who used male condoms stated that the main problem was the tearing of the condom during intercourse.

- **Intra-uterine device**

A problem of offensive yellowish vaginal discharge was reported. The problems experienced by these women were not unique to this study. All these side-effects were also reported in previous studies (Maforah et al 1997:80; Mofokeng et al 1996:13; Maja 2002:204; Wood, Tortu, Rhodes & Deren 1998:159).

4.8 COUNSELLING ON CONTRACEPTIVE METHODS

4.8.1 Places where contraceptives were obtained

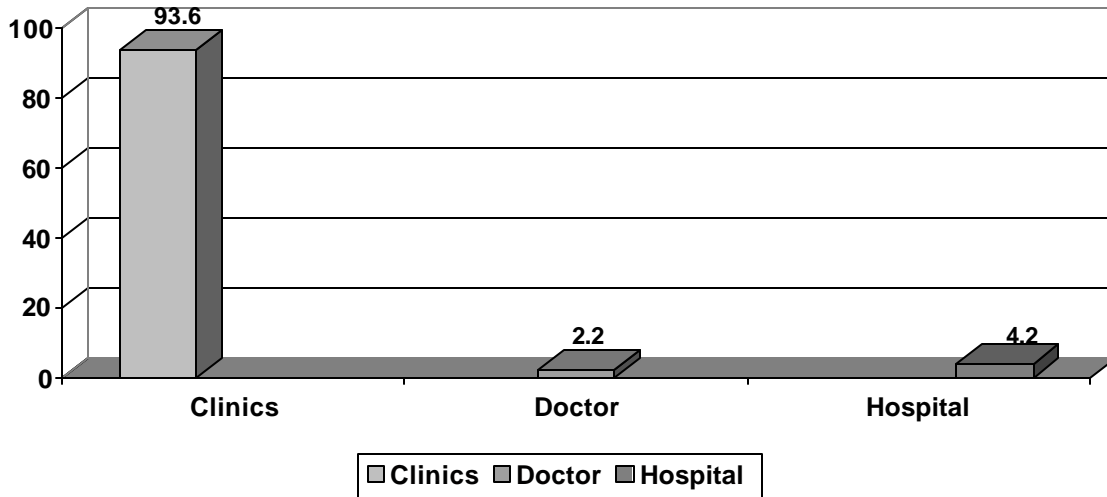


Figure 4.18

Places where contraceptives were obtained (n = 47)

Of the total number of 47 women who used contraceptives, 93,6% (n = 44) women obtained contraceptives from the clinics. A small number of these women 4,2% (n = 2) and 2,2% (n = 1) obtained them from the hospital and from the doctor respectively. In considering that the majority of these women were unemployed, it could be assumed that these women used the public sector because of financial reasons. According to the DOH (2001:2) contraceptives in the public sector are supplied free of charge in the RSA. The place where each client obtained her contraceptives would also determine the place where she should have received counselling about the effective use of contraceptives generally, and of her selected method specifically.

4.8.2 Counselling received

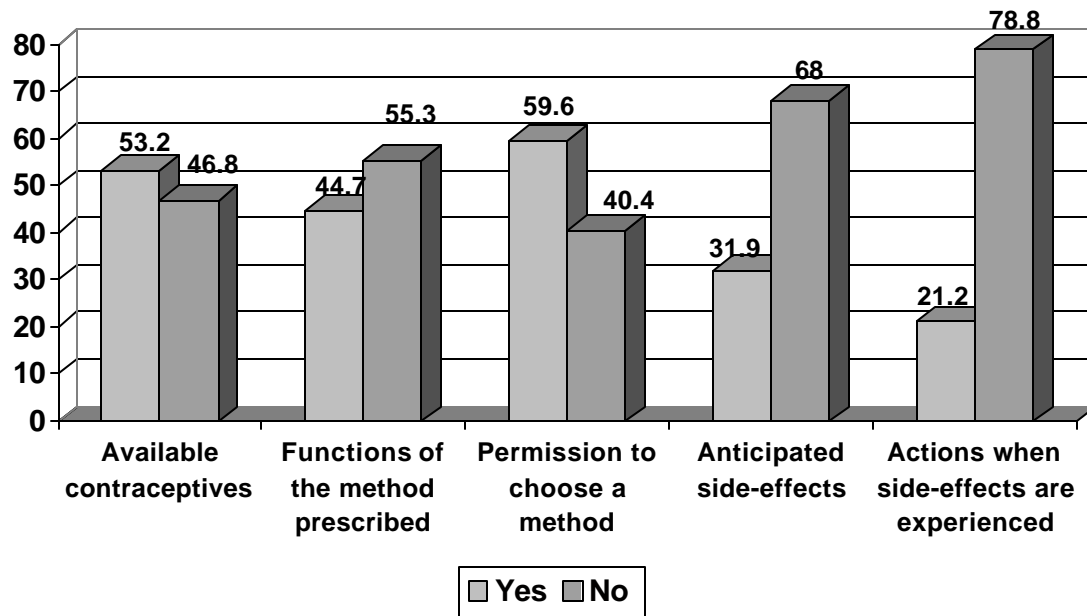


Figure 4.19

Counselling received (n = 47)

According to DOH (2001:19-21) counselling on the method of contraception should be done in a private room. The client has to be told about all available methods of contraception, she should be allowed to choose a method that best suits her circumstances. It is after a client has made her choice of a method that specific counselling should be given, a client is then told how her method functions, what are the anticipated side-effects and what should be done in case she experiences any of the side-effects.

Figure 4.19 indicates that some women (59,6%; n = 28) requested TOP at the Bethal Hospital, were allowed to choose their own contraceptives but 40,4% (n = 19) of the women's contraceptive methods were chosen by the contraceptive service providers.

Although some women (53,2%; n = 25) were counselled about available contraceptives, 46,8% (n = 22) of these women did not receive this information. In spite of the fact that more than half of the women (55,3%; n = 26) were told how the method of contraception they were using was functioning, the other 44,7% (n = 10) did not get this information.

With reference to the anticipated side-effects, this information was not communicated to 68,0% (n = 32) of women, only 31,9% (n = 15) received this information. Furthermore, 78,8% (n = 37) of these women were not told what to do if side-effects occurred, only 21,2% (n = 10) received this information.

4.9 ATTITUDES AND PERCEPTIONS ON CONTRACEPTION

4.9.1 The recommendation of contraceptives to somebody else

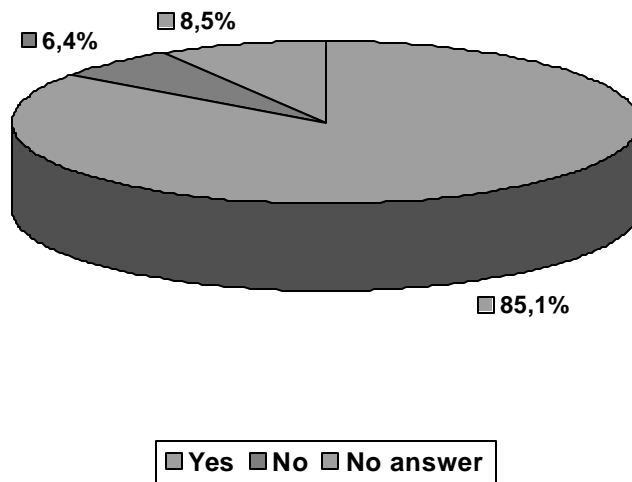


Figure 4.20

The recommendation of contraceptives to somebody else (n = 55)

According to the data displayed in figure 4.20, although many of these 47 women experienced problems with the contraceptive method used, they nevertheless continued to believe in using

contraceptives. As many as 85,1% (n = 40) of these women were still willing to recommended contraceptives to somebody else and only 6,4% (n = 3) said they would not recommend contraceptives to somebody else, while 8,5% (n = 4) did not answer this question.

4.9.2 Contraceptive methods that could be recommended to other women

Table 4.13 Contraceptive methods that could be recommended to other women

METHOD	FREQUENCY (n)	PERCENTAGE (%)
Pill	6	12,8
Injectables	21	44,7
IUCD	2	4,3
Condoms	13	27,6
No reply	5	27,6
TOTAL	40	100,0

A method of choice was the injectable contraceptives which was preferred by 44,7% (n = 21) of the women followed by 27,6% (n = 13) women who chose condoms, the pill was preferred by 12,8% (n = 6) and IUCDs by 4,3% (n = 2) women. These women seemed to be aware of STD/HIV infection since the male condom was chosen as a contraceptive, preceded by injectables only.

4.9.3 Reasons why the chosen methods were regarded to be the best

- **The pill**

The women who chose the pill stated the following reasons:

- It is safe.
- They were familiar with the method.
- Menstruation occurs monthly.

- **Injectables**

Injectable contraceptives were preferred for the following reasons:

- You do not have to take a pill daily.
- There is no forgetting taking a pill daily.
- It is private, it can be used without other people being aware especially the partner.
- They were familiar with the injections.

- **Intra-uterine device**

The women who chose IUCD said it was a better method because menstruation occurred monthly and there was no weight gain during the use of this method.

- **Condoms**

Condoms were regarded as:

- Safe.
- Being available when required.
- They were used during sexual intercourse only.
- They prevented STDs and pregnancy at once simultaneously.

These results supported those of Maja (2002:199) where almost similar reasons were stated for choosing the abovementioned methods. An apparent contradiction appeared in that women in Maja's study preferred pills as the second choice (by 13 women), but condoms were also the third contraceptive method of choice for the adult women participating in Maja's (2002:199) study.

4.10 ATTITUDES OF THE CONTRACEPTIVE PROVIDERS

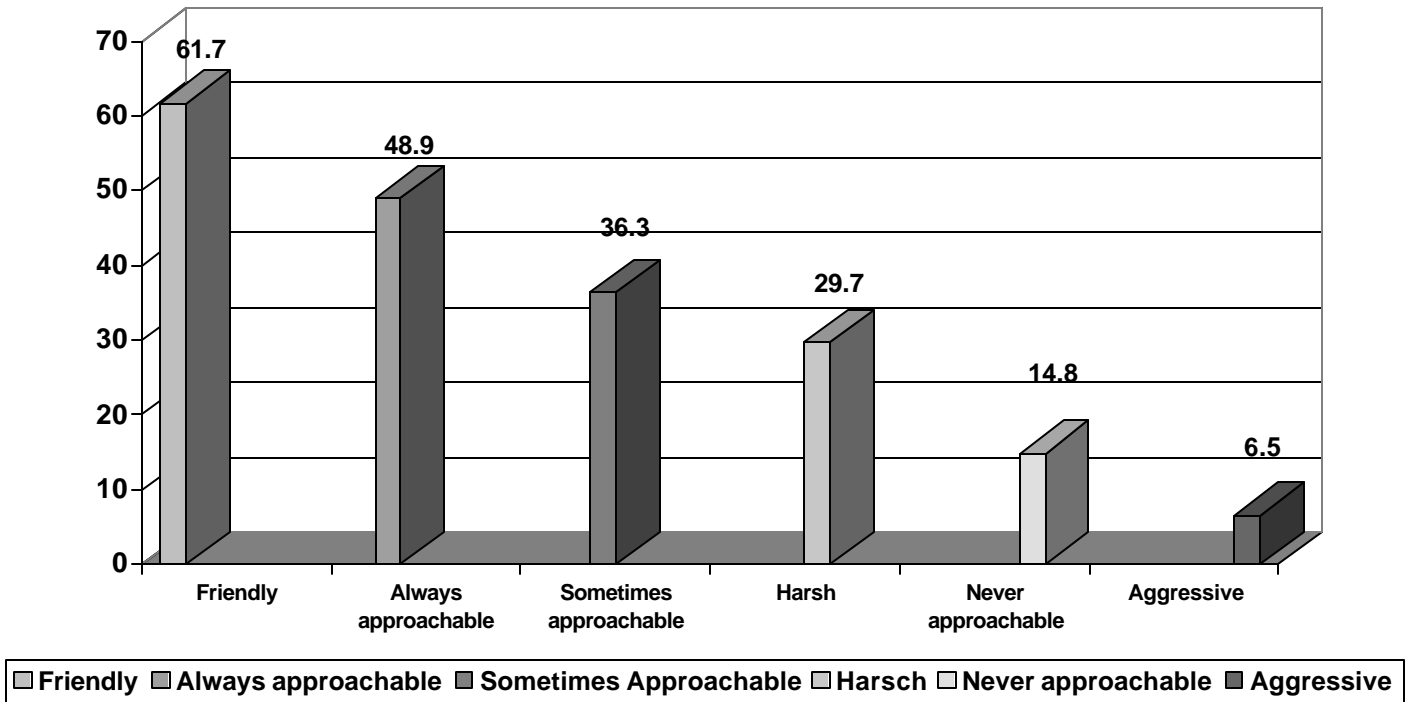


Figure 4.21

Attitudes of the contraceptive providers (n = 47)

Figure 4.21 reveals that the majority of these 47 women who had used contraceptives, 61,7% (n = 29) perceived their contraceptive providers to be friendly and 48,9% (n = 23) perceived them as always being approachable. A smaller number of women, 33,6% (n = 17) perceived their contraceptive providers as being sometimes approachable and 29,7% (n = 16) perceived them as being harsh. A minority, 14,8% (n = 7) perceived their contraceptive providers never to be approachable and 6,5% (n = 3) as being aggressive. Only 2,0% (n = 1) said the nurses were polite.

These results are consistent with those of Ehlers (2003:23) where most of the adolescent mothers regarded nurses in the reproductive services as being helpful and only a minority of adolescents were dissatisfied with the services they received.

Maja (2002:217) also obtained positive results in terms of clients' perceptions concerning contraceptive providers, 31,0% felt that their contraceptive providers were helpful, 1,9% felt that the health workers were rude and 0,6% said they were polite.

4.11 LACK OF CONTRACEPTIVE RESOURCES AND CONTRACEPTIVE PROVIDERS

4.11.1 Perceptions of the contraceptive services

Table 4.14 Perceptions of the contraceptive services

SERVICE	FREQUENCY (n)	PERCENTAGE (%)
Busy	21	44,7
Very busy	24	51,1
Extremely busy	2	4,2
TOTAL	47	100,0

As many as 51,1% (n = 24) of these women regarded contraceptive services as being very busy, 44,7% (n = 21) viewed their contraceptive serves as being busy and only 4,2% (n = 2) viewed it as being extremely busy.

4.11.2 Perceptions on the number of staff

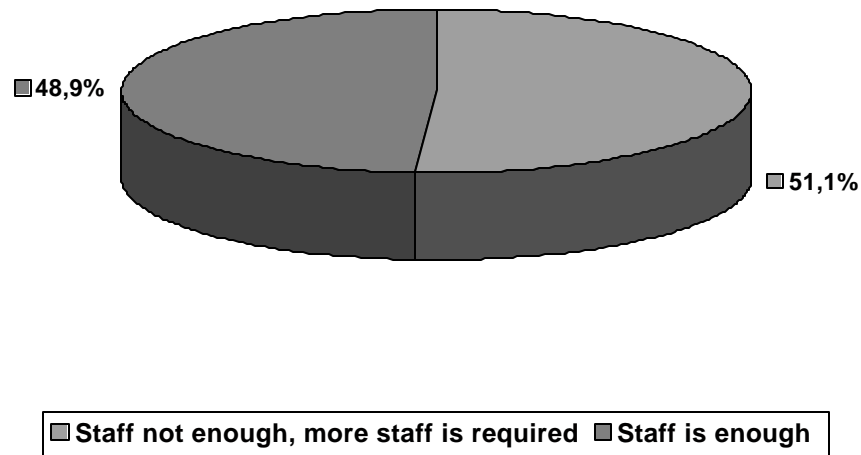


Figure 4.22

Perceptions on the number of staff (n = 47)

Results displayed in figure 4.22 correspond with those portrayed in table 4.14, whereby the majority of these women, 51,1% (n = 24) regarded their contraceptive services as being very busy. Here also 51,1% (n = 24) of these women felt that the staff in their contraceptive services was not enough, more staff was required. The women who felt that the staff at their contraceptive services was enough was 48,9% (n = 23).

4.11.3 Amount of time waited

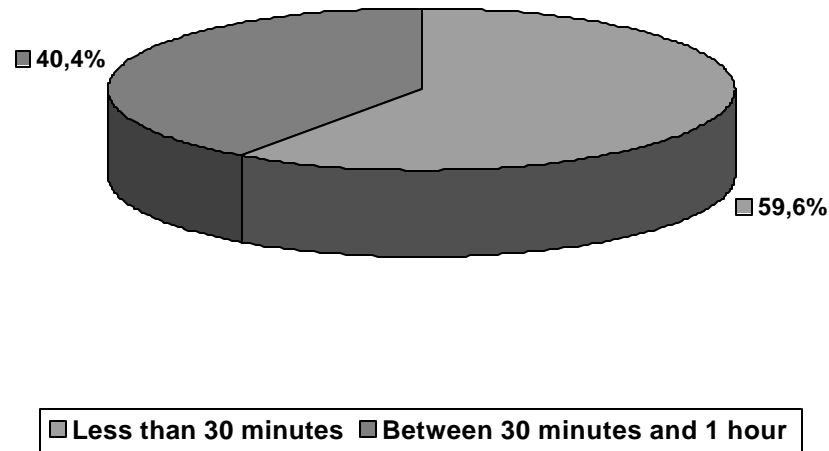


Figure 4.23
Amount of time waited (n = 47)

Results obtained in figure 4.23 apparently confirmed those portrayed in figure 4.22 indicating that 51,1% (n = 24) of these women felt that the staff at their contraceptive services was not enough, that more staff members were required. In figure 4.23 , 59,6% (n = 28) of these women waited for less than 30 minutes to be attended to in their contraceptive services; 40,4% (n = 19) waited between 30 minutes and 1 hour. None of these women waited for more than an hour.

4.11.4 Privacy

In terms of privacy the majority of these women, namely 95,7% (n = 45) had a private room where they could talk to their contraceptive providers without the next person overhearing what they were saying. It was only 4,3% (n = 2) who said they did not have privacy where they obtained contraceptives. These results appeared to contradict those obtained by Chimere-Dan (1996:7) where in Khayelitsha in the

RSA, contraceptive services were characterised by shortages of staff, poor services, low staff morale and nurses who were not client friendly. Troskie and Raliphada-Mulaudzi (1999:47) also observed that more than one woman entered the same cubicle simultaneously to receive their contraceptives, due to the lack of space in the Limpopo Province of the RSA. These results seemed to indicate that women enjoyed more privacy during contraceptive consultations in the Gert Sibande District of the Mpumalanga Province than women did in either the Limpopo Province or the Western Cape Province of the RSA.

4.12 SECTION 4: TERMINATION OF PREGNANCY

4.12.1 Information of the person who gave the advice for TOP

Table 4.15 Information of the person who gave the advice for TOP

RESPONSIBLE PERSON	FREQUENCY (n)	PERCENTAGE (%)
No one	16	29,1
Mom	3	5,5
Partner	12	21,8
Friend	15	27,3
Clinic sister	3	5,4
Medical doctor	6	10,9
TOTAL	55	100,0

Most of these women, 29,1% (n = 16) decided on their own to go for a TOP, 27,3 % (n = 15) were advised by friends to do so, 21,8% (n = 12) were advised by their partners, 10,9% (n = 6) were advised by medical doctors, 5,4% (n = 3) were advised by their mothers and 5,4% (n = 3) by clinic nurses.

Myburgh et al (1998:18) and Suffla (1997:214) stipulated that some women preferred to deal with the issues of TOP alone. They believed that the next person would not understand what they were going

through. These results appeared to support these statements, as 29,1% (n = 16) of these women did not get anybody's advice prior to requesting TOPs.

4.12.2 Previous terminations of pregnancy

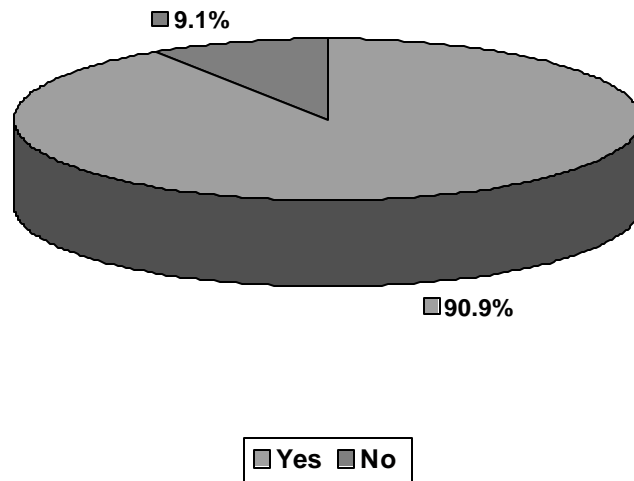


Figure 4.24

Previous terminations of pregnancy (n = 55)

The majority of these women, 90,9% (n = 50) were coming for TOP for the first time and only 9,1% (n = 5) said it was not their first time. Of those who were not coming for the first time all of them said they did it once before. However, these findings could neither be confirmed nor refuted. The respondents' answers were accepted without further questions from the interviewer.

4.12.3 Confidants for termination of pregnancy

Table 4.16 Confidants for termination of pregnancy (n = 55)

CONFIDANT	FREQUENCY (n)	PERCENTAGE (%)
Mom	5	9,1
Dad	1	1,8
Sister	15	27,3
Brother	2	3,6
Relative	1	1,8
Partner	11	20,0
No one	16	29,5
Friends	17	30,9

The total number in table 4.16 exceeds the number of the total sample (n = 55), because some women confided to more than one person. Of these women, 30,9% (n = 17) chose to share information on TOP with their friends, followed by those 29,5% (n = 16) who did not share this information with anyone. Those who shared this information with their sisters were 27,3% (n = 15), followed by those who shared it with their mothers, 9,1% (n = 5). The brothers and relatives were the least people chosen as confidants by the women who requested TOPs.

Adanlawo and Moodley (1999:100) found that 32,0% of the women in their study did not share information about TOP, 51,8% confided to their spouses. Another similar finding in both these studies is that friends and sisters were the most preferred persons. An apparent contradiction observed is that in this study 20,0% of the women confided to their partners, whilst in Adanlawo and Moodley's (1999:100) study 51,8% of women in that study confided to their partners.

4.12.4 Information on whether contraceptives will be used post TOP or not

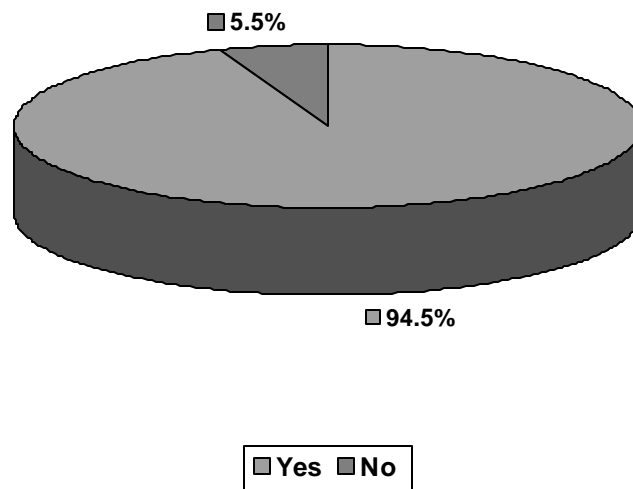


Figure 4.25

Information on whether contraceptives will be used post TOP or not (n = 55)

At the most, 94,5% (n = 52) of these women were willing to use contraceptives after their TOPs, only 5,5% (n = 3) were not willing to use contraceptives. This result appeared to be in line with those in figure 4.16 where 85,5% (n = 47) of these women had used contraceptives previously. These results are also consistent with those of Adanlawo and Moodley (1999:100) where 95,8% of women in that study were willing to use contraceptives post TOP and only 1,2% were not willing to do so.

4.12.5 Preferred method of contraception post TOP

Table 4.17 Preferred method of contraception post TOP

PREFERRED METHOD	FREQUENCY (n)	PERCENTAGE (%)
Injectables	31	59,6
Pill	5	9,6
IUCD	2	3,8
Male condom	7	13,5
Female condom	1	1,9
Sterilisation	6	11,5
TOTAL	52	100,0

Of the total number of women 94,5% (n = 52) who were willing to use contraceptives post TOP, 59,6% (n = 31) preferred injectable contraceptives followed by 13,5% (n = 7) preferred male condoms, then 11,5% (n =6) preferred sterilisation, pills were preferred by 9,6% (n = 5), and IUCDs by 3,8% (n = 2) and lastly the female condom by 1,9% (n = 1).

These results demonstrate consistency when linked with those obtained in table 4.11 indicating that of those women who did previously utilise contraceptives, 58,1% (n = 32) used injectables, 41,8% (n = 23) used a pill and 14,5% used male condoms.

Some consistency was also observed where women were asked to choose a method they would recommend to others, and 44,7% (n = 21) chose injectables, 27,6% (n = 13) chose condoms, 12,8% (n = 6) pills and only 4,3% (n = 2) chose IUCDs (table 4.13). Contraceptive methods were almost chosen in the similar fashion by women post TOP in Adanlawo and Moodley's (1999:100) report.

4.12.6 Reasons for preferred contraceptive methods

The same reasons mentioned in section 4.10 were repeated here, an addition was that some women believed that injectable contraceptives stayed longer in one's bloodstream than the other methods. In reference to the pill, IUCDs and condoms similar reasons were given as those in section 4.10.

4.12.7 Intentions not to use contraceptives

Those women (5,5%; n = 3) who did not intend using contraceptives cited as reason that they would prefer to refrain from future sexual activities.

4.12.8 Information as to whether TOP would be a future option

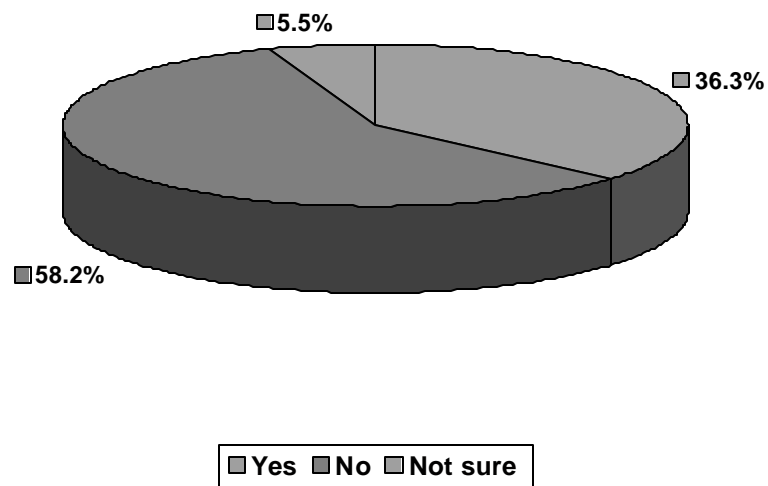


Figure 4.26

Information as to whether TOP would be a future option (n = 55)

As many as 58,2% (n = 32) of these women would not consider undergoing another TOP, 36,3% (n = 20) said they would do so and 5,5% (n = 3) were unsure.

Those who would not consider another TOP said:

- They didn't want to get used to doing this procedure (n = 15).
- This was not the right thing to do (n = 11).
- They would never have sex again (n = 2).
- It would never happen again (n = 1).
- One teenager said "If I were to be pregnant again, I will kill myself" (n = 1).

Those that would consider another TOP said:

- They already had the required number of children, another pregnancy would mean another TOP (n = 13).
- The service was good (n = 5).
- The service was close to them (n = 1).
- If there were no problems with the current TOP (n = 1).

4.13 RELATIONSHIPS BETWEEN THEORETICAL FRAMEWORK AND RESULTS OBTAINED

Orem's general theory of nursing was used in this study in order to interrelate, compare and to uncover relationships of the concepts of contraceptive challenges giving a systematic view of this phenomenon.

- **The self-care construct**

According to George (2002:127-129) the self-care construct is performance of activities that an individual initiates and performs, aided by her intellectual curiosity, instruction and supervision, in order to maintain humane functioning and development.

- **Results**

The results obtained in this study portrayed that some of the women who requested TOPs belonged to the self-care construct. These were the women who had an educational standard ranging from grade 8 to grade 12, who received sexuality education. These women had some educational background, and received sexuality education on menstruation, sex, conception and contraception. These women initiated contraceptive usage, 85,5% (n = 47) (figure 4.16), because they had the intellectual curiosity, knowledge and understanding to use contraceptives for some time six years or more in some cases.

- **The self-care deficit construct**

George (2002:129-130) stipulates that with the self-care deficit construct determination is made as to when nursing care is required and who needs it. It is said to be required when the ability to perform self-care requisites is absent or limited or when special techniques and scientific knowledge are required to provide care. The nursing activities in the self-care construct include entering and maintaining nurse-patient relationships, responding to patients' requests and needs, prescribing and regulating help, and counselling patients about contraceptives, side-effects and possible actions to take should side-effects occur.

- **Results**

In determining who needs contraceptives and when contraceptives are required to the obtained results. All women in this study required contraceptives, and these contraceptives were required post TOP. Women who belonged to the self-care construct, that is, those who initiated contraceptive use and stopped along the way (85,5%), (figure 4.16) also required to re-initiate contraceptive use. Nurse-client relationships should be established post TOP, and contraceptives should be discussed. Nurses have to determine how these patients could be helped in order to use contraceptives effectively. In determining these patients' needs with reference to contraceptives, the nurses should acknowledge that the identified contraceptive challenges that were experienced by these women included that they were from low socio-economic and low educational backgrounds (figure 4.6, table 4,2). Some of them, believed they required their partners' permission to use contraceptives (table 4.8). A majority of these women could not access contraceptives over weekends nor during lunch periods and at the worst contraceptive services were only available one day per week for them (figure 4.15, table 4.10). Some of these women (68,1%) (n = 32) experienced side-effects from the methods they were using (figure 4.17). As many as 68,0% (n = 32) were not properly counselled on dealing with the side-effects (figure 4.19). These are some of the challenges that nurses should consider when prescribing and regulating contraceptive use.

- **Nursing systems construct**

The nursing systems construct has the wholly compensatory, partly compensatory and the supportive educative systems. These systems are nursing approaches that are utilised based on the patient's ability to meet his/her self-care needs (George 2002:130-133).

- **The wholly compensatory nursing system**

It is designed for a patient who cannot perform activities to meet his/her needs, like a non-responsive patient who requires oxygen, body hygiene and passive exercises (George 2002:132).

The results indicated that the wholly compensatory nursing system could be utilised to provide contraceptives to the 72,7% (n = 40) women who had no schooling at all and to the 20,0% (n = 11) of women who had an education standard that was below grade 7 (figure 4.1). Also to the 78,2% (n = 43) women who were unemployed (figure 4.6), to the 21,8% (n = 12) women who required somebody else's permission to use contraceptives (table 4.8), to the 3,6% (n = 2) who did not have access to contraceptive services (figure 4.13). This nursing system is also relevant to the women who did not receive education about various sexuality issues (figure 4.7) and to those 14,5% (n = 8) who did not use contraceptives prior to this pregnancy (figure 4.16). These women should be given all the information and support they might require to initiate contraceptive use and to continue effectively. Basic information should be provided including basic reproductive anatomy, physiology, contraception and conception. Method specific counselling should be given after a method had been selected. They will then be told how that method functions, its anticipated side-effects and what to do if side-effects were experienced.

- **The partly compensatory nursing system**

The partly compensatory nursing system is care given to a patient who can partly help the nurse in performing certain activities geared towards health (George 2002:132).

The partly compensatory nursing system is an approach that should be utilised for women who, according to these results, experienced contraceptive challenges at a particular level not completely. Those are the women who obtained information about contraception during their teenage stage (figure 4.7 and table 4.4), those with an educational standard ranging from 8 to 12 years of successful schooling (figure 4.1), those that obtained an income even though it was minimal (below R1 000,00 per month) (table 4.2). Although 96,4% (n = 53) women could access contraceptive services, they could not access these services over weekends nor during lunch periods. Some could only access these

services one day per week (figures 4.13 and 4.15). The 85,5%(n = 47) of women who used contraceptives prior to the present pregnancy also fell into this category, because 68,1% (n = 32) of these women experienced side-effects (figure 4.17). The partly compensatory nursing system would suit this category of women, because they are regarded as being partly capable of helping the nurse in the effective implementation of contraceptive use, because they had some basic education, they obtained some form of sexuality education, they received an income, they could access contraceptive services, they initiated contraceptive use though they experienced problems with its sustained utilisation. Partly compensatory nursing care, in counselling these women about the management of side-effects, might have been absent. However, should the partly compensatory nursing care be provided, enabling more women to carry on using contraceptives while managing the side-effects, then more women might use contraceptives effectively, reducing the number of TOPs requested and/or performed.

- **The supportive education system**

According to George (2002:133), the supportive education system is providing nursing care to a person who is able to learn to perform the required self-care measures, like an adolescent with a metabolic problem.

With reference to contraceptive provision, the supportive education system is an approach that must be given to clients who are found to have all the necessary qualities that can aid in effective contraceptive use. This will include clients who are educated sufficiently to understand information pertaining specifically to them, and those who have the necessary background information on sexuality, who are not negatively influenced by gender, to an extent that they do not use contraceptives effectively.

4.6 SUMMARY

The results indicated that women who requested TOPs at the Bethal Hospital (Gert Sibande District) experienced the following contraceptive challenges: low socio-economic status, lack of information on emergency contraceptives. Although as they could access contraceptive services, these services might not be available to them over weekends, nor during lunch periods, and probably only a few days per week. A majority of these women who utilised contraceptives previously, experienced side-effects. Counselling received on the method of choice was not adequate. Contraceptive services were found to be very busy and the staff was regarded as not being enough, more staff was required.

In relation to TOPs most women requested TOPs for the first time, the person with whom the information on TOP was shared, were friends. A majority of these women were willing to utilise contraceptives post TOP. The post TOP contraceptive method of choice was the injectable contraceptives followed by the condoms, pills, sterilisations and IUCDs respectively. A majority of women would not consider undergoing another TOP.

These women did not experience contraceptive challenges in terms of educational status, sexuality education, contraceptive knowledge, gender issues, accessibility to a contraceptive service, prior utilisation of contraceptives, attitudes and perceptions on contraceptives and the attitudes for the contraceptive providers.