KNOWLEDGE, UTILISATION OF CONTRACEPTIVES AND SEXUAL ACTIVITY AMONG CLIENTS WHO CHOOSE TO TERMINATE A PREGNANCY AT PRINCE MSHIYENI MEMORIAL HOSPITAL

by

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DECLARATION

I declare that the dissertation **KNOWLEDGE, UTILISATION OF CONTRACEPTIVES AND SEXUAL ACTIVITY AMONG CLIENTS WHO CHOOSE TO TERMINATE A PREGNANCY AT PRINCE MSHIYENI MEMORIAL HOSPITAL** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

_____ June 2013

CHARITY CHIPILI MAZUBA **Date**

KNOWLEDGE, UTILISATION OF CONTRACEPTIVES AND SEXUAL ACTIVITY AMONG CLIENTS WHO CHOOSE TO TERMINATE A PREGNANCY AT PRINCE MSHIYENI MEMORIAL HOSPITAL

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ABSTRACT

The aim of this study was to investigate sexual activity as well as contraceptive knowledge and use among termination of pregnancy (TOP) clients at Prince Mshiyeni Memorial Hospital's TOP clinic in the province of KwaZulu-Natal (KZN).

This was a non-experimental quantitative study in the form of a cross sectional study. Self-administered questionnaires were used for collecting data from 61 respondents selected non-randomly.

The majority of the respondents were single young women between 18 and 27 years of age. Sexual intercourse frequency was mostly once a month (91.8%). Most were unemployed and dependent on government grants and had heard of both contraception in general and emergency contraception. Only 44 (78.6%) had used contraceptives before and the most frequently used method of contraception was the injection (36.6%).

Despite the respondents having heard of contraception, the median score of the knowledge of contraception was only 16%. The distribution of knowledge was very wide, but on the whole the level of knowledge of contraception was very low.

KEY CONCEPTS

Abortion; termination of pregnancy (TOP); sexual activity; contraception.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CDCs	Centres for Disease Control
CINAHL	Computerised Index of Nursing and Allied Health Literature
COCs	Combined Oral Contraceptives
CTOP	Choice on Termination of Pregnancy Act
DoH	Department of Health
DMP	Adepot medroxyprogestrone acetate
EC	Emergency contraception
ECPs	Emergency contraception pills
EVA	Electrical vacuum aspiration
FPA	Family Planning Association of Maine
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IPAS	A global non-governmental organisation dedicated to ending preventable deaths and disabilities from unsafe abortion
IPPF	International Planned Parenthood Foundation
IUDs	Intrauterine devices
KZN	KwaZulu-Natal
LAM	Lactation amenorrhea method
MVA	Manual vacuum aspiration
NET-EN	Norethisterone enantate
NEXUS	The National Research Foundation
NdoH	National Department of Health
PMMH	Prince Mshiyeni Memorial Hospital
POP	Progestin-Only Pill
RHRU	Reproductive Health Research Unit
SACBR	The South African Centre for Bio-Ethical Reform
SADHS	South African Demographic Health Surveys
SASOG	South African Society of Obstetricians and Gynaecologists
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan African
STIs	Sexually transmitted infections
TOP	Termination of pregnancy
UN	United Nations

List of abbreviations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
WHO	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In countries around the world, women who are determined to limit their family size and time their childbearing use all available means to do so; if contraception is not viable option, women turn to abortion (also referred to as termination of pregnancy) – even if it is illegal (Deschner & Cohen 2003:7).

Unintended pregnancy is a primary reason for termination of pregnancies. Access to safe and voluntary family planning counseling and services significantly reduces unintended pregnancies and pregnancy terminations, and saves women's lives (Smith, Ashford, Gribble & Clifton 2009:6).

The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has had tremendous life saving benefits. Yet despite these impressive gains, contraceptive use is still low and the need for contraception is high in some of the world's poorest and most populous places (Smith et al 2009:3).

In order to curb maternal morbidity and mortality owing to unsafe/backstreet abortion, the South African Government, implemented the Choice on Termination of Pregnancy (CTOP) Act in February 1997, now called the CTOP Amendment Act (No 38 of 2004). The CTOP Amendment Act allows women to terminate pregnancies on request until the 12^{th} week of gestation. In cases of socio-economic hardship, rape or incest, and for reasons related to the physical and mental health of the pregnant woman or fetus, terminations can be performed up to 20 weeks (Harries, Stinson & Orner 2009:2).

However, according to the spokesperson for the National Department of Health (NDoH) Mr Fidel Hadebe, CTOP legislation is been abused as young women especially teenagers seem to be using CTOP as a form of contraception (Mapumulo 2011). This

study hence seeks to determine sexual activity and contraception knowledge and utilisation among women who choose to terminate a pregnancy at Prince Mshiyeni Memorial Hospital (PMMH).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 Source and background of the problem

PMMH is situated in Umlazi township on the east coast of KwaZulu-Natal. It is located South West of Durban which is the largest and busiest port in Africa.

The township was created by the apartheid government as a separated land into which the majority of the black population of Durban was forced to live. This township is the second largest township in South Africa; Soweto being the largest (Ulamzi 2008).

The size of the population of Umlazi township is approximately 1.6 million (PMMH Official Publication 2010:15). The township is challenged by unemployment and poverty directly emanating from the apartheid regime. A few positive developments in the township have attempted to uplift the socio-conomic standards of the residents. The developments among others include the provision of education from primary school to tertiary levels (Mangosuthu University of Technology) and free decent low cost houses for those who live in informal settlements. The Toyota motor company has a factory in the vicinity of Umlazi and this has created jobs for the people of Umlazi and surrounding areas.

Despite the positive developments, the township has the highest death toll and crime rate record in the world (Sports Ministry South Africa Mission 2009). The high incidence of crime against women in the form of domestic violence and rape in most cases is as a result of historically unequal power relations between men and women. Factors contributing to these unequal power relations include:

- Cultural, for example, gender specific socialisation and belief in inherent male superiority.
- Women's economic dependence on men which underpins their vulnerability to violence and difficulty in extricating themselves from violent relationships (United

Nations Children's Fund [UNICEF] 2000:7; KZN Department of Community Safety and Liaison 2010:13).

According to Albertyn (2003 cited in Maree 2010:5), South African women have little say in their sexual relations because of cultural norms and the patriarchal system. Paying "lobola" empowers men to feel that they can dictate the conditions under which sexual acts can occur and physical violence is often used to force a woman to submit in their sexual relationship (Maharaji 2001:157, cited in Maree 2010:5).

Globally, one in five women has been physically or sexually abused by someone whom they know (WHO 1997, cited in Hessinl 2004:11). Adolescents and young women are more at risk of rape and sexual abuse than older women.

Two of the direct results of rape and sexual abuse are the possibilities of contracting sexually transmitted infections (STIs) including the Human Immunodeficiency Virus (HIV) and ending up with unintended pregnancy. It is believed that 50% of the Umlazi residents are HIV positive (Ecumenical and Interreligious Institute 2007). Other studies put the HIV prevalence at more than 50% (Bishop Farrell 2007).

According to the observation of staff working in the TOP clinic, the majority of women seeking TOP at PMMH are young women and adolescents. The KZN teen pregnancy rate is at 440/1000 as reported by the KZN Annual Report (KZN DoH 2005/2006:57).

1.3 RESEARCH PROBLEM

The TOP clinic at PMMH's Obstetrics and Gynecology department is the busiest in KZN (Naude 2002:32). The department has a high number of women seeking TOP voluntarily. According to PMMH's TOP statistics, on average, 68 bookings are made weekly and an estimated 270 bookings per month.

Every year, 55 million unintended pregnancies occur in developing countries to women not using a contraceptive method; 25 million of these pregnancies occur as a result of incorrect or inconsistent use of a contraceptive and method failure. About 35 million abortions occur in developing countries each year (Curtis, Huber & Moss-Knight 2010:44).

In Sub-Saharan Africa (SSA), only 17% of married women of reproductive age use a modern contraceptive, even though a far higher proportion want to avoid becoming pregnant soon or ever. Thirty-nine percent of pregnancies in the region are unintended, ranging from 30% in Western Africa to 59% in Southern Africa. In 2008, about 60% of women (47 million) in the region (SSA) who wanted to avoid a pregnancy either were not using family planning or were using a traditional (unreliable) method. These women accounted for 91% of unintended pregnancies (Guttmacher Institute & United Nations Population Fund [UNFPA] 2009:1).

In South Africa, since the inception of the Choice on Termination of Pregnancy Act of 1996 in February 1997, legal terminations have seen a steady increase nationally; for example, from February 1997 to January 1998 a total of 29,375 abortions were performed nationally; for the same period (February 1998 to January 1999) the figure (45,611) had almost doubled (Naude 2002:8–12).

A large number (1,259) of abortions was performed in KZN in 1997 (HST 2010). This number had sharply increased by ten times by 2005. A significant reduction occurred from 12,706 in 2005 to 4,332 in 2010. Despite this significant reduction, one cannot confidently conclude that the statistics are complete and accurate; for example, DoH revealed that 38,321 abortions were performed in 2010 whereas Abbas, advocacy manager for the private abortion clinic group, Marie Stopes stated that 51,185 abortions were performed by Marie Stopes clinics nationwide; 13,000 more than recorded by the DoH (European Pro-choice Network 2011). Other reasons for the dramatic reduction of abortions between 2009 and 2010 according to the European Pro-choice Network (2011) are as follows:

- Decreasing number of state employed nurses who are prepared to perform the procedure.
- Long waiting lists at government institution in addition to poor record keeping by the state institutions.

Evidence shows that the rate at which the demand for TOP services is increasing in some provinces is alarming, for example, in the Province of Limpopo, there were 570

TOPs in 1997 and 10,862 in 2007. Although the figure for 2008 had dropped to 5773, the TOP rate has remained high as shown by the 2010 statistics of 8,342 (HST 2010).

According to Johnston (2010), from 1971 to 1996, 24,446 TOPs were procured by South African women either in South Africa or abroad. From the time that abortion was legalised (1997) up to the end of 2008, a staggering 703,315 TOPs were performed in South Africa (SACBR 2010). If the statistics from the District Health systems provided by HST (2010) are added to 703,315, the figure of TOPs performed from 1997 to 2010 in South Africa could be around 839,258.

This huge demand for TOP services can, therefore, be an indication of inadequate contraceptive services, missed opportunities for emergency contraception, poor health seeking behaviours of women in their reproductive years and missed opportunities for health education and promotion (KZN DoH 2004:13).

It is figures like these which persuaded the researcher to pursue this study because there is no information on sexual activity and knowledge and utilisation of contraceptives at PMMH's TOP clients in KZN.

1.4 AIM OF THE STUDY

1.4.1 Research aim

The aim of this study is to investigate sexual activity as well as contraceptive knowledge and use among TOP clients at PMMH's TOP clinic in KZN.

1.4.2 Research objectives

- Investigate sexual activity prevalence among voluntary TOP clients at PMMH's TOP clinic.
- Determine factors influencing use of contraceptives before pregnancy.
- Determine knowledge of contraceptives of TOP clients.

1.5 SIGNIFICANCE OF THE STUDY

Findings from this study will aid in determining the factors influencing use of contraception. Recommendations for improving family planning and use of reproductive health services could be made for this community so that fewer clients would need to request TOP.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Abortion

- Branford (1988) cited in Gumede (2004:4) defines abortion as the expulsion of a fetus from the uterus before it is able to survive on its own. The expulsion can either be spontaneous or induced. Induction can either be safe or unsafe (Gumede 2004:4).
- TOP is a special type of abortion offered by both public and private health facilities to women with unwanted pregnancy and it simply means separation and expulsion by medical or surgical means, of the contents of the uterus of a pregnant woman.

1.6.2 Contraceptive

- Contraceptive is a device which is used to prevent pregnancy. This can either be temporarily (loop insertion, pill, etc) or permanently (tubal ligation, hysterectomy or vasectomy).

1.6.3 Sexual activity

- Sexual activity, also known as copulation or coitus refers to the act in which the male reproductive organ enters the female reproductive tract (Adolescent sexuality [s.a.]).
- Also sexual activity is the insertion of a man’s erect penis into a woman’s vagina and is the primary mechanism of human reproduction (Beltina Encyclopedia [s.a.]).

1.6.4 TOP clients

- This refers to any woman who voluntarily chooses to terminate a pregnancy regardless of age.

1.7 RESEARCH DESIGN

Polit and Beck (2004:730) define a research design as the overall plan for addressing a research question including specifications for enhancing the study's integrity.

This quantitative study used a non-experimental method in the form of a cross sectional study. However, because large samples of clinical populations were not easy to come by, the accrual of study participants took 3 weeks (Stommel & Wills 2004:163). The study was in the form of a survey, a method advantageous to this study for the following reasons:

- In a relatively small study population which is representative of the overall study population, an accurate picture of the population can be provided (LoBiondo-Wood & Haber 2002:224).
- Because they are non-experimental designs, surveys are frequently used in research when it is unethical to manipulate variables in human subjects (LoBiondo-Wood & Haber 2002:222; Polit & Beck 2004:188; Stommel & Wills 2004:359).
- The survey method ensured anonymity as no names or any other details were included in the analysed and presented data.

1.8 RESEARCH METHODS

1.8.1 Population

The population was all women seeking termination of pregnancy voluntarily between the 20th of August to 6th September 2012 at PMMH's TOP clinic.

1.8.2 Sampling

Sampling refers to the process of selecting a portion or subset of the population to represent the entire population (Polit & Beck 2004:291, 731).

The researcher used a convenience sampling (non-probability sampling) technique in order to recruit consecutive respondents who met the inclusion criteria from those women who presented to the facility.

1.8.3 Inclusion and exclusion criteria

According to Stommel and Wills (2004:305), in clinical studies, inclusion and exclusion criteria, combined with the selection of clinical sites for recruitment, provide the precise operational definition of the study population. The research excluded:

- Pregnant women below the age of 18 years as these constitutionally are considered to be minors and hence the need for parental consent for inclusion in research.
- Women carrying fetuses with gross abnormalities or with life threatening conditions and rape victims (including incest).
- Women who were unable to self-administer the questionnaire.

Criteria included only literate women who were 18 years and over seeking TOP voluntarily at PMMH's TOP clinic.

1.8.4 Data collection

Burns and Grove (2003:45) state that, data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study.

In this cross sectional survey, a self-administered questionnaire with closed end questions was used as a sole tool for data collection. LoBiondo-Wood and Haber

(2002:301) define questionnaires as paper-and-pencil instruments designed to gather data from individuals about inter alia knowledge, attitudes, beliefs and feelings.

1.8.5 Research setting

The research was conducted in the TOP clinic of PMMH. PMMH was ideal for this study as it serves the largest and most populated township in KZN; also the hospital's maternity department is the busiest in KZN hence it was much easier for the researcher to collect data.

1.8.6 Data analysis

Data analysis was done using the Statistical Package for Social Sciences (IBM SPSS V. 19 [SPSS Inc., Chicago, Illinois]).

1.9 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted only among literate women seeking TOP voluntarily at PMMH's TOP clinic. Therefore, the illiterate women and those women who sought TOP in other public institutions, private facilities, using native doctors or self-induced means were not included in this study. Hence the difference between the sample and other women was not ascertained.

1.10 STRUCTURE OF THE DISSERTATION

The following chapter, chapter 2 gives a detailed discussion of existing literature on sexual activity, contraceptive knowledge and use in relation to TOP.

Chapter 3 gives a detailed discussion of the research design and research method employed for conducting the research. Measures the researcher used to enhance the validity of the design have also been elaborated.

The discussion on the research results is given in chapter 4. The results were given in accordance with the research objectives.

Chapter 5 concludes the project and it is in this chapter where an overall discussion of the research findings and recommendations were made.

1.11 CONCLUSION

In the first chapter of the research, an overall introduction and detailed discussion on the source and background of the problem; and the research problem have been extrapolated. Also the aim and objectives; research significance; definitions of terms; research design and methodology; study scope and limitation; and structure of the dissertation have been outlined.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 provided the background and rationale for this study. The following chapter, chapter 2 explores the literature reviewed by the researcher on the topic “knowledge, utilisation of contraceptives and sexual activity among clients who choose to terminate a pregnancy at Prince Mshiyeni Memorial Hospital (PMMH)”.

The key concepts used for the literature search are abortion, termination of pregnancy (TOP/CTOP), sexual activity and contraception. The researcher reviewed articles retrieved from the internet and books published from 2000 to date and also requested from the University of South Africa (UNISA) an extensive search list of related topics. The following databases were viewed in-order to review the research topics provided by UNISA:

- Oasis Library Catalogue
- Computerised Index of Nursing and Allied Health Literature (CINAHL)
- The National Research Foundation (NEXUS)

Literature reviewed showed that extensive research has been carried out on abortion, sexual activity, and contraceptive knowledge and use. But the researcher found no information on sexual activity and contraceptive knowledge and use among TOP clients at PMMH’s TOP clinic.

2.2 SEXUAL ACTIVITY

2.2.1 Sexual debut

First sexual experiences are part of the transition to adulthood, and they are influenced by the environment, context and culture in which young people develop (Pettifor, O’Brien, MacPhail, Miller & Rees 2009:82).

A review of sexual relations among young people in developing countries reveals a variation in age of sexual debut by regions. For example, data collected in Latin America shows that sexual debut occurs at an earlier age (age 15) compared to Sub-Saharan Africa (SSA) and Asia, where the median age at first sex is between 18 and 20 among females and 15 and 20 years of age among males (Brown et al 2001, cited in Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wky, Mbelle, Van Zyl, Parker, Zungu, Pezi & SABSSM III implementation team 2009:64).

Premarital exposure to pregnancy risk has increased with the widening gap between sexual debut and the age of marriage, and increased sexual activity prior to marriage placing young women at increased risk when they are most socially and economically vulnerable (Williamson, Parkes, Wight, Petticrew & Hart 2009:2; WHO 2007b:6).

According to Hindin and Fatusi (2009:59), most men and women become sexually active during adolescence. WHO (2000) also states that, in every setting sexual activity begins during adolescence among many young people and much of this activity is risky with contraceptive use most of the time erratic. This results in unwanted pregnancies and sexually transmitted infections (STIs) with unsafe TOPs been observed in most settings.

In a study conducted by WHO (2007b:6) on “adolescent health in Sri Lanka,” despite strong cultural and religious traditions that impose restrictions on sex before marriage, the age of sexual debut or commencement has been found to be around 15.3 years for males and 14.4 years for females.

Recent evidence from the Demographic and Health Surveys, and AIDS (Acquired Immune Deficiency Syndrome) Indicators Surveys show that median age at first sex among 20-24-year-old women ranges from a low of 16 years or younger in Chad, Mali and Mozambique to a high of 19.6 in Senegal. Overall the median age in the rest of SSA is about 18.5 years (Hindin & Fatusi 2009:59). By the age 20, 75% of young women in SSA report having had sex (Williamson et al 2009).

There is evidence that South African youth are sexually active at a young age. In a study of sexual behaviour of Cape Town high school students in 1990, 23.4% of boys and 5.5% of girls had had sex at age 14 years, and there was a substantial increase in the number of students who had experienced sex between grades 8 and 11. Another study of risk factors for teenage pregnancy among sexually active black adolescents in Cape Town reveals that the mean age at first sexual intercourse is 14 years in pregnant and non-pregnant teenagers (Nyakoe 2008:15–16).

A nationwide survey, the South African Youth Risk Behaviour Survey conducted in 2002, revealed that 41% of boys and girls between grade 8 and 11 admitted to being sexually active, and 14% reported that they had initiated sex before the age of 14 (Reddy et al 2003, cited in Nkambule 2009:16).

More recent South African data shows similar findings. A national survey of HIV and sexual behaviour in 15–24 year olds found that 67% of them had had sexual intercourse, and that the median age of sexual initiation was 17 years while 8% had sexual debut at 14 years or younger (Nyakoe 2008:16).

By the end of their childhood (18 years), 42% of women and 63% of men had become sexually active (Berry & Hall 2009:2).

However, focusing on adolescent black children and teenagers, Preston-Whyte and Zondi (cited in Nicholas, Daniels & Hurwitz [s.a.]) posit that both boys and girls admitted experiencing sex before their 12th or had experienced penetration before they reached physical maturity. By age 13, most had been sexually active, if not regularly, then at least on a number of occasions with full penetration being the rule.

2.2.2 Nature of sexual partnerships

Multiple sexual partnerships remain common in SSA, with men having more lifetime partners than women have and been less faithful to their spouses (Vinod, Hong, Bignami-VanAssche & Barrere 2009:21).

According to Hindin and Fatusi (2009:56), in SSA, more than 20% of young men who had ever had sexual intercourse, had had multiple partners in the past 12 months, compared with fewer than 10% of young women.

Pettifor, Measham, Rees and Padian (2004:1996) state that male multiple partnership is condoned and even encouraged in South Africa while women are expected to be monogamous and unquestioning of their partner's behaviour.

Studies conducted among South African adolescents in 1990s and early 2000s describe gender norms that define successfully masculinity as having multiple sex partners, and that deem using physical and sexual violence to establish control over female partners as acceptable behaviour (Pettifor et al 2009:82).

Multiple partnerships include intergenerational relationships motivated by financial exchange, usually between younger females and older males (HSRC 2008, cited in Shisana et al 2009:65). Other studies across Africa report prevalence estimates for the exchange of sex by young women for money or gifts ranging from 5%–78% (Luke 2005a; Matasha et al 1998; Meekers & Calves 1997; Nyazi et al 2001; Nzyuko et al 1997; all cited in Dunkle, Jewkes, Nduna, Levin, Sikweyiya & Koss 2007:1236). In South Africa, a study in Cape Town reveals that 21.1% of pregnant and 18.8% of non-pregnant teenagers reported having sex for money or presents (Jewkes, Vundule et al 2001; cited in Dunkle et al 2007:1236).

2.2.3 Coercive, male-dominated sexual relationships

According to Auerbach, Byram and Kandathil (2005:01), sexual abuse/coercive sex includes rape within marriage and dating relationships; rape by strangers; unwanted sexual advances or harassment; forced marriage; denial of the right to use contraception or other measures to protect against STIs and pregnancy.

According to Nicholas, Daniels and Hurwitz [s.a.]), South Africa is a strongly male-dominated society in which violence against women is at a high level.

Young women who have their sexual debut at an early age are more likely than other women to report that their first partner had physically forced them to have sex (Pettifor

et al 2009:87). A study of youth in a Xhosa township reveals pervasive male control over almost every aspect of women's early sexual experiences, enacted in part via violence and coercive coitus (Pettifor et al 2004:1996).

A study on "gender and sexuality" by Jewkes and Morrell (2010:5) state that, with sex viewed as a need, particularly of men (but within a context also of women), wooing women with gifts, or other services for sex is seen as largely culturally acceptable practices.

The same authors further state that, historically, sexual relationships between individuals are part of socially negotiated relationships between families, with marriages formalised through payment of lobola by men. Nowadays, marriage occurs relatively late in adult life (at a mean age of 28 years for women); if at all sex happens outside of marriage, "serious" intent is demonstrated by gift giving. In this cultural milieu it is easy for men to assume some form of patriarchal ownership over women and to establish or show this ownership through physical violence.

Albertyn (2003, cited in Maree 2010:5) also states that, South African women have little say in their sexual relations because of cultural norms and the patriarchal system. Paying "lobola" empowers men to feel that they dictate the conditions under which sexual acts can occur and physical violence is used to force a woman to submit in their sexual relationships (Maharaji 2001:157, cited in Maree 2010:5).

Economic need is a key reason for young women to become sexually active or engage in unprotected sexual intercourse. Almost one in five females aged fifteen to nineteen in Ghana, Malawi and Uganda who have ever had sex report that their first sexual experience occurred through force or at their partner's insistence. In an interview, young women mentioned four primary reasons for their having unwanted sex: they feel pressured because their partner has given them money or gifts; their partner flatters them, pesters them or threatens to have sex with other partners; and they passively accept unwanted sex, for example by treating coercion as normal behaviour (Biddlecom, Hessburg, Singh, Bankole & Darabi 2007:14–15).

A recent study in Botswana and Swaziland also finds that women who lack sufficient food are 70% less likely to perceive personal control in sexual relationships, 50% more

likely to engage in intergenerational sex, 80% more likely to engage in survival sex, and 70% more likely to have unprotected sex than women receiving adequate nutrition (United Nations Programme on HIV/AIDS [UNAIDS] 2008:11).

2.3 CONTRACEPTION

Contraception can be defined as any means to prevent pregnancy and can either be temporary or permanent (International Planned Parenthood Federation [IPPF] 2012).

There are three main routes to preventing or ending pregnancy before birth: the prevention of fertilisation of the ovum by sperm cells ("contraception"), the prevention of implantation of the blastocyst ("contragestion") and the chemical or surgical induction of the developing embryo or, later, fetus ("abortion"). The term "contraception" often refers to both contraception and contragestion (Grobler 2003:9).

2.3.1 Contraception methods

2.3.1.1 Temporary methods

2.3.1.1.1 Natural and traditional family planning

Natural family planning methods can be used for planning and preventing pregnancies by observing the naturally occurring signs and symptoms of the fertile phases of the menstrual cycle, with the avoidance of intercourse during the fertile phase if pregnancy is not desired (WHO definition, cited in KZN DoH 2004:23). The following are considered natural family planning methods:

- Breastfeeding also called lactational amenorrhea method (LAM) is only effective if a woman breastfeeds exclusively or almost exclusively and continues to be amenorrheic. It is almost effective during the first six months (98%–99%) post-natally. The main disadvantage of LAM as a contraception method is that the return to menses and fertility is unpredictable. Therefore it is recommended that a woman considers other options either as a back-up method to breastfeeding or as a replacement method as breastfeeding loses its effectiveness as a contraceptive (IPPF 2012).

Other methods in this group include the following:

- Rhythm method, calendar method, body temperature method, and cervical mucus change method. According to Andrews and Boyle (2003:93), natural methods of family planning are based on the recognition of fertility through signs and symptoms and abstinence during periods of fertility. Therefore, according to the same authors, the ability to control fertility successfully requires an understanding of the menstrual cycle and conditions under which pregnancy can or cannot occur, for example, cervical mucus method – a woman would have to avoid sex when cervical mucus is clear.

Some examples of traditional methods include:

- Thigh sex – the penis does not penetrate the vagina. The semen is deposited on to the thighs.
- The "rope" or "wool" method which involves tying a cord around the waist to which herbs are attached with the belief that the cord will protect the woman against conception.
- The snail shell method which involves hiding a used sanitary towel in a snail shell in a secret place and only retrieving it when the woman is ready to conceive (Mqhayi, Smith, McFadyen, Beksinska, Connolly, Zuma & Morroni 2004).

2.3.1.1.2 Barrier method

Barrier methods place a physical impediment to the movement of sperm into the female reproductive tract. The most popular barrier method is the male condom, a latex or polyurethane sheath placed over the penis. Condoms offer dual protection against pregnancy and STIs, and are one of the most effective means of preventing the transmission of HIV. In a study of 546 prostitutes in the United States of America, 11% of the 524 prostitutes who reported having unprotected vaginal intercourse were HIV positive. None of the 22 prostitutes whose clients used condoms in episode of vaginal intercourse was HIV positive (Centres for Disease Control [CDC] 1987, cited in Olatunji 2004:14).

Other barrier methods include the following:

- Spermicides: chemicals which either kill spermatozoa or weaken them to an extent that prevent fertilisation. Spermicides are placed in the vagina prior to sexual intercourse. These come in different forms, for example, foam preparations, creams and jellies, pessaries, film strips (which can either be placed in the vagina or over the glans penis).
- A contraceptive sponge: which is 5 cm in diameter and must be positioned accurately over the cervix. Because it is not easy to position, it is merely regarded as a spermicide carrier as it is impregnated with the spermicide nonoxynol–9 (Grobler 2003:20).

2.3.1.1.3 Hormonal contraception

These come in various forms, for example, synthetic oestrogens and progestin combinations or progestin only form. Commonly used oestrogen and progestin forms include the combined pills, and the progestin only pill (mini pill), injectables (for example, Depo Provera), and intrauterine devices (copper loop).

2.3.1.1.3.1 Progestin-only pill (POP) and injectables

- POP (also known as mini pill) is 90 to 95% effective during the first year of typical use with a higher failure rate among women under the age of 25 years compared to older women (KZN DoH 2004:76). This difference according to KZN DoH (2004:75) could be attributed to declining fertility with age, and better compliance regarding regular pill taking among women 25 years and older.
- Progestin only injectable contraceptives account for an increasingly large proportion of the mix of modern contraceptive methods used by women around the world, particularly in SSA. Injectable contraception is very effective, safe and causes little metabolic disturbance. In South Africa, about 66% of all clinic clients make use of injectable contraception.

Although injectables such as depot medroxyprogestrone acetate (DMPA) and norethisterone enantate (NET-EN) are among most efficacious methods available, their effectiveness in practice is reduced because their continuation rates are lower than

those of other methods (Baumgartner, Morroni, Mlobeli, Otterness, Myer, Janowitz, Stanback & Buga 2007:66; Grobler 2003:63).

2.3.1.1.3.2 Combined oral contraceptives (COCs)

Combined oral contraceptives (COCs) are available as:

- Monophasic COCs – which contain same quantities of oestrogen and progestin in all 21 active pills. These are then followed by 7 placebos. Recently released preparations have 24 active pills and only 4 placebos.
- Biphasic COCs – contain a constant dose of oestrogen in all the active pills and in addition, the first eleven active pills contain a low dose of progestin while the next 10 tablets contain a slightly higher dose. These are then followed by 7 iron tablets (placebos).
- Triphasic COCs – contain both hormones in low doses, divided into three phases of slightly different dosages, followed by 7 placebos (Grobler 2003:36).

The theoretical efficacy of COCs approaches 100%, but the use effectiveness is influenced by factors such as patient error, absorption defects, and interaction with other drugs (Grobler 2003:36).

2.3.1.1.3.3 Intrauterine contraception (IUD)

Definition: a small contraceptive device which is inserted into the uterus to prevent pregnancy (Family Planning of Association of Maine [FPA] 2006). Intrauterine contraception is especially suitable for women who are not in favour of oral contraceptives, who are forgetful or, in particular, for whom systemic steroids are contraindicated. There are two types of intrauterine contraceptives – medicated and un-medicated (Grobler 2003:77).

- Un–medicated IUDs are manufactured from plastic. This type of loop elicits a foreign body reaction when inserted into the uterus hence preventing pregnancy. The best known type was the Lippes loop which is now obsolete. This type of loop could be left in the uterus indefinitely without losing its effectiveness (Grobler 2003:77).

- The medicated or bio–active IUDs are smaller than the un–medicated ones, have a polyethylene base with copper wire coiled around them, or contain progesterone or a progesterone in their stems, which is released at a predetermined rate through a silastic membrane. These devices are more effective than the un–medicated ones and cause fewer side-effects. However, they have a limited effective lifespan and must be replaced after a certain period (Grobler 2003:78).

2.3.1.1.3.4 Emergency contraception (EC)

According to WHO (2005b), EC refers to backup methods for contraceptive emergencies which women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. Cheng et al (2004, cited in Maharaji & Rogan 2007:1) clinically define EC as the use of a drug or device as an emergency measure to prevent or reduce the risk of an unwanted pregnancy.

EC, also known as post-coital contraception or the morning-after pill, can be used up to five days (120 hours) after unprotected sexual intercourse. There are two methods of EC and these are:

- Emergency contraceptive pills (ECPs) – contain either progestin or a combination of progestin and oestrogen in higher doses than regular contraceptives. ECPs work primarily by preventing or delaying ovulation or stopping a fertilised ovum implanting in the uterus (DISA [s.a.]). ECPs are safe and effective, and can prevent pregnancy when taken within 3 days (72 hours) after unprotected sexual intercourse. However, if taken within 24 hours, ECPs prevent more than nine out of ten pregnancies that would have happened had no pills been taken (DISA [s.a.]).

ECPs are safe and suitable for all women including those women who cannot use on-going hormonal contraceptive methods because of the short-term nature of their use, and no medical conditions make them un safe for any woman (WHO 2005b).

- IUD – can be inserted internally within five days of unprotected sex and is another less frequently used form of EC (Beitz 2002, cited in Maharaji & Rogan

2007:2). The IUD works by keeping the sperm from joining the egg or keeping a fertilised egg from implanting in the uterus. The IUD can be removed after the next period or it can be left in place to be used as a regular contraception method (DoH & Human Services, USA 2011:2).

2.3.1.1.4 TOP

Most women want to have children at some point in their lives, but successfully planning when to start and when to stop can be difficult in the absence of reliable contraceptive methods. Helping women practice contraception to reduce their risk of having unplanned pregnancies can go a long way toward bringing down levels of unsafe pregnancy terminations, as well as the overall level of TOPs (Singh, Wulf, Hussain, Bankole & Sedgh 2009:37).

"In countries around the world, women who are determined to limit their family size and time their childbearing will use all available means to do so; if contraception is not a viable option, women will turn to TOP – even if it is illegal". Policy makers who seek to reduce the incidence of TOP would do well to address its root cause – unintended pregnancy – by facilitating widespread access to modern contraception and by promoting their effective use (Deschner & Cohen 2003:7).

2.3.1.1.4.1 Methods of TOP

- Medical abortion: terminates a pregnancy through the use of medicines. The most commonly used and most effective regimen is the combination of mifepristone (a drug which inhibits the effects of progesterone) and misoprostol (which causes the dilation of the cervix and uterine contractions). Medical abortion is recommended as soon as pregnancy is confirmed, up to 7–8 weeks (56 days). In South Africa it can only be done if a woman is fewer than 8 weeks (56 days) pregnant (IPAS 2003:2).

Early medical termination with mifepristone and prostaglandin analogue (for example, misoprostol) in controlled settings is extremely safe (South African Society of Obstetricians and Gynaecologists [SASOG] [s.a.]). This is to ensure that the abortion is complete. However, with self-medication, the South African public health sector cannot

ensure this control as many women who would otherwise benefit would not be able to return for review to ensure that evacuation of the pregnant uterus has been complete. The alternative would be to admit women until they have aborted. This is not possible owing to limited space within facilities. For these reasons medical TOP could not be entertained as a public health programme (Mhlanga 2003:121).

- Surgical abortion: use of trans-cervical procedures for terminating pregnancy, including vacuum aspiration and, dilatation and evacuation (WHO 2012:iv). Manual vacuum aspiration (MVA) is the method used in public health facilities in South Africa and it is also one of the techniques recommended by WHO (the other been electrical vacuum aspiration [EVA]). The cervix is prepared by use of a prostaglandin analogue 24 hours before surgery and the client is asked to return the following day or when she starts bleeding for the procedure. Women can leave the health care facility as soon as they feel able and their vital signs are within normal limits (WHO 2012:2).

A study comparing the efficacy, safety and cost-effectiveness of MVA with EVA in first trimester pregnancy losses reveals that MVA is safer as no uterine perforation occurs versus two perforations in the EVA group. Review of literature in this regard shows a uterine perforation rate of 0.06% for MVA with minor complications though not seen in this study in 0.7%–2% cases; infection being the most commonest. The authors of this study therefore concluded that MVA is a safe and effective alternative to traditional EVA in terms of cost, reduced need for general anaesthesia and need for electricity (Nasira, Ghazala, Saba & Mohsina 2011:149, 152).

2.3.1.1.4.2 Use of TOP in South Africa – what do women know about TOP?

Abortion is a time-restricted health service, therefore because of this restriction, women must know ideally before falling pregnant that TOP is legal and an accessible option in the case of unwanted pregnancy (Morroni, Myer & Tibazarwa 2006:2).

A study conducted by Jewkes, Gumede, Westaway, Dickson, Brown and Rees (2005:1240) demonstrates that approximately half of the women (46%) in the study knew abortion was legal. Women who sought help from lay abortionists or an illegal abortion from a nurse, pharmacist or doctor (using surgical procedure) were significantly

less likely to know abortion was legal than women who self-induced (20% versus 55%). Of those with knowledge of the law, the majority (81%) knew that TOP was available on request or to women arguing grounds of poverty. Most women who knew there was a time limit in pregnancy up to which terminations could occur thought it was three months; only one woman knew it was up to five months; only fourteen women (30% of those knowing the law) knew of a facility where a woman could get a termination legally.

Another study by Morroni et al (2006:2−3) among 831 women (628 urban participants and 203 rural participants), shows that overall 32% (n=264) of women did not know that the law in South Africa allows for legal TOP and this proportion was substantially higher in the rural region (40%, n=82) compared to the urban region (29%, n=182). Furthermore, among the 567 respondents who were aware of legal terminations, almost half (48%, n=272) did not know there was a time restriction for a legal TOP on request. Of the 295 who knew the time restriction, 20% (n=59) thought that it was 12 weeks or fewer, 4% (n=12) thought it was more than 12 weeks, and 76% (n=224) did not know what the time restriction was.

However, despite these conflicting findings on the knowledge of TOP Legislation, “An evaluation of the implementation of the CTOP Act” by the DOH (2000:96) concludes that the most substantial barrier to using legal services is lack of knowledge of the law and of the facilities performing terminations.

2.3.1.1.4.3 Legal framework in South Africa

South Africa reformed the abortion law in-order to improve the health of women and prevent deaths among women. The Act, the Choice on Termination of Pregnancy Act (CTOP), of 1996, represents a departure from the past where the woman was always regarded as a minor irrespective of her age or marital status (Mhlanga 2003:115).

The CTOP Act was approved to protect many women for whom a pregnancy could represent a life-threatening condition or a severe risk of physical or mental abnormality to the fetus; and also to assist victims of rape or incest, and those who could be affected significantly both socially and economically by the pregnancy (Lang, Joubert & Prinsloo 2005:52).

However, in South Africa, since the inception of the CTOP Act of 1996 in February 1997, legal terminations have seen a steady increase nationally; for example, from February 1997 to January 1998 a total of 29,375 TOPs were performed nationally, for the same period (February 1998 to January 1999) the figure almost doubled (45,611) (Naude 2002:8–12).

According to Johnston (2010), from 1971 to 1996, 24,446 TOPs were procured by South African women either in South Africa or abroad. From the time abortion was legalised up to the end of 2008, a staggering 703,315 abortions were performed in South Africa (SACBR 2010). If the 2009 and 2010 statistics are added to the 703,315, the figure is pushed to 839,258 as the number of abortions performed in South Africa from 1997 to 2010.

There were 1,259 TOPs performed in KZN in 1997 (HST 2010). This number of abortions increased ten times more by 2005. A significant reduction occurred from 12,706 in 2005 to 4332 in 2010. Despite this significant reduction, the figure remained higher than the 1997 figure of 1,259.

Also the existence of discrepancies between data presented by the DoH and other sources discredits the validity of the above reduction in the statistics. For example, the DoH revealed that 38,321 abortions were performed in 2010 whereas Abbas, advocacy manager for the private abortion clinic group, Marie Stopes stated that 51,185 TOPs were performed by Marie Stopes clinics nationwide; 13,000 more than recorded by the DoH (European Pro-Choice Network article dated 24/03/2011). Abbas further states that the number of abortions at the group's clinics have increased by an average 10% a year since 1997 (European Pro-Choice Network 2011). HST (2010) also gives a different figure of 68,736 as statistics for the number of abortions performed in 2010.

Other cited reasons for the dramatic reduction of TOPs between 2009 and 2010 according to the European Pro-Choice Network article (European Pro-Choice Network 2011) include:

- Decreasing number of state employed nurses who are willing to perform the procedure.

- Long waiting lists at government institutions in addition to poor record keeping by state institutions.

The United Nations (UN) has agreed that TOP should never be promoted as a family planning method, and should be utilised only when contraception has failed (Lang et al 2005:52). The National Department of Health (NDoH) spokesperson Mr Fidel Hadebe states that CTOP Legislation is been abused as young women especially teenagers seem to be using CTOP as a form of contraception (Mapumulo 2011).

This huge demand for TOP services can, therefore, be an indication of inadequate contraception services, missed opportunities for emergency contraception, poor health seeking behaviours of women in their reproductive years and missed opportunities for health education and promotion (KZN DoH 2004:13).

2.3.1.2 Permanent methods

Surgical sterilisation in men and women is a method that aims at permanently ending reproductive functions. Bilateral tubal ligation (in women) and vasectomy (in men) are aimed at preventing the sperm-oocyte contact and hence, conception (Grobler 2003:102). According to IPPF (2012), sterilisation is over 99% effective against pregnancy.

2.3.2 Contraception knowledge

Poor knowledge about contraception is often cited as a reason for ineffective use of contraceptives (Arai 2003; Bankole, Ahmed, Neema, Ouerdraogo & Konyani 2007; both cited in Panday, Makiwane, Ranchod & Letsoalo 2009:31). Studies have, however, shown that most young people are well informed about modern methods of contraception (Panday et al 2009:31).

The 1998 South African Demographic and Health Survey (SADHS) reports almost universal knowledge of modern methods of contraception among unmarried sexually-active women (99.2%) and similar high percentages of knowledge of the pill (96.4%) and condoms (94.3%). Slight lower levels of contraception knowledge (85%) about modern contraception are reported among sexually-inexperienced women in the study

(Panday et al 2009:31). The 2003 SADHS shows similar findings but there has been a decline in the level of knowledge of contraceptive methods since 1998, and also a decline in the proportion of women who have ever used contraception (Nyakoe 2008:21–22).

Evidence from a study conducted by Oindo (2002:34) in Kisumu, Kenya, demonstrated a 99.2% level of knowledge of at least one contraceptive among the youth (99.5% for males and 99% for females).

According to WHO's (2007a:5) fact sheet, knowledge of contraception, i.e., knowing of at least one modern method of averting pregnancy is universal among married women aged 20–24 and is 94% among the 15–19 age group. WHO (2007a:5) further explains that the gap between knowledge levels and actual use of contraceptives is large. Despite this gap the usage of modern contraceptives among newly or currently married women has been increasing significantly over the past 7 years.

2.3.3 Contraception use

The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has had tremendous life saving benefits. Yet despite these impressive gains, contraceptive use is still low and the need for contraception high in some of the world's poorest and most populous places (Smith et al 2009:3).

Women who do not want to become pregnant offer a range of reasons for not using modern contraception. Many believe they are unlikely to become pregnant and a large proportion are concerned about the side effects; some women – or their husbands or family members – are opposed to contraception on personal or religious grounds; however, large numbers of at risk women are not using contraception simply because the appropriate information, supplies and services are not available or affordable (Guttmacher 2009b:3).

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in SSA. Globally, contraceptive use has risen, from 54% in 1990 to 63% in 2007. Regionally, the proportion of married women aged 15–49

reporting use of any contraceptive method has risen minimally between 1990 and 2007 from 17% to 28% in Africa; 57% to 67% in Asia; and 62% to 72% in Latin America and the Caribbean, with significant variations among countries in these regions (WHO 2011).

Substantial variations in contraceptive use exist in many developing countries despite the fact that factors shaping these variations are little understood. Previous studies suggest that variations in contraceptive use typically remain after accounting for individual and household factors. Contextual factors such as community-level cultural beliefs, the presence of quality reproductive health services, the physical characteristics of the area, macroeconomic factors, and the presence of transport routes have been suggested as causes for geographic differences in contraceptive use (Stephenson, Baschieri, Clements, Hennink & Madise 2007:1233).

Worldwide, the use of modern contraception methods is often associated with higher levels of education (Kimuna & Adamchak 2001; Koc 2000; Oppong 1983; all cited in Maharaji & Rogan 2007:27). According to Gribble and Haffey (2008:1), survey data consistently show that with a given country, wealthier women are more likely to use modern family planning methods than poorer women. The same authors further state that, in SSA as a whole, three times as many wealthy women use modern contraception as do poor women.

In SSA, 23% of married women are using family planning–18% with a modern method and 5% with a traditional method (Gribble & Haffey 2008:1). According to Sharan, Ahmed, May and Soucat 2010:447), use of traditional methods tend to be higher in settings in which acceptance of family planning is low. Sharan et al (2010:448) continue stating that recent trends in method choice show that in many countries of the SSA, use of traditional methods has declined and use of modern methods increased.

Contraceptive use in South Africa is high compared to that of other SSA countries, the major form of contraception being modern methods of contraception (NDoH 2006, cited in Maharaji & Rogan 2007:27). A South African study on rural women concludes that the proportion of women who have ever used or were currently using a contraception method increased with level of education from 16% among uneducated women to 67% among those with schooling (Chimere-Dan 1996, cited in Maharaji & Rogan 2007:27).

Smith et al (2004) cited in (Maharaji & Rogan 2007:27) believe that women who had reached grade 10 or beyond were more likely to use contraception than women with no education (78.1% versus 33.1%). Maharaji and Rogan (2007:27) attribute these findings to increasing awareness in schools and education of pupils on safe sex practices and contraception use.

2.4 CONCLUSION

Chapter 2 explored literature reviewed by the researcher. Chapter 3 discusses the methodology which the researcher used for data collection.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

Chapter 2 gave a detailed discussion of available literature on the proposed research topic. This chapter covers the study design, study population and sample, data collection method and instrument, ethical considerations, validity and reliability, and data analysis plans.

3.2 RESEARCH SETTING

The research was conducted at the TOP clinic of PMMH. PMMH was ideal for this study as it serves the largest and most populated township in KZN. The hospital's maternity department is the busiest in the province and made respondent recruitment much easier for the researcher.

3.3 RESEARCH DESIGN

Polit and Beck (2004:730) define a research design as the overall plan for addressing a research question including specifications for enhancing the study's integrity.

This quantitative study used a non-experimental method in the form of a cross sectional study. This study was in the form of a survey. In this cross sectional survey, information was obtained at a single point in time. However, because large samples of clinical populations (this also applies to TOP clients) are not easy to find, the accrual of study participants took longer (Stommel & Wills 2004:163). Respondents were only studied once. The survey method was advantageous to this study for the following reasons:

- In a relatively small study population (as that of TOP clients) which is representative of the overall study population, an accurate picture of the population can be provided (LoBiondo-Wood & Haber 2002:224). It is assumed

that TOP clients presented at the TOP facility randomly (making the sample representative of the large population of TOP clients), hence provided an accurate picture of the overall TOP clients population in Umlazi.

- As a survey is a non-experimental design and it would be unethical to manipulate variables in human subjects, it was suitable for this proposed study (Stommel & Wills 2004:359, LoBiondo-Wood & Haber 2002:222; Polit & Beck 2004:188).

Surveys also have disadvantages and of relevance to this study is the fact that Information obtained in survey studies tends to be relatively superficial as breadth is emphasised rather than depth. However, it is beyond the scope of this study to probe deeply into such complexities as, for example, why individuals choose to terminate pregnancies (LoBiondo-Wood & Haber 2002:224; Polit & Beck 2004:234).

3.4 RESEARCH METHOD

3.4.1 Population

The population was all women seeking termination of pregnancy (TOP) voluntarily from the 20th of August to 6th September, 2012 at PMMH's TOP clinic.

3.4.2 Sample and sampling

3.4.2.1 Sample

Stommel and Wills (2004:297) define a sample as any subset of cases or observations drawn from a larger population of cases or observations.

The sample included sixty–one literate pregnant women who were 18 years and over seeking TOP voluntarily at PMMH's TOP clinic and who were willing to participate from the 20th August to 6th September, 2012. The reason for this is that first, women younger than 18 years are constitutionally considered as minors and hence the need for parental consent to be included in a study; and second, the research topic is sensitive hence the researcher believed it was easier for respondents to respond on paper than been interviewed, therefore a self-administered questionnaire was used resulting in the exclusion of illiterate women.

3.4.2.2 Sampling

According to Burns and Grove (2003:496), sampling is a process of selecting a group of people, events, behaviours, or other elements that are representative of the population being studied.

The researcher used a non-probability sampling technique. This is because probability sampling can only be used if the sampling frame is complete. Polit and Beck (2004:725) define non-probability sampling as the selection of respondents or sampling units from a population using non-random procedures, for example, convenience, judgmental and quota sampling.

The convenience sampling technique was used as the researcher used consecutive respondents meeting inclusion criteria from those women who presented to the facility. According to Stommel and Wills (2004:301), convenience sampling is the most common approach in clinical studies.

3.4.3 Inclusion and exclusion criteria

According to Stommel and Wills (2004:305), in clinical studies, inclusion and exclusion criteria, combined with the selection of clinical sites for recruitment, provide the precise operational definition of the study population.

The research excluded:

- Pregnant women younger than 18 years as these constitutionally are considered to be minors and hence the need for parental consent for inclusion in research.
- Women who were carrying foetuses with gross abnormalities or with life threatening conditions and rape victims (including incest).
- Women who were unable to self-administer the questionnaire.

Criteria included only literate women who were 18 years and older seeking TOP voluntarily at PMMH's TOP clinic.

3.4.4 Data collection

Burns and Grove (2003:479) believe that, data collection is the identification of subjects and the precise, systematic gathering of information (data) relevant to the research purpose or specific objectives, questions, or hypotheses of a study.

Data collection was conducted at the TOP clinic of PMMH using a self-administered questionnaire. PMMH was ideal for this study as it serves the largest and most populated township in KZN; and the hospital's maternity department is the busiest in the province and hence respondent recruitment was much easier for the researcher.

3.4.5 Development and testing of the data collection instrument

The questionnaire was initially drafted in English and was submitted to the Department of Health studies (University of South Africa [UNISA]) and was then peer reviewed by medical and nursing staff. It was then translated into Zulu and then retranslated back into English. The questionnaire was also submitted to the Head Office of KZN Department of Health.

A pilot study had already been conducted among 6 clients – 3 of each version of questionnaire was administered. On the day of the pilot study, prospective respondents were approached by the team leader in the TOP clinic and introduced to the researcher. This was before they had received counseling. In a private room, the reason for the research was given and respondents were informed that participating was not compulsory. Respondents were also informed that there would be no remuneration for participating. The written informed consent form was read to each respondent before she answered the questionnaire and the researcher explained that answering the questions in the questionnaire meant she had consented to be included in the research. No information which could lead to the identification of respondents was included.

The same procedure used to collect data in the pilot study was used for the main study. However, the researcher did not include in the main study the respondents who had participated in the pilot study. Data collection for the main study was conducted on alternate days in order to reduce the chances of women who had participated on the

previous day meeting the women participating on the following day as this could influence their way of answering the questions, hence introducing bias into the study.

3.4.6 Characteristics of the data collection instrument

LoBiondo-Wood and Haber (2002:301) define questionnaires as paper-and-pencil instruments designed to gather data from individuals about inter alia knowledge, attitudes, beliefs and feelings.

The self-administered questionnaire contained closed ended questions and an “other” category. The final question was an open question. The questions were designed as closed ended because by conducting a literature review, a substantial amount of information about the phenomenon can be found that can be incorporated into the response options.

This questionnaire contained sections A, B, C and D based on the study objectives and was available both in English and Isizulu.

Section A of the questionnaire consisted of questions 1 to 8 on socio-demographic data. The questions aided with the collection of respondent’s data on age, race, religion, marital status, living arrangements, type of family, educational background and source of income. The demographic data will be analysed in chapter 4 in order to determine sample characteristics (Burns & Grove 2003:99).

Section B aimed at collecting and evaluating data on previous and current sexual activity; age at menarche and sexual debut; age of first partner; number of current sexual partners; number of previous pregnancies and children (living and dead). The section consists of questions 9 to 17. The information would help to evaluate the potential risk of pregnancy among the respondents.

Section C which consisted of questions 18 to 29 measured the level of contraception knowledge of the TOP client. This data was crucial as it would help policymakers design policies aiming at facilitating widespread promotion of and access to modern contraceptive so as to prevent unintended pregnancy which is the root cause of abortion (Deschner & Cohen 2003:7). The section included questions on emergency

contraception besides the natural, temporary regular and permanent methods, plus the condom.

Section D consisted of questions 30 to 39 and determined factors influencing contraceptive use. The final question of this section was an open-ended question that gave respondents an opportunity to ask questions which were left out or bring up issues not covered in the questionnaire.

3.4.7 Data analysis

Data analysis was done using the Statistical Package for Social Sciences (IBM SPSS V. 19 [SPSS Inc., Chicago, Illinois]). Since the objectives were purely descriptive in nature, descriptive analysis was performed. Sexual activity, contraception knowledge and use were assessed objectively by scoring each participant's responses to the knowledge questions and expressing the score as a percentage. This score was summarised using mean, standard deviation and range. Statistics summary consisted of frequency tables and graphs.

3.5 VALIDITY

3.5.1 External validity

Polit and Beck (2004:217, 718) define external validity as the degree to which study results can be generalised to settings or samples other than the one studied. In–order to enhance external validity, the researcher:

- Recruited sixty-one study respondents for generalisation purposes, as according to Parahoo (2006:276), even in a highly randomised study, if the number of study respondents is below fifty, the external validity of the findings may be questionable.
- Used a self-administered questionnaire in order to prevent interviewer bias.
- Administered the questionnaire to individuals so as to enhance the response rate. TOP clients were more likely to decline to participate in a group context owing to the sensitive nature of the topic and associated stigma.

- Administered the questionnaire on alternate days in order to reduce the chances of women who participated on the previous day meeting the women participating on the following day as this would influence their way of answering questions, hence introducing bias into the study.

3.5.2 Validity

LoBiondo-Wood and Haber (2002:314) explain that validity refers to whether a measurement instrument accurately measures what it is supposed to measure. One of the most common and useful classifications schemes attempting to categorise the validities underlying measurement is content, face, criterion and construct validity. Face and content validities are of importance in this study, and are often used interchangeably in research literature though some methodologists argue that they should not be thought of as synonymous (De Vos 2002:166).

3.5.2.1 Face validity

According to Burns and Grove (2005:377–378, cited in De Freitas 2007:82) face validity refers to subjective judgment on whether the research instrument appears to measure what it is supposed to measure. The researcher believes the research instrument measured what it was supposed to measure. The pilot study demonstrated that the research methodology was adequate and feasible.

3.5.2.2 Content validity

According to Burns and Grove (2003:478), content validity refers to the extent to which the method of measurement includes all the major elements relevant to the construct being measured. Inclusion of all major elements is not possible; however, the open ended question gave respondents a chance to refer to issues or ask questions relevant to the topic not included by the researcher.

Content validity represents the universe of content or the domain of a given construct. The universe of the content provides the framework and basis for formulating the items that adequately represent the content. Hence, when issues of validity arise, the researcher has to submit the items in the tool to the panel of judges considered to be

experts in the concept (LoBiondo-Wood & Haber 2002:314). This questionnaire was, therefore, submitted to medical and nursing staff for peer review in order to achieve content and face validity.

The questionnaire was also pre-tested in the TOP clinic of PMMH with a group of six women who met the inclusion criteria in order to determine the feasibility of the study and if the methodology was adequate and appropriate (Bless & Higgson-Smith 2000:155, cited in De Vos 2002:211).

3.5.3 Reliability

Reliability is defined as the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit & Beck 2004:730).

In order to enhance reliability, the questionnaire was first written in English, then translated into Isizulu; and re-translated back to English in order to limit misinterpretation and at the same time to accommodate women who were uncomfortable with English. A written questionnaire was used; hence all respondents precisely answered the same questions and responses were recorded in a uniform manner (Boynton & Greenhalgh 2004:1312).

The researcher questioned the respondents who participated in the pilot study upon completion of the questionnaire about whether the instructions (in various sections) and questions were clear and not leading. All six respondents indicated that the questions and responses, phrasing of questions and the instructions were clear; and that the questions were not leading.

3.6 ETHICAL CONSIDERATIONS

Permission to conduct this study in the TOP clinic at PMMH was obtained from the Hospital's ethics committee and the Health Research and Knowledge Management Sub-component (DoH, KZN). The research proposal was also approved by the Department of Health Studies Higher Degrees Committee of the University of South Africa (UNISA) before the researcher conducted a pilot study at PMMH's TOP clinic.

Informed consent is a legal requirement which governs a patient's ability either to accept or reject participation in a study. Informed consent was obtained from the respondents before the questionnaires were administered. The researcher did not collect information on respondents who explicitly refused to participate (LoBiondo-Wood & Haber 2002:273).

Owing to its sensitive nature, respondents' human rights were protected by maintaining anonymity and confidentiality.

3.6.1 Anonymity

Refers to the protection of respondents in a study such that even the researcher cannot link individuals with the information provided (Polit & Beck 2004:710). In order to maintain anonymity, a self-administered questionnaire was used for data collection. The questionnaire was administered in privacy to one person at a time and no identifying information about respondents was included in this questionnaire in order to prevent the linking of respondents to information provided (Stommel & Wills 2004:382).

3.6.2 Confidentiality

Is the protection of respondents in a study such that individual identities are not linked to information provided and are never publicly divulged (Polit & Beck 2004:714). In order to ensure confidentiality, the researcher:

- Did not obtain any identifying information (for example, name, address, etc)
- Reported research information in aggregate form (Polit & Beck 2004:150)
- Destroyed identifying information immediately
- Did not assign an identification number to each respondent

3.7 CONCLUSION

This chapter discussed the methodology which the researcher used for conducting the pre-test and main study. In chapter 4, the researcher discusses the procedure for data analysis and research findings.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter discusses the methods and procedures used in data analysis, presentation and description of the research findings of 61 multiple choice questionnaires administered to clients who had terminated a pregnancy in the TOP clinic of PMMH, KZN.

4.2 DATA MANAGEMENT AND ANALYSIS

Data collection took place at PMMH's TOP clinic between the 20th and 6th of September 2012. Data was collected twice a week on Tuesdays and Thursdays. Each day after data collection, the researcher thoroughly checked the questionnaires for completeness, consistency and accuracy. All the questionnaires which were not consistent, complete and accurate were re-administered to other respondents who met the inclusion criteria on the alternate day. The multiple choice answers on the questionnaire were then coded with consecutive numbers and entered on the excel spreadsheet for the purpose of analysis. IBM SPSS version 19 was used to analyse the data.

4.3 RESEARCH RESULTS

The analysed data was based on the questionnaire and is presented below. Statistics summary consisted of tables and graphs.

4.3.1 Sample characteristics

4.3.1.1 Item 1: Age distribution of respondents

The age distribution of the 61 respondents is shown in table 4.1 below.

Table 4.1 Age distribution of respondents (N=61)

Age intervals	Frequency	Percentage
18–22	21	34.4
23–27	21	34.4
28–32	10	16.4
33–37	06	9.8
38–42	03	4.9
Total	**61**	**100.0**

The majority were young women between 18 and 27 years (age group 18–22, 34.4% [n=21]; age group 23–27, 34.4% [n=21]; age group 28–32, 16.4% [n=10]; age group 33–37, [n=6]; age 38–42, 4.9% [n=3]).

The results show that with increasing age, the rate of TOP decreases. The finding of increased number of TOP among adolescents is well documented in several studies. For example, in a similar South African study by Nyakoe (2008:35), of 203 respondents who participated in the study, 53% (n=107) were adolescents (age <15, 2% [n=4]; age 15–19, 20% [n=40]; age 20–24, 31% [n=63]). In the age <15 group, the youngest was 13 years.

4.3.1.2 Item 2: Race

This item was answered by all 61 female respondents who were all of African ethnicity.

4.3.1.3 Item 3: Religion of respondents

In table 4.2 the religion of the respondents is presented. All 61 respondents answered this question.

Table 4.2 Religion of respondent (N=61)

Religion	Frequency	Percentage
African indigenous	29	47.5
Catholics	19	31.1
Christians	09	14.8
Muslims	00	0.0
Zion	02	3.3
Other	02	3.3
Total	**61**	**100.0**

The majority (47%, n=29) of the respondents were African indigenous; followed by 31.1% (n=19) of Catholics; 14.8% (n=9) of the respondents did not specify their religion instead stated that they were Christians, 3.3% (n=2) were Zionist and a further 3.3% (n=2) did not specify what religion they belonged to. None of the respondents belonged to the Muslim religion.

In this study, the results show that 96.6% belonged to a religion (two dominant denominations been the African indigenous and the Catholic Church). According to Maja (2007a:33), religious affiliations may impact on the use of contraception, for example Christianity teaches that God wants man to multiply and rule the earth hence use of contraception would be against the teaching. “Research conducted in RSA, found that some women resorted to abortion, even though they acknowledged their communities' strict disapproval, on conventional religious grounds, of pregnancy terminations” (Maforah, Woods & Jewkes 1997:82, cited in Maja 2007a:34). According to Maja (2007a:34), these women failed to prevent unwanted pregnancy via the use of contraception on religious grounds but resorted to TOP in order to comply with the religious doctrines. According to Sarpong [s.a.], in African traditional religion, one of the most important concept is the respect for sacredness of life. Intentional termination of pregnancy or contraception is rare, if not an impossibility. The Catechism of the Catholic Church (Article 5:2270) states “human life must be respected and protected absolutely from the moment of conception”.

4.3.1.4 Item 4: Marital status of respondents

In table 4.3 marital status of the respondents is presented. This question was answered by all 61 respondents.

Table 4.3 Marital status of respondents (N=61)

Marital status	Frequency	Percentage
Single	56	91.8
Married	03	4.9
Other	02	3.3
Total	61	100.0

Most respondents were single (never married, 92% [n=56]), 4.9% (n=3) were married and remaining 3.3% (n=2) did not state their marital status. Abdool-Karim (2001:195, cited in Maree 2010:3) observes that only a few sexually active women living in KZN at that time were married. Denis (2006:5, cited in Maree 2010:3) states: “Social class, rather than race or culture, results in blacks not getting married in South Africa”. The reason for this is that many black people cannot afford lobola as they are too poor.

Overall, in South Africa, the proportion of never married women has increased in the child bearing age group from 54% in 1996 to 55% in 2000 and, 58% in 2007. The figures hence show that more than half of women in childbearing age are never married (Palamuleni 2010:49).

4.3.1.5 Item 5: Who do you live with?

Figure 4.1 below shows with whom respondents lived. All 61 respondents answered this question.

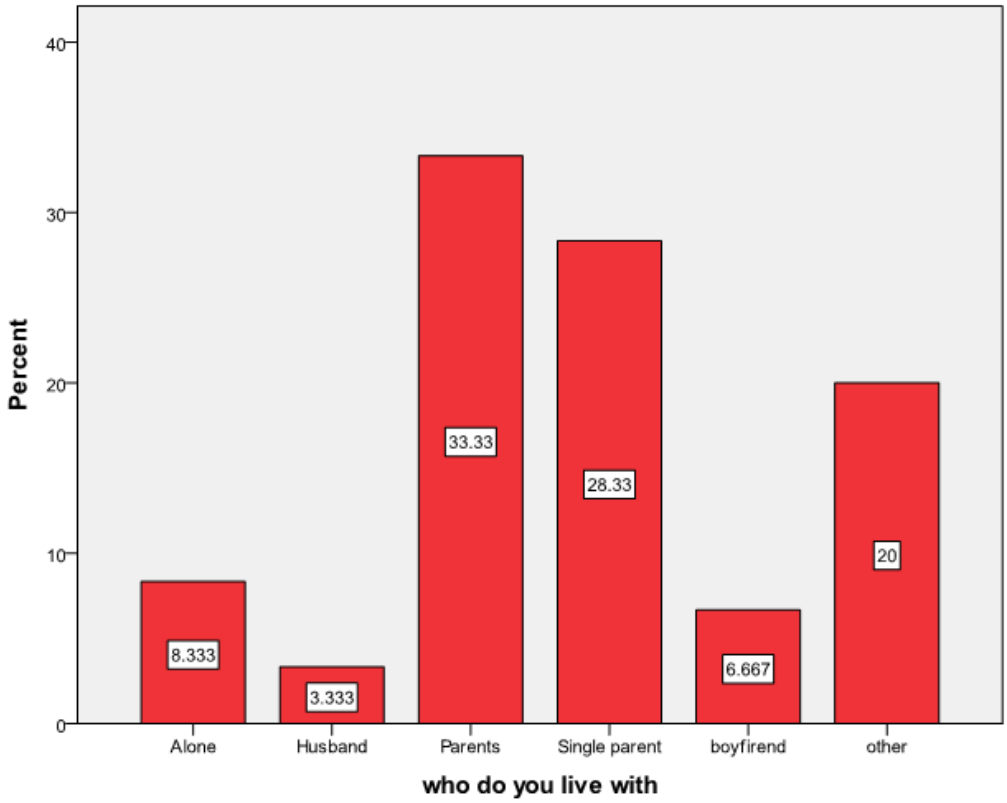

Figure 4.1 With whom respondents lived

One third (33.33%, n=20) lived with both parents; 28.33% (n=17) lived with one parent, mostly their mother; 6.7% (n=4) lived with boyfriends; 8.33% (n=5) lived alone and 3.33% (n=2) with husbands. Of those who said other (20%, n=12), it was mostly extended family.

The results presented in this report show that the majority of respondents lived with both parents. Living with both parents is associated with non-risky behaviour, for example, having protected sex and a delay in sexual debut for both males and females. McGarth, Nyirenda, Hosegood and Newell (2008:i54) reveal that maternal death is significantly associated with earlier sexual initiation among women, in the same way was a paternal death. However, the same authors also found a significant association between place of residence and risky behaviour, for example engaging in unprotected sex and living in a periurban area were associated with early sexual debut.

Umlazi township is made up of mono-functional/low density suburban development, which takes little account of the specific needs of the predominantly low-income population and provides little assistance to residents in order to escape the cycles of poverty (Executive Summary 2008:7). In the poverty stricken areas of the township,

residents are living below the poverty line. A recent study by the UNAIDS (2008:11) in Botswana and Swaziland shows that, women who lack enough food are 70% less likely to perceive personal control in sexual relationships, 50% more likely to engage in intergenerational sex, 80% more likely to engage in transactional sex and 70% more likely to have unprotected sex than those with enough food.

Family structural characteristics play an important role in understanding and determining young women's sexual behaviour including pregnancy (Langille, Flowerdew & Andreou 2004; Miller, Bayley, Christensen, Leavitt and Coyl 2003; both cited in Panday et al 2009:34). According to Gordon (1996, cited in Panday et al 2009:35), the family influences young adults' early belief systems and values, and hence their behaviour.

In traditional Zulu culture, parents did not discuss sex with their children instead recognised women (iqhikiza) and men provided the education. The collapse of this system has left a vacuum which has not been filled by the South African education system resulting in teenage pregnancies (Ndinda, Uzodike, Chimbwete & Mgeyane 2011:7).

A study in Ghana showed that school going youth who reported parent-child communication on issues related to HIV/AIDS were more likely to have used condoms at their last sexual encounter, but communication was not associated with sexual debut. An interesting finding stated by these authors however, is that communication with teachers was associated with delayed first sex (Hindin & Fatusi 2009:60). The parent-child communication aspect needs to be explored in-depth among this group of women. According to Babatunde (2012), parents do not listen to young women. Instead, parents give instructions to young people all the time. In order for young women to reach their full potential, they need supportive environments, education and reproductive health services so as to be able to make choices.

4.3.1.6 Item 6: If married, what type of family are you living in?

Married respondents (4.9%, n=3), were asked to indicate the type of family their lived in. Type of family respondents lived in is presented in table 4.4 below.

Table 4.4 Type of family respondents lived in (N=3)

What type of family are you living in?	Frequency	Percentage
Nuclear family	2	3.3
Extended family	0	0.0
Other	1	1.6
Total	**3**	**4.9**

Only 4.9% (n=3) of the 61 respondents were married. Of the 4.9% (n=3), 3.3% (n=2) lived in nuclear families and 1.6% (n=1) lived alone.

4.3.1.7 Item 7: Education level

The education level of respondents is shown in table 4.5.

Table 4.5 Education level (N=57)

Education level	Frequency	Percentage
Some primary	05	8.8
Completed primary	05	8.8
Learner at high school	16	28.1
Completed high school	18	31.6
Learner at tertiary	12	21.1
Completed tertiary	01	1.8
Total	57	100.0
Missing system	04	-
Total	**61**	-

Only 57 respondents answered the question regarding their level of education and results show that most of the respondents had completed high school (32%, n=18). Twenty-eight percent (n=16) were learners at high school, 21.1% (n=12) were still learners at tertiary education level, and only 1.8% (n=1) had a tertiary qualification. Out

of the remaining 14 respondents, 4 did not state their education attainment, 5 (8.8%) completed primary education and a further 8.8% (n=5) had some primary schooling.

Overall, the census data for 2001 presented by the Executive Summary (2008:8) reported that 36% of the Umlazi population had secondary education, 26% had completed grade 12, 10% did not attend formal educational institutions, 15% completed primary school and 6% had some form of primary education. Only 7% of the Umlazi population had some form of or completed tertiary.

A similar study in South Africa on "an assessment of contraceptive use by patients requesting TOP" by Nyakoe (2008:36) found that 86% of respondents had secondary school education or higher. Lamptey et al (1985, cited in Gyimah 2003:4) found that educated women were more likely to use modern contraception alongside abortions for timing and spacing of birth.

4.3.1.8 Item 8: Income sources

Respondents' income sources are shown in table 4.6 below. All 61 respondents answered this question.

Table 4.6 Income sources (N=61)

Income sources		Count	Percentage
Employed	No	50	82.0
	Yes	11	18.0
Self-employed	No	56	91.8
	Yes	05	8.2
Government grant/pension	No	39	63.9
	Yes	22	36.1
Boyfriend	No	55	90.2
	Yes	06	9.8
Other	No	49	80.3
	Yes	12	19.7

The majority of the respondents were dependent on government grants as their income (36%, n=22); 18% (n=11) were employed; 9.8% (n=6) dependent on their boyfriends

and a further 8% (n=5) self-employed. Of those who listed other sources of income, this was mainly non-specific sources or family.

According to data from the Census 2001 (Executive Summary 2008:8), 28% of Umlazi township's working age population were working in the formal sector and, the unemployment rate was at 38%. The unemployment rate included people who were self-employed and the job seekers. The relatively low levels of employment in the formal sector were partly due to the fact that the majority of the Umlazi population has a grade 10 or below education level and, were semi-skilled or unskilled. Statistics for the township which were also provided by Statistics South Africa 2001 show that 30% of the population reported having no income (Executive Summary 2008:8−9).

According to Maharaji (2008:51), the most populous age cohorts in Ulamzi are between the ages of 15-19; 20-24 and 25-29. On top of this, ages zero through to 29 make up an estimated 50% of the entire Umlazi population. The same data also show a decline in the population from age cohort of 30 indicating the impact of HIV/AIDS related deaths among adults and, a 5% increase in births of newborns, adolescents and young adult population. The result of this phenomenon is a trend suggestive of a high unemployment and dependency level given the high percentage of youths. This explains why the majority of the participants (36.1%, [n=22]) in this study reported government grants as their source of income.

4.3.2 Objective 1: Investigate sexual activity prevalence among voluntary TOP seekers at PMMH's TOP clinic

4.3.2.1 Item 9: At what age did you start having periods?

Table 4.7 below presents age at menarche of respondents. Only 55 respondents answered this question.

Table 4.7 Age at menarche (N=55)

Age at menarche		Count
N	Valid	55
	Missing	06
Minimum (age)		12
Maximum (age)		20
Percentiles	25th	13.00
	50th	14.00
	75th	15.00

The median (50th percentile) age respondents started having menstrual periods was 14 years, with a range from 12 to 20 years. According to Biddlecom et al (2007:21), today, worldwide, adolescent reach puberty at a younger age than previous generations because of improved nutrition, health and socioeconomic conditions.

4.3.2.2 Item 10: At what age did you first have sexual intercourse?

Age of sexual debut is presented in table 4.8 on page 61. Only 54 respondents answered this question.

Table 4.8 Age at sexual debut (N=54)

At what age did you first have sexual intercourse?		Frequency
N	Valid	54
	Missing	07
Minimum (age)		14
Maximum (age)		23
Percentiles	25th	16.00
	50th	18.00
	75th	19.00

Table 4.8 above shows that the average age of first sexual intercourse among 54 respondents who answered the question was 18 years, and this ranged from 14 to 23 years. A prospective population-based HIV and sexual behaviour survey in the rural Umkhanayakude district of KZN, by McGarth et al (2008:i49; i52), found that the median age of first sex for young women and men was 18.5 years and 19.2 years respectively. This finding according to McGarth et al (2008:i52) is consistent with Bakilana's estimate

of 18 years for South African women using 1998 demographic and health surveys (DHS) data and survival analysis approach.

By age 20, 75% of young women in SSA report having had sex (Williamson et al 2009:2). Overall the median age of sexual debut among women in the rest of SSA is about 18.5 years (Hindin & Fatusi 2009:59). Given that the median age of first sex is comparable with those from other studies (studies conducted in South Africa and other SSA countries), sexual debut has not changed over the past years.

4.3.2.3 Item 11: Why did you decide to have sexual intercourse at this age?

Table 4.9 provides the reasons for respondents deciding to have sexual intercourse at this age. All 61 respondents answered this question.

Table 4.9 The reasons adolescents decided to have sexual intercourse at that age (N=61)

Reason for having sexual intercourse at that age		Frequency	Percentage
Was married	No	61	100.0
	Yes	00	0.0
To keep my partner	No	51	83.6
	Yes	10	16.4
Financial gain	No	60	98.4
	Yes	01	1.6
Peer pressure	No	51	83.6
	Yes	10	16.4
Curiosity/experimentation	No	56	91.8
	Yes	05	8.2
Thought we would marry	No	52	85.2
	Yes	09	14.8
Romantic love	No	39	63.9
	Yes	22	36.1

Adolescence is defined as a transition stage between childhood and adulthood. The following reasons were provided for adolescents to have sexual intercourse at this age. None gave the reason of being married. Romantic love was the most common reason (36%). Peer pressure and wanting to keep a partner followed at 16.4% (n=10). Nine

(14.8%) of the respondents thought they would marry; a further 8.2% (n=5) were experimenting and only 1 of the 61 respondents had sex at that time for financial gain.

The study population comprised mostly of adolescents (18–22 years, 34.4% [n=21]; 23–27 years, 34.4% [n=21]). Many researchers and developmental specialist in the United States use the age span 10-24 years as a working definition of adolescence (Department of Health and Human Services, USA 2011). This stage is characterised by low self-esteem especially among girls (Coleman & Hendry 1980, cited in Nkambule 2009:23). Low self-esteem has been associated with early and unwanted pregnancies and with sexual risk-taking in SSA settings (Gueye, Castle & Konate 2001:57).

Lebese, Davhana-Maselesele and Obi (2011:6) observe that, peers are a source of information on sexual matters. Respondents reported that they spent most time discussing sex issues and non-participation or not giving one's own sexual account resulted in been regarded as “fools” by others and were hence encouraged to have sex so as to be more socially acceptable.

Closely related to peer pressure are mass media which contribute to increasing sexual activity among adolescents as the latter form a predominantly large media audience. Television and radio programs broadcast/air different sexually related behaviours which lead to the desire or curiosity to experiment with what is perceived as "modern behaviour. “As a result, in South Africa, the rate of first child birth is high and basically the feature of the black/African and colored/mixed-race populations and is found both in urban and rural areas (Gareme & Swang 2008:98).

Older women are more likely to report that they had sex with marriage in mind. This can, therefore, be taken as the reason for only 14.8% (n=9) reporting marriage as a reason for sex given that the majority of respondents were adolescents; the majority (31.6%, n=18) of which were out of high school and looking forward to furthering their education in higher education institutions.

Biddlecom et al (2007:15) states that findings from several studies suggest that economic need is a key reason for women deciding to become sexually active or engage in risky sex. However, transactional sex is subject to underreporting because of social desirability bias (Pettifor et al 2004:2002). In this study only 1 respondent (1.6%)

reported having sex for financial gain even if 9.6% (n=6) reported boyfriends as sources of income. The finding of this report is comparable to 1.3% of women reported by Pettifor et al (2004:2002) in a study on “sexual power and HIV risk, South Africa”.

4.3.2.4 Item 12: What was the age of your first sexual partner?

The ages of first sexual partners of all 61 respondents are graphically presented in figure 4.2 below.

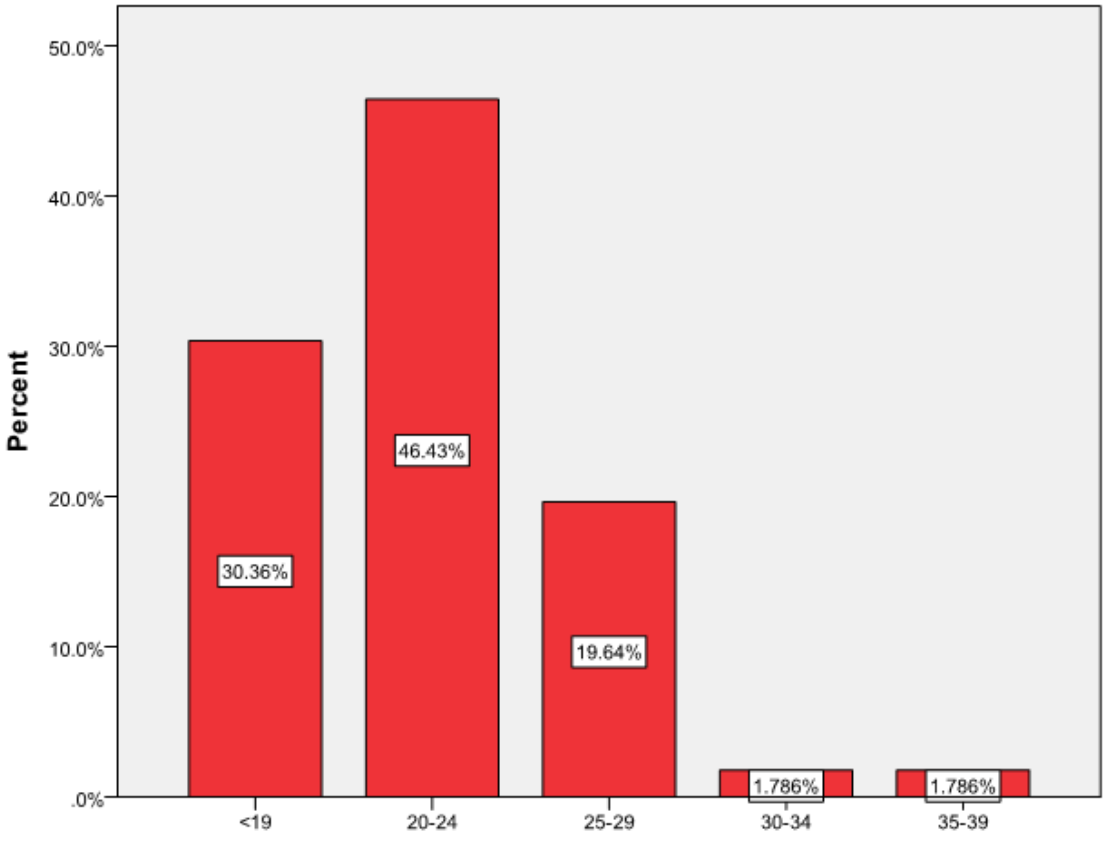

Figure 4.2 Age of sexual partner

Most partners were between the ages of 20 and 24 years (46%). There was therefore an age difference of 2–6 years given mean age of 18 years at sexual debut. This finding is close to that of 1–4 years difference found by Pettifor et al (2009:84) in the study “Early coital debut and associated HIV risk factors among young women and men in South Africa”. Other South African data also put the age differential for women’s first sexual partners at 4 years older (McGarth et al 2008:i52).

Young women who have sex with older partners are at increased risk of not using contraception, contracting sexually transmitted infections (STIs) and becoming pregnant (Kirby 2007, cited in Panday et al 2009:30).

Current sexual activity

4.3.2.5 Item 13: Frequency of current sexual activity

Respondents' sexual activity frequency is given in table 4.10. The question was answered by 52 respondents.

Table 4.10 Frequency of current sexual activity (N=52)

Frequency of current sexual activity	Frequency	Percentage
Less than once a week but more than once a month	06	11.5
Once a week	19	36.5
More than once a week	03	5.8
Once a month	21	40.4
Other	03	5.8
Total	**52**	**100.0**
Missing system	09	-
Total	**61**	-

The frequency of sexual intercourse was mostly once a month (40%, n=21); 36.5% (n=19) had sex once a week; 11.5% (n=6) had sex less than once a week but more than once a month and a further 5.8% (n=3) had sex more than once a week. Those who reported under "other" (5.8%, n=3) specified mostly every 2 months or no specific frequency.

According to Kirby (2007, cited in Panday et al 2009:30), the more frequently young people have sex, the greater the likelihood of the female partner conceiving. Jewkes et al (2001, cited in Panday et al 2009:30) also show that young women who have coitus more than once a week were significantly at an increased risk of becoming pregnant.

Overall, sexual activity frequency among the respondents in this study was very low (once a month for 40% [n=21] of the respondents) given that the majority were single. It is a well known factor that poor knowledge and non-use of contraception results in

unwanted pregnancy-"the root cause of abortion." According to MacPhail, Pettifor, Pascoe and Rees (2007:5), women consider using contraception when involved in long term regular relationship and also when reporting increased sexual activity in the past month.

4.3.2.6 Item 14: How many sexual partners do you have?

Figure 4.3 graphically shows the number of sexual partners respondents had. All 61 respondents answered this question.

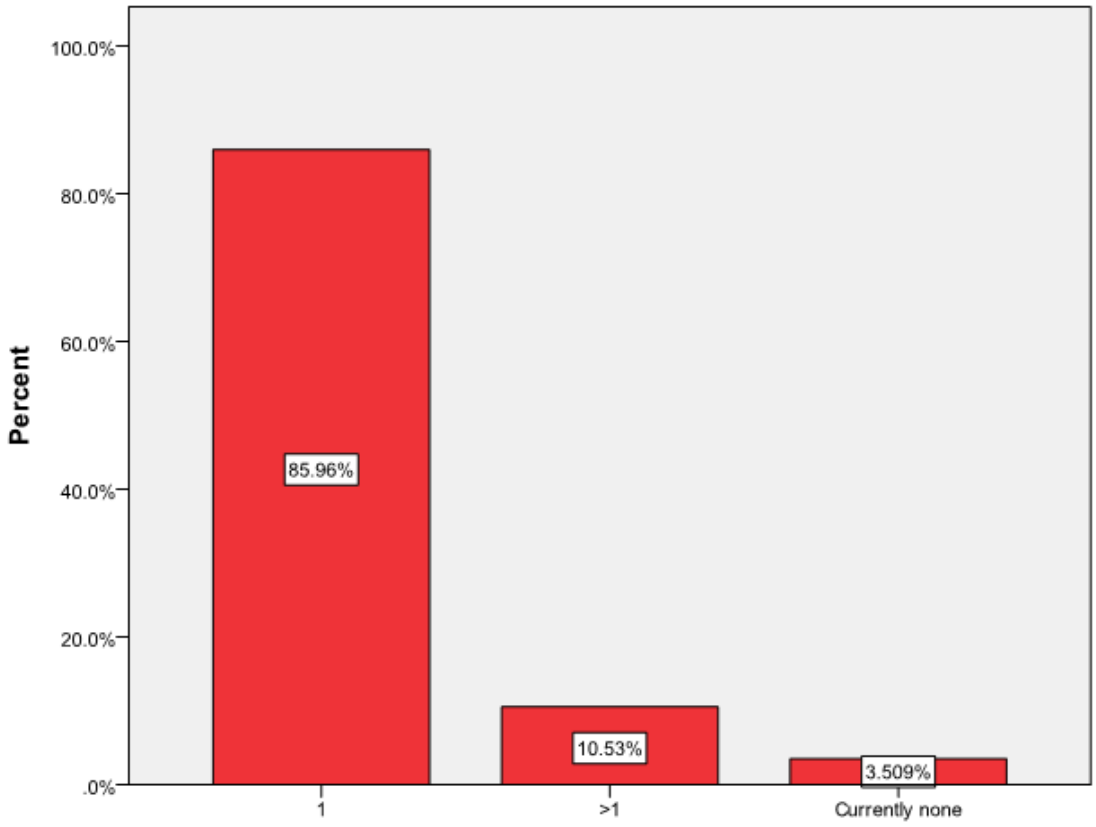

Figure 4.3 Number of sexual partners

Of the 61 respondents who answered question 14, 85.96% (n=52) had only one current partner, 10.53% (n=6) had more than one partner each and 3.5% (n=2) had none. Of the 10.53% (n=6), 4 of the respondents had 2 partners each and the remaining 2 had 3 partners each. Two (3.5%) respondents had ended their relationships with the partners who had made them pregnant and were not in any relationships at the time of the study.

According to the Human Sciences Research council (HSRC) (2008, cited by Shisana et al 2009:65), multiple partnerships include intergenerational relationships which are motivated by financial exchange-usually between younger females and older males. In South Africa, a study by Jewkes et al in Cape Town reveals that 21.1% of pregnant and 18.8% of non-pregnant teenagers reported having sex for money or presents (Jewkes, Vundule et al 2001; cited in Dunkle, Jewkes, Nduna, Levin, Sikweyiya & Koss 2007:1236).

Contrary to popular perceptions about multiple partnerships among young people, in the 2003 Reproductive Health Research unit (RHRU) survey, 25% of males and 45% of females reported one lifetime sexual partner in the age group 15–24 years. Females in the age group 15–24 years (90.4%) showed a greater propensity for sticking to one partner in past 12 months and this pattern has persisted since that time to date. The findings of this study also report 85.96% (n=52) having only one current partner, with only 10.53% (n=6) having multiple partners and a further 3.5% (n=2) not in an active relationship.

4.3.2.7 Item 15: Have you been pregnant before?

Table 4.11 on page 69 shows the number of respondents who have had previous pregnancies. This question was answered by 58 respondents.

Table 4.11 Have you been pregnant before? (N=58)

Have you been pregnant before	Frequency	Percentage
Yes	47	81.0
No	11	19.0
Total	**58**	**100.0**
Missing system	03	
Total	**61**	

The majority (81%, n=47) had been pregnant before, 19% (n=11) were pregnant for the first time. Women who begin child bearing during adolescence are at an increased risk of having more births over a short period of time. In the United States of America, 25%

of teenage mothers give birth to another child within 2 years of having the first one (National Campaign to prevent teenage pregnancy 2002, cited in Panday et al 2009:27).

Despite the age at first birth been low, South African findings deviate from this norm as women significantly delay the birth of the second child. It is only after the first pregnancy that young women are educated on contraceptives and subsequently offered contraceptive services with preference for hormonal contraceptives (MacPhail et al 2007:5).

The desire to delay the second birth could have been among other reasons (socio-economical hardships and continuation of education, etc) the majority in this study chose to end their pregnancies.

4.3.2.8 Item 16: How many times have you been pregnant before?

Table 4.12 below indicates the number of times respondents have been pregnant in the past. Only 46 respondents indicated the number of times of past pregnancies.

Table 4.12 How many times have you been pregnant before? (N=46)

How many times have you been pregnant before?	Frequency	Percentage
1	27	58.7
2	09	19.6
3	07	15.2
4	01	2.2
5	02	4.3
Total	**46**	**100.0**
Missing system	01	
Total	**47**	

Of the 46 respondents who answered this question, 59% (n=27) had been pregnant once before; 20% (n=9) 2 times; 15% (n=7) 3 times; 2.2% (n=1) 4 times and 4.3% (n=2) respondents had been pregnant 5 times before.

MacPhail et al (2007:5) state that contraceptive use among young South African women is associated with having been pregnant before. Women who reported previously been

pregnant were more likely to report using hormonal contraception. The reason for this finding, according to the same authors, is that it is only after first pregnancy that young women are educated on contraception and are offered contraceptive services with hormonal methods given preference.

This is also the finding reported by Nyakoe (2008:36) who shows that as parity increases, the number of women seeking TOP decreases progressively. The study reveals that of the 203 respondents requesting TOP, 35% were pregnant for the first time, followed by 32% who had had one previous live birth. Only one respondent was a para 9.

The findings of this report are similar to those produced in the study by Nyakoe (2008:38) although the vast majority were respondents who have been pregnant once; the number of women requesting TOP also decreased with only one (para 4) and 2 (para 5) requesting TOP.

4.3.2.9 Item 17: How many children do you have?

The number of live children is shown in table 4.12.

Table 4.13 How many children do you have? (N=46)

How many children do you have?	Frequency	Percentage
1	29	63.0
2	07	15.2
3	07	15.2
4	01	2.2
5	02	4.3
Total	**46**	**100.0**

Of the 46 respondents who had children, 29 (63%) had 1 child each, 7 (15.2%) had 2 each, another 7 (15.2%) had 3 each. only 1 had 4 children and 2 had 5 each.

The evidence shown by the findings confirm the results presented by other studies which reveal that most South African women delay the birth of a second child. Qualitative research indicates that educational aspirations are a significant reason for

women delaying a second birth in South Africa (Kaufman et al 2001, cited in Panday et al 2009:28). Two respondents had lost 1 child each.

4.3.2.10 Item 18: Did you think you could fall pregnant the first time you had sexual intercourse?

Table 4.14 reveals the answers to this question. A total of 56 respondents answered this question.

Table 4.14 Did you think you could fall pregnant the first time you had sexual intercourse? (N=56)

Did you think you fall pregnant the time you had sex?	Frequency	Percentage
Yes	34	60.7
No	22	39.3
Total	**56**	**100.0**

Of the 56 respondents who answered question 18, 60.7% (n=34) thought they could fall pregnant during first sexual intercourse and 39.3% (n=22) answered in the negative.

According to Prata, Morris, Mazive, Vahidnia and Stehr (2006:194), the relationship between perception of risk and sexual behaviour is complex and poorly understood. Kirby (2007, cited in Panday et al 2009:33) states that, “when young people perceive themselves to be at risk for pregnancy or HIV, they are more likely to adopt protective behaviours”. The same authors continue by stating that, despite having the competency to accurately identify the presence of risk, young people are not competent enough to evaluate the costs or results of been involved with the risk before taking it. Knowledge of conception and the fertile period is generally poor among young women regardless of their level of education. Substantial percentages of youth believe that sexual debut or occasional sex does not carry pregnancy risk. Common misconceptions or myths include among others: the belief that conception can only occur if the blood of sexual partners got used to the other's blood and this they believe can only occur through repeated coitus; multiple sexual partnership would prevent conception since blood was

not the same each time; and avoiding sex during menstruation as this is believed to be the fertile period.

4.3.3 Objective 2: Determine the knowledge of contraceptives of TOP clients

Questions which were used in the knowledge score were questions 19, 20, 22, 25, 26, 27, 28 and 29.

Table 4.15 below presents the distribution of contraception knowledge among the respondents.

Table 4.15 Distribution of contraception knowledge (N=61)

Knowledge of contraception		
N	Valid	61
	Missing	0
Minimum (score %)		4.00
Maximum (score %)		72.00
Percentiles	25th	12.0000
	50th	16.0000
	75th	24.0000

The median (50th percentile) knowledge of contraception score was 16% with an inter-quartile range from 12 to 24%. Scores ranged from 4 to 72%. Thus the distribution of knowledge was very wide, and on the whole the level of knowledge of contraception was very low.

4.3.3.1 Item 19: At which part of the menstrual cycle are women more fertile and therefore at risk of pregnancy?

Table 4.16 shows the answers to this question which was answered by 60 respondents.

Table 4.16 Part of the menstrual cycle women are more at risk of pregnancy? (N=60)

Which part of the menstrual cycle are women more fertile and therefore at risk of pregnancy?	**Frequency**	**Percentage**
During period	11	18.3
Mid-cycle	19	31.7
Just before period	21	35.0
Do not know	09	15.0
Total	**60**	**100.0**

Of the 60 respondents who answered question 19, only 31.7% (n=19) knew the most fertile period of a woman's menstrual cycle. The majority (35%, n=21) reported just before a period, 18.3% (n=11) thought during a period a woman is more fertile, and a further 15% (n=9) did not know when a woman was more fertile and at more risk of pregnancy.

In a study by Byamugisha, Mirembe, Faxelid and Gemzell-Danielsson (2006:196) on "EC and fertility awareness among university students in Kampala", the findings showed that, respondents' knowledge of the fertile period in the menstrual cycle is limited.

4.3.3.2 Item 20: Can you fall pregnant during a period?

Table 4.17 below illustrates the answer to this question. This question was answered by 60 respondents.

Table 4.17 Can you fall pregnant during a period? (N=60)

Can you fall pregnant during a period?	**Frequency**	**Percentage**
Yes	23	38.3
No	21	35.0
Do not know	16	26.7
Total	**60**	**100.0**

Table 4.17 above shows that 38.3% (n=23) thought that a woman could fall pregnant during a period, 35% (n=21) did not think so and 26.7% (16) of the respondents were unsure.

This finding shows that the respondents' level of knowledge of fertility was low as only 21 (35%) knew that the chances of conceiving during a period are very rare.

4.3.3.3 Item 21: Have you ever heard of contraceptives or family planning?

Table 4.18 illustrates the answer to this question which was answered by all 61 respondents.

Table 4.18 Have you ever heard of contraceptives or family planning? (N=61)

Have you ever heard of contraceptives?	Frequency	Percentage
Yes	54	88.5
No	7	11.5
Total	**61**	**100.0**

Eighty-nine percent (88.5%, n=54) of the 61 respondents reported having heard of contraceptives and only 11.5% (n=7) of respondents had never heard of contraceptives or family planning before.

According to the WHO's (2007a:5) fact sheet, knowledge of contraception, that is, knowing of at least one modern method of averting pregnancy is universal among married women aged 20-24 while 94% of the 15-19 age group are conversant with contraceptives.

The 1998 South African Demographic and Health Survey (SADHS) reports almost universal knowledge of modern methods of contraception among unmarried sexually-active women (99.2%) and similar high percentages of knowledge of the pill (96.4%) and condoms (94.3%). Slight lower levels of contraception knowledge (85%) of modern contraception are reported among sexually-inexperienced women in the study (Panday et al 2009:31). The 2003 SADHS shows similar findings but there has been a decline in the level of knowledge of contraceptive methods since 1998, and also a decline in the proportion of women who have ever used contraception (Nyakoe 2008:21-22).

4.3.3.4 Item 22: If yes, which method/s have you heard of?

Table 4.19 illustrates contraceptive method/s which respondents had heard of. All 61 respondents answered this question.

Table 4.19 Contraceptive method/s respondents have heard of (N=61)

Contraceptive method/s respondents heard of			
Mini pills	No	55	90.2
	Yes	6	9.8
Combined pills	No	56	91.8
	Yes	5	8.2
Condom	No	28	45.9
	Yes	33	54.1
Loop/coil	No	54	88.5
	Yes	7	11.5
Nor-plant	No	53	86.9
	Yes	8	13.1
Injection	No	32	52.5
	Yes	28	45.9
Sterilisation	No	46	75.4
	Yes	15	24.6
Diaphragm	No	58	95.1
	Yes	3	4.9
Calendar method	No	53	86.9
	Yes	8	13.1
Withdrawal method	No	56	91.8
	Yes	5	8.2
Rhythm method	No	53	86.9
	Yes	8	13.1
Body temperature method	No	58	95.1
	Yes	3	4.9
Cervical mucus change	No	59	96.7
	Yes	2	3.3
Foam/jelly/spermicide	No	60	98.4
	Yes	1	1.6
LAM	No	54	88.5
	Yes	7	11.5
Abstinence	No	52	85.2
	Yes	9	14.8
Other	No	61	100.0
	Yes	0	0.0

The condom was the most popular method (54.1%, n=33) followed by the injection (45.9%, n=28). It is amazing that the pill (both mini and combined respectively) was not among the popular listed methods. Only 9.8% (n=6) and 8.2 (n=5) reported having heard of the mini and combined pills method. The least known method was the foam/jelly or spermicide. The popularity of the condom could have been as a result of increasing emphasis placed on the promotion of condom use especially among teenagers for both STIs and pregnancy protection. Condom use has been identified as a more effective strategy in the fight against HIV/AIDS epidemic SSA is currently facing.

Kistnasamy, Reddy and Jordaan (2009:425) state that the condom was the most popular method of contraception given in response to the question "do you or your partner use any form of contraception during sexual intercourse?" Over 50% of sexually active respondents reported preferring the condom while only 15% used the pill or injection.

4.3.3.5 Item 23: Sources of information

Figure 4.4 graphically reveals respondents' sources of information on contraceptives.

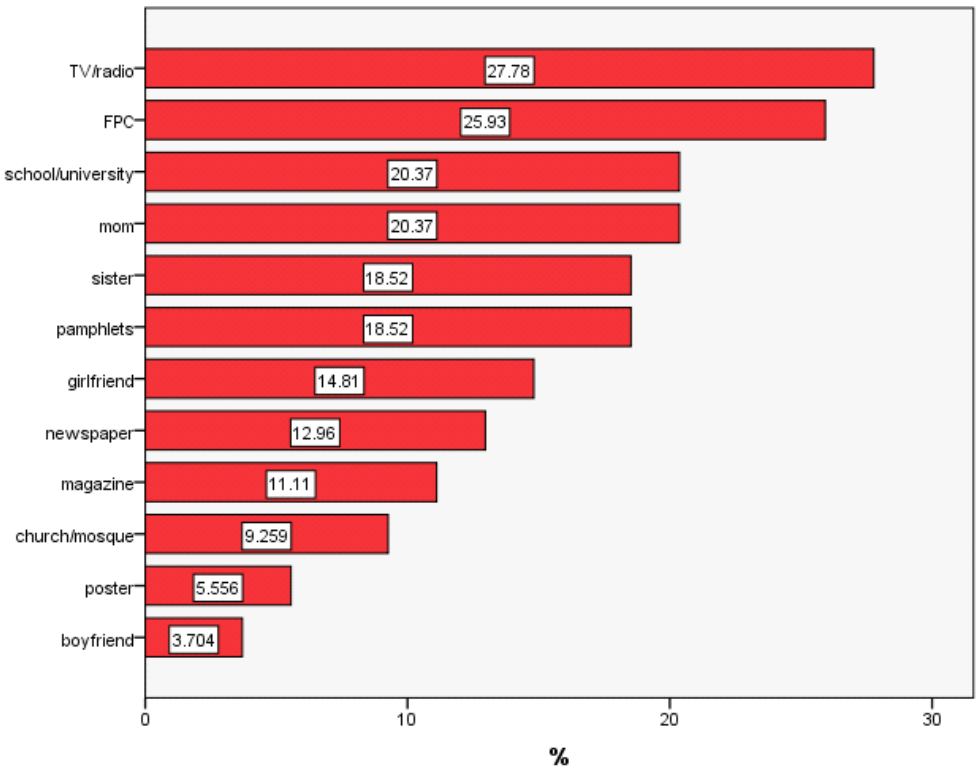

Figure 4.4 Sources of information

This question was answered by all 61 respondents. The majority (27.8%, n=17) mentioned TV/radio as source of information, followed by 25.93% (n=16) who mentioned maternal and child health facilities (FPC) while 20.37% (n=12) cited school as a source of information. Family also were among the top sources; 20.37% (n=12) mentioned their mother and 18.52% (n=11) cited a sister as sources.

Studies have shown that child-parent communication plays an important role in young women's decision making pertaining to sexuality. Gordon (1996, cited in Panday et al 2009:35) states that, the family influences young adults' early belief systems and values, and behaviour. Therefore adolescents or young women whose parents are clear and open about sex issues are less likely to have sex at an early age.

The least popular sources were the boyfriend (4%), posters (6%) and the church (9%). It is not surprising that the church is among the least popular sources as many churches or religions do not permit use of contraception as it is considered sinful.

A review of 7 qualitative studies by Williamson et al (2009:8), reveals that male partners manipulate, force, threaten and even use violence to get young women not to use contraception. This is particularly the case with condoms which some of the young women's partners do not want to use because they reduce sexual pleasure. This could be one of the reasons for not citing the male partner as a source of information.

4.3.3.6 Item 24: Have you heard of emergency contraception (EC) before?

Table 4.20 illustrates the answers given to question 24 which was answered by all 61 respondents.

Table 4.20 Have you heard of EC before? (N=61)

Have you heard of EC before	Frequency	Percentage
Yes	46	75.4
No	15	24.6
Total	61	100.0

Table 4.20 shows that 75.4% (n=46) of 61 respondents had heard of emergency contraception before. The finding of this report is somehow amazing as most studies conducted in SSA countries including South Africa show that knowledge of emergency contraception is low.

In a study on "knowledge, practices, and attitudes of emergency contraception among university students in KwaZulu-Natal", Hoque and Ghuman (2012:5) observe that, overall, 49.8% of the respondents had heard of emergency contraception prior to the study. The same authors report that the percentage was lower than that in the previous study (56.5%) conducted among other tertiary students in the same region. Further on according to the same authors, many other studies conducted among universities reflect higher rates; for example, Cameroon (63%), Ghana (51.4%), Nigeria (67.8%), Nepal (66%), Mexico (95%), the USA (94%) and another South African study among young women aged 15–24 attending public sector health facilities a low of 17%.

A South African survey conducted among (n=310) women requesting termination of pregnancy in two hospitals ("rural" and "urban") by Robert (2007:41) shows that, among women interviewed at the rural hospital, 23.8% of women mentioned emergency contraception as a method of contraception whereas none at the urban hospital did so.

4.3.3.7 Item 25: Which of the following methods of EC have you heard of?

Table 4.21 illustrates the methods of EC respondents knew about. Only 44 respondents answered this question.

Table 4.21 Methods of EC respondents heard of (N=44)

Methods of EC respondents heard of	Frequency	Percentage
Loop	05	10.9
Morning after pill	39	84.8
Total	44	95.7
Missing system	02	4.3
Total	**46**	**100.0**

Most of those who were aware of EC, knew about the morning after pill (84.8%, n=39), and only 10.9% (n=5) knew about the loop. Two (4.3%) of the 44 respondents who have heard of EC did not specify the method/s they were aware of. It is not surprising that respondents mentioned the morning after pill as the method they had heard of given that the loop is not among the popular methods used for regular birth control in most of the public facilities.

Stephenson, Beke and Tshibangu (2008:63) in a study on "community and health facility influences on contraceptive method choice in Eastern Cape" explain that, first, women who are autonomous (working) and living in wealthier communities are more likely to be using either a pill or more permanent methods of contraception rather than the injection; second, women living in communities with well-staffed (especially more doctors) and equipped health facilities are more likely to be using the loop and the male /female sterilisation methods rather than the injection. The majority of the South African women depend on Primary Health Care (PHC) facilities for family planning services. PHC facilities are nurse "driven" facilities. This shows why the loop is not so common as most of the PHC trained registered nurses need additional training to equip them with the necessary skills for inserting a loop. Most loops (50%) currently are inserted by private sector doctors (Osman 2012).

4.3.3.8 Item 26: If you have unprotected sexual intercourse, up to how many hours do you have to take the emergency contraception pill (ECP)?

Table 4.22 reveals the answers given by 45 respondents to question 26.

Table 4.22 Up to how many hours do you have to take ECP? (N=45)

Up to how many hours do you have to take ECP after unprotected sexual intercourse	Frequency	Percentage
Up to 12 hours	15	33.3
Up to 24 hours	09	20.0
Up to 48 hours	02	4.4
up to 72 hours	03	6.7
Up to 1 week	02	4.4
Do not know	14	31.1
Total	**45**	**100.0**

Correct response scores were 6.7% (n=3). Over one third (33.3%, n=15) thought one had up to 12 hours to take ECP after exposure to unprotected sex; 20% (n=9) reported 24 hours and 31.1% (n=14) of the women did not the time limit. Only 2.1% (n=1) reported 7 days as the time limit.

4.3.3.9 Item 27: If you have unprotected sexual intercourse, up to how many hours/days do you have to get a loop inserted?

Table 4.22 shows respondents responses to the time limit of using an IUD as a form of EC. This question was answered by 47 respondents.

Table 4.23 Up to how many hours/days do you have to get a loop inserted? (N=47)

Time limit for inserting a loop after unprotected sexual intercourse	Frequency	Percentage
Up to 24 hours.	07	14.9
Up to 72 hours.	01	2.1
Up to 05 days.	03	6.4
Up to 07 days.	01	2.1
Do not know.	35	74.5
Total	**47**	**100.0**

Like question 26, correct response score for this question was 6.4% (n=3). Seven (14.9%) respondents thought they needed up to 24 hours; 2.1% (n=1) reported 7 days, another 2.1% (n=1) reported up to 72 hours. A staggering 74.5% (n=35) did not know the time limit for having a loop inserted.

The results of questions 26 and 27 show low knowledge of EC among women seeking voluntary TOP. According to Ellertson, Shochet, Blanchard and Trussell (2000; cited in Myer, Mlobeli, Smith & Morroni 2007:14), overall, EC awareness is lower in South Africa than recent data from Europe and North America reflects. A more recent study by Hoque and Qhuman (2012:5), reveals a lack of knowledge of EC. In this study, 29.7% did not know the correct time limits.

4.3.3.10 Item 28: How effective is EC in preventing pregnancy compared to other contraceptives?

Table 4.24 reveals the effectiveness of EC compared with other contraceptives. This question was answered by 45 respondents.

Table 4.24 How effective is EC in preventing pregnancy compared to other contraceptives? (N=45)

How effective is EC in preventing pregnancy compared to other contraceptives?	Frequency	Percentage
Less effective than others	2	4.4
Same as others	7	15.6
More effective than others	7	15.6
Not effective at all	0	0.0
Do not know	29	64.4
Total	**45**	**100.0**

The findings show that 4.4% (n=2) thought EC is less effective than other methods of contraception; 15.6% (n=7) thought it is more effective than other methods; another 15.6% (n=7) regarded EC as just like other methods and none (0%) thought it was not effective at all. Although zero percent of the respondents thought EC is not effective, the majority (64.4%, n=29) who responded to this question were ignorant of whether it is effective.

Smit et al (2001, cited in Maharaji and Rogan 2007:31−32) state that even women who had heard of EC were often misinformed about its attributes and many women were not aware of its indications.

4.3.3.11 Item 29: Which of the following contraceptive methods also protect you from STIs?

Table 4.25 illustrates contraceptive methods that offer protection from STIs. All 61 respondents answered this question.

Table 4.25 Which contraceptive method/s also protect you from STIs (N=61)

Which contraceptive method also protects you from STIs?		Frequency	Percentage
Contraceptive pills	No	57	93.4
	Yes	04	6.6
Loop	No	61	100.0
	Yes	00	0.0
condoms	No	13	21.3
	Yes	48	78.7
Abstinence	No	48	78.7
	Yes	13	21.3
Injectables	No	58	95.1
	Yes	03	4.9
Withdrawal method	No	61	100.0
	Yes	00	0.0

Knowledge scores for the two methods which can be used for protection from STIs were at 78.8% for the condom and 21% (n=13) for abstinence. All the respondents knew that the loop and withdrawal methods could not be used for protection from STIs. However, the contraceptive pills and injections were mentioned as methods that could be used as protection against STIs (6.6% [n=4] and 4.9% [n=3] respectively).

Waiting till one is ready to have sex with one faithful HIV negative or free of other STIs partner is best for young women given that condoms are not 100% safe. However, if one cannot wait condoms can be used because condoms offer dual protection against pregnancy and STIs, and are among the most effective means of preventing the transmission of HIV. In a study of 546 prostitutes in the United States of America, 11% of the 524 prostitutes who reported having unprotected vaginal intercourse were HIV positive. None of the 22 prostitutes whose clients used condoms in episodes of vaginal intercourse was HIV positive (Centers for Disease Control [CDC] 1987, cited in Olatunji 2004:14; Maharaji 2006:28).

4.3.4 Objective 3: Determine factors influencing use of contraceptives before pregnancy

4.3.4.1 Item 30: Have you ever used any contraceptive before?

Table 4.26 reveals previous use of contraceptives. Only 56 respondents answered this question.

Table 4.26 Have you ever used contraceptives before (N=56)

Have you ever used contraceptives before	Frequency	Percentage
Yes	44	78.6
No	12	21.4
Total	**56**	**100.0**
Missing system	5	-
Total	**61**	-

The remainder of the analysis is confined to those respondents who had used contraceptives before (78.6%, n=44). Seventy-nine percent (n=44) of the respondents who answered the question had used contraceptives before and 21.4% (n=12) had never used contraception.

Overall the prevalence rate of contraception use in South Africa is at 65% and is among the highest in SSA countries. The major form of contraception use consists of modern methods of contraception (NDoH 2006, cited in Maharaji & Rogan 2007:27; Osman 2011).

4.3.4.2 Item 31: If yes, which method/did you use?

Figure 4.5 graphically presents percentage of respondents who used a particular form of contraceptive before.

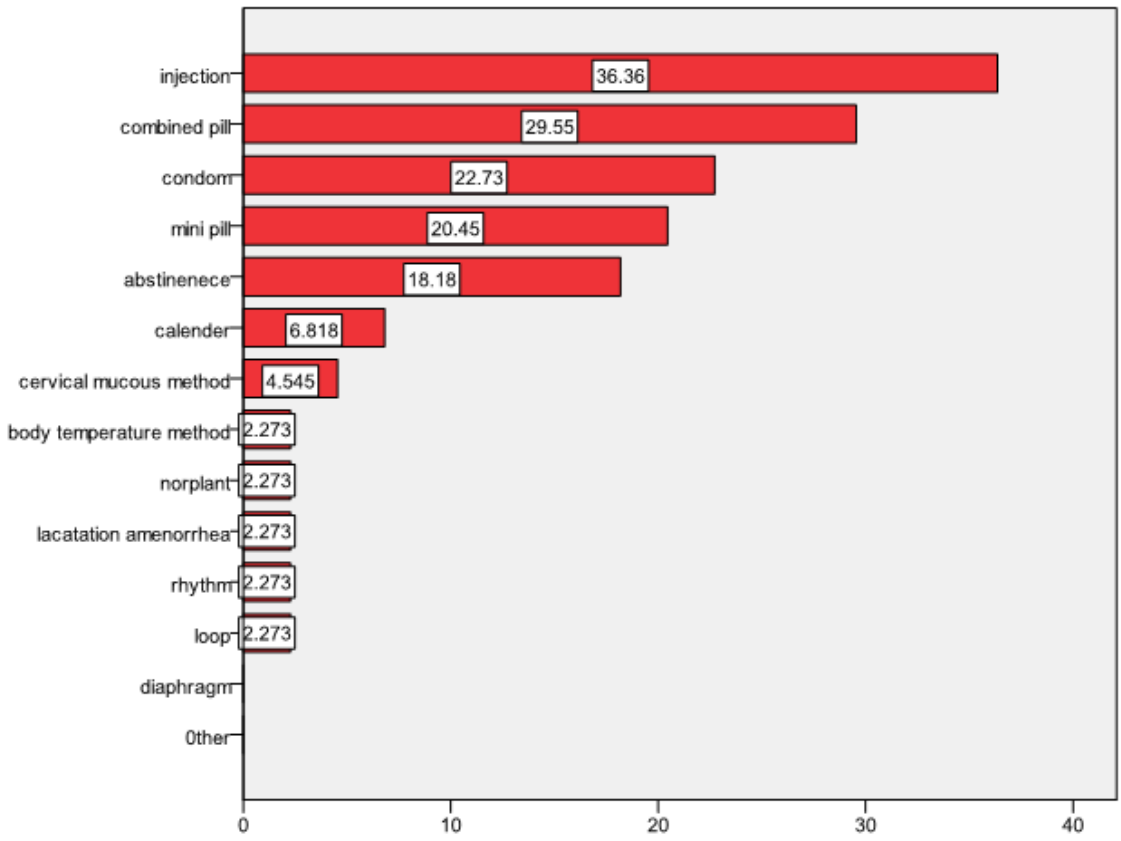

Figure 4.5 Percentage of respondents who used a particular form of contraceptive

Of those (n=44) who reported having used contraceptives before, the most frequently used form was the injection (36.4%) followed by combined pill (29.6%) and condom (22.7%). According to the 1998 Demographic and Health Survey (DHS), 30% of sexually active women use injection form of contraception (Maharaji 2006:28).

Prior studies have shown that, women who rely on public services for contraception are more likely to use the injection and pill forms of contraception including condom. A study by Gready, Klugman, Xaba, Boikanyo and Rees (2000:25) shows that, 85% of women attending gynaecologists and general practitioners indicate that their method mix consisted predominantly of the pill, intrauterine devices and female sterilisation regardless of race. However, the vast majority of women attending public facilities are given injectables as their first option. Several women attending public facilities describe health workers in these facilities as “pushing depo”.

As in other parts of Africa, young South African women are at increased risk of contracting HIV infection. In this context, promotion of dual protection has played a critical role as more sexually active females are increasingly using condoms. According to Panday et al (2009:30), condom use has increased dramatically since the 1990s. The 1998 SADHS reported that only 7.6% of sexually-active females aged 20-24 years used a condom at last sex. This increased to 47% in the 2002 SABMM survey and 55.7% by the 2005 SABMM survey. Similarly, the 2003 RHRU survey showed that 52% of youth who reported ever having had sex had used a condom at last sex. The proportion had increased to 62% in the 2006 Kaiser/SABC survey. Lovelife (2012:9) reported that, of those who had had sex, 94.2% of young people had ever used a condom-more specifically 96.6% and 91.8% for males and females respectively.

4.3.4.3 Item 32: What factor/s influenced your choice?

Table 4.27 illustrates factors that influenced choice of contraception. This question was answered by 44 respondents.

Table 4.27 Factors influencing respondents' choice of contraception (N=44)

Factors influencing their choice of contraception		**Frequency**	**Percentage**
Cheaper	No	40	90.9
	Yes	04	9.1
Partner	No	38	86.4
recommended	Yes	06	13.6
Easy to use	No	26	59.1
	Yes	18	40.9
Friend advised	No	39	88.6
	Yes	05	11.4
Close friend using	No	42	95.5
	Yes	02	4.5
Adverts	No	44	100.0
	Yes	00	0.0
asy to obtain	No	41	93.2
	Yes	03	6.8
Did not affect	No	41	93.2
libido	Yes	03	6.8
Other	No	44	100.0
	Yes	00	0.0

The factors which influenced their choice of contraceptives are shown in table 4.27. Most frequently it was ease of use that influenced their choice (41%, n=18). Unlike the pill which needs taking daily, the injectable user visits the family planning facility 4 to 6 times per year for re-injections. This could have been the reason for the majority of respondents perceiving it as easy to use.

A recent study by Crede, Hoke, Constant, Green, Moodley and Harries (2012:197) reveals that current use of contraception among postpartum HIV positive and negative women in Cape Town was at nearly 99% and the vast majority of women in both samples were using short acting methods, primarily the 3-monthly-injectable, depo provera. Among these women the four most common cited reasons for the method choice were convenience, provider recommendation, absence of side effects and effectiveness in preventing pregnancy.

4.3.4.4 Item 33: Where were you getting your contraceptive?

Figure 4.6 graphically provides information on where the 44 respondents who had used contraceptives before obtained the contraceptives.

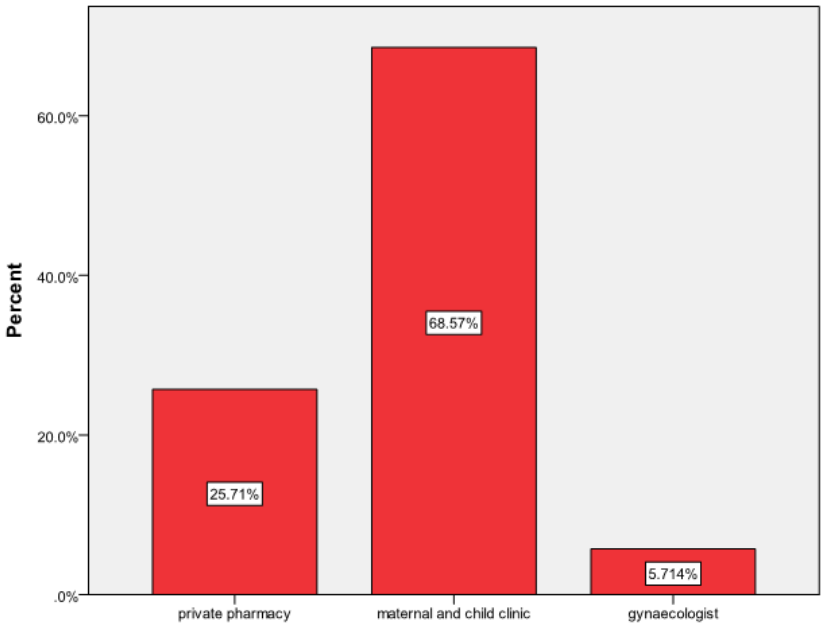

Figure 4.6 Where respondents getting contraceptives

The results in figure 4.6 show that the majority of the 44 respondents, were obtaining their contraceptives from the maternal and child health clinic (68.6%, n=30), 25.71% (n=11) obtained contraception from the private pharmacy and the remaining 5.71% (n=3) from gynaecologists.

Black people account for 77% of South Africa's total population and the majority (61%) of them live in poverty. Stephenson et al (2008:66-67) demonstrate that there is a relationship between the community one lives in and the available choice of methods. "Choice of contraceptive method follows racial stratification: whites, who rely less on public family planning services, utilise a wider range of modern contraceptive methods whereas the black and colored populations rely heavily on the injection, which accounts for 35% and 25%, respectively, of their method use," and hence linking the injection to public facilities as the source of contraception.

4.3.4.5 Items 34: Were you using contraceptives when you fell pregnant?

Table 4.28 illustrates possible contraceptive use when pregnancy occurred. Only 41 of the 44 respondents answered this question.

Table 4.28 Were you using contraceptives when you fell pregnant (N=41)

Were you using contraceptives when you fell pregnant?	Frequency	Percent
Yes	30	73.2
No	11	26.8
Total	**41**	**100.0**
Missing system	3	-
Total	**44**	-

The results show that the majority (73.2%, n=30) were using contraception at the time they fell pregnant and 26.8% (n=11) were not.

4.3.4.6 Item 35: If answer to question 34 is yes, then how did you fall pregnant? Twenty-nine respondents answered this question

Table 4.29 illustrates the reasons for pregnancy among 29 respondents who were using birth control.

Table 4.29 Reasons for pregnancy in those using contraceptives (N=29)

Reasons for pregnancy in those who were using contraceptives	Frequency	Percentage
Missed a pill or 2	05	17.2
Boyfriend refused to wear condom	06	20.7
Missed injection appointment	09	31.0
Condom burst	08	27.6
Not using condom consistently	01	3.4
Total	**29**	**100.0**
Missing system	01	-
Total	**30**	-

Of the 29 respondents who were using contraceptives when they fell pregnant, the majority 31% (n=9) missed injection appointment; 27.6% (n=8) had a condom burst, 20.7% (n=6) boyfriend refused to use a condom; 17.2% (n=5) missed a pill or two and the remaining 3.4% (n=1) used the condom inconsistently.

Condoms must be used both consistently and correctly in order to achieve the maximum protective effect. Inconsistent use can lead to STIs acquisition or pregnancy because transmission/conception can occur with a single act of intercourse (Centers for Disease Control and Prevention [CDC] 2012:1). During the first year of typical use, the effectiveness of condoms is 88-98% and depends on correct and consistent use (KZN DoH 2004:41). Therefore, condoms must always be used in-conjunction with a highly effective hormonal contraception method. Condom use in south Africa is increasing with the percentage of adults aged 15-49 using a condom at last sex growing from 31% in 2001 to 64.8% in 2008 (Avert 2012).

For women who have achieved the desired family size or want to avoid pregnancy for a certain period, the injectable and pill contraceptives (including condoms) may not be ideal. The reason for this is that method effectiveness is dependent on daily dosing at the same time for the pill and/or timely visits four to six times per year for re-injections. Success when using these methods is dependent on consistent use of the method. Previous research has shown that, in South Africa, a substantial number of women who use the injection form of contraception return late for re-injection (Crede et al 2012:197). Therefore, there is a need for consideration of long term or permanent method use in public health facilities (IUDs, implants and sterilisation of both males and females).

4.3.4.7 Item 36: Have you ever used a condom before?

Table 4.30 shows previous condom usage among 31 respondents who answered this question.

Table 4.30 Have you ever used a condom before (N=31)

Have you ever used a condom before?	**Frequency**	**Percentage**
Yes	27	87.1
No	04	12.9
Total	**31**	**100.0**
Missing system	13	-
Total	**44**	**-**

Of those who had used contraceptives before, 87.1% (n=27) had used a condom before and 12.9% (n=4) had not. The findings of this study are in line with those of other recent studies. Lovelife (2012:9) reports that young people are still not consistent with condom use but despite the inconsistency, of those who had had sex, 94.2% of young people had used a condom in the past. This percentage was slightly higher for men (96.6%) than women (91.8%).

4.3.4.8 Item 37: If no, what is or are the reason/s for not using a condom?

Table 4.31 presents the reasons for not using condoms among the 4 respondents who had not used condoms before.

Table 4.31 Reason/s for not using a condom (N=4)

Reasons for not using a condom	**Frequency**	**Percentage**
Had only one sexual partner	01	3.2
Boyfriends' objection	03	9.7
Other	00	0.0
Total	**04**	**12.9**

Three (9.7%) respondents who had never used a condom before gave a reason of having only one sexual partner and 3.2% (n=1) reported boyfriend's objection to using condoms. The HIV/AIDS pandemic has taken a grave toll on SSA where AIDS is the prime cause of death despite different prevention strategies (Elbe 2002; cited in Mswela 2009:172/360). South Africa has one of the largest numbers of people living with HIV/AIDS of any country in the world-an estimated 4–6 million (Maharaji 2006:28). The overall general population prevalence as estimated by WHO/UNAIDS is at 17.9% and the number of people living with HIV in South Africa for 2010 at 5.575 million. The highest prevalence was recorded in KZN which increased from 38.7% in 2008 to 39.5% in 2009 and stabilised at 39.5% in 2010 (The National Antenatal Sentinel HIV and Syphilis Prevalence, South Africa 2010).

In this context, the promotion of dual protection-simultaneous protection against unwanted pregnancy and HIV and other STIs-plays an important role in public health interventions (Maharaji 2006:28). The condom is the only barrier method which can both prevent pregnancy and STIs including HIV/AIDS. However, a condom is a male-determined method: it is usually the man who determines whether or not to use it (Chimbindi, McGrath, Herbst, Tint & Newell 2010:93). Also, the use of the condom is influenced by the length of the relationship-the longer a relationship lasts, the greater the likelihood that condom use will be discontinued (Maharaji 2006:29). Therefore, emphasis must be placed on dual contraception so that even if the male partner refuses to wear the condom or if it bursts, the woman remains protected from conceiving.

4.3.4.9 Item 38: If the answer to question 34 is no, what are the reasons for not using contraception?

Table 4.32 reveals the reasons for not using contraception at the time of current pregnancy. This question was answered by 7 respondents.

Table 4.32 Reasons for not using contraception at time of conception (N=7)

Reasons for not using contraception at the time of current pregnancy	Frequency	Percentage
Had no knowledge of contraception	03	42.9
Had sexual intercourse infrequently	02	28.6
Thought it was for married couples	01	14.3
Religion does not allow contraception	01	14.3
Total	**07**	**100.0**
Missing system	04	**-**
Total	**11**	**-**

The 7 respondents who had not been using contraceptives at the time of conceiving gave the following reasons for not doing so. Most (43%, n=3) of them had no knowledge of contraception; while 29% (n=2) reported having infrequent sexual intercourse as a reason; 14.3% (n=1) reported that contraception is for married couples only and a further 14.3% (n=1) cited religious grounds. The remaining four were not included in the analysis as they did not state their reasons.

4.3.4.10 Item 39: What would you like to know about contraception?

An estimated 87% (n=53) responded to this item. The issues respondents raised fall under the following broad categories:

4.3.4.10.1 Side effects

The most mentioned were weight gain, amenorrhea associated with the injection, nausea and vomiting in the case of the pill and not forgetting the frequently mentioned side effect-water in the vagina.

4.3.4.10.2 Action of contraceptives

The majority wanted to know how contraceptives work and if they do work how one falls pregnant.

4.3.4.10.3 Future fertility

Some respondents expressed their concern over future fertility.

4.3.4.10.4 Post-abortion contraception

Respondents wanted to know if besides the hormonal contraceptives tubal ligation could be offered.

4.3.4.10.5 Condoms

Some respondents wanted to know if it was possible for one to use only a condom as a contraceptive. Another respondent wanted to know what would happen if a man ejaculated and continued to have sex using the same condom. Would the sperm in the condom come out and cause pregnancy?

The findings of this study show that overall, respondents' knowledge levels were very low. Respondents did not know how contraception works in order to prevent pregnancy. Concerns such as water in the vagina, amenorrhea, weight gain were amongst most of the raised issues. Health workers do not provide much information during counseling as shown by questions such as:"What are the instructions for using injection and what must I do if I miss my injection appointment?" Concerns regarding future fertility were also raised as respondents thought contraception could lead to infertility because of the amenorrhea as in the case of injectables. The reason for this is that most respondents believed that a woman is more fertile during a period. This is also an indication of lack of knowledge of a woman's menstrual cycle in-relation to the fertile period. Some respondents wanted to know if male contraception is possible. Another indication that today's society needs to involve men in issues related to contraception and also that a variety of methods must be accessible especially in public facilities. It was evident that respondents want long-acting methods/permanent methods, a desire evident in questions such as: How does fertility return after 5 years of using Depo injection? Is sterilisation an option post-abortion?

4.4 OVERVIEW OF RESEARCH FINDINGS

This was a cross-sectional study conducted among 61 respondents with a response rate of 100%. The majority of the respondents where young women between the ages of 18 and 27 years. The major findings of this study are as follows:

- The mean age at first sex has remained steady, 18 years as shown by other studies.
- The prevalence of sexual intercourse among the respondents is very low and frequency mostly once a month (40% of respondents).
- The median knowledge of contraception score is 16% with an inter-quartile range from 12 to 24%.
- Scores ranged from 4 to 72%. Thus the distribution of knowledge is very wide and on the whole, the level of knowledge about contraception is very low; 79% had used contraceptives before with the injectables continuing to be the most used form of contraception.

4.5 CONCLUSION

This chapter discussed the methods and procedures used for the data analysis, presentation and description of the research findings. IBM SPSS version 19 was used to analyse the data. Responses were described using frequency tables and bar charts in the case of categorical variables, and summary statistics such as the median, inter-quartile range and range in the case of non-normally distributed continuous variables were employed. Knowledge was scored by summing the correct responses to the knowledge questions and expressing the scores as a percentage correct out of a total of 25 possible points. Questions used in the knowledge score were: Q19, Q20, Q22, Q25, Q26, Q27, Q28 and Q29. Since knowledge score was significantly skewed, non-parametric statistics were used to describe this variable.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the final chapter of this study investigating the knowledge, utilisation of contraceptives and sexual activity among women who have terminated pregnancy at the Prince Mshiyeni Memorial Hospital's (PMMH) TOP clinic, conclusions and recommendations of the study are presented. This facility was chosen for this study as the site for data collection because it is the busiest TOP clinic in KZN (Naude 2002:32).

The researcher summarised and interpreted the study findings with reference to the study objectives which were:

- Investigate sexual activity prevalence among voluntary TOP clients at PMMH's TOP clinic.
- Determine knowledge of contraceptives of TOP clients.
- Determine factors influencing use of contraception before pregnancy.

5.2 RESEARCH FINDINGS

The majority of the women from the sample were young women between the ages of 18 and 27 years (18–22 years, 34.4% [n=21]; 23-27, 34.4% [n=21]). The majority of them were either still in high school (28.1%, n=16), or had just completed grade 12 (31.6%, n=18), and/or were undergoing further schooling in tertiary institutions (21.1%, n=12). Most were single (91%, n=56), lived with both parents (33.33%, n=20) and were dependent on government grants as their source of income (36.1%, n=22). These women were all black Africans.

5.2.1 Sexual activity

The mean age at menarche was fourteen years and sexual debut was at eighteen years. Overall, sexual activity frequency among the respondents was very low (once a month for one third (40%, n=21) of the respondents, followed by once a week (36.5%, n=19).

The majority of these women had only one sexual partner who were in most cases between two and six years older than the women. According to Kirby (2007, cited in Panday et al 2009:30), young women who have sex with older partners are at increased risk of engaging in sexual activity, not using contraception, contracting sexually transmitted infections (STIs) and becoming pregnant.

In this study the majority of respondents (81%, n=47) had been pregnant once before. South African women delay the birth of a second child because It is only after first pregnancy that young women are educated on contraceptives. They are then offered contraceptive services with preference to hormonal contraceptives (MacPhail et al 2007:5).

5.2.2 Knowledge of contraceptives among TOP clients

Three quarters of the respondents (75.4%, n=46) had heard of emergency contraception and only 11.5% (n=7) had not heard of contraception in general.

The condom was the most popular method (54.1%, n=33) of contraceptive heard of followed by the injection (45.9%, n=28). Despite 88.5% and 75.4% of respondents having heard of both EC and contraceptives in general, knowledge of contraception on the whole was very low.

In a study among university students in KZN, Kistnasamy et al (2009:425) reveal that even though most students were aware that EC involved taking pills post-coitally, they were neither familiar with the most effective time frames for taking ECPs nor with the side effects associated with its use.

According to Nyakoe (2008:21-22), knowledge of contraceptive methods has declined since 1998 and the proportion of women who have ever used contraception has also declined.

5.2.3 Factors influencing the use of contraceptives

A high percentage (79%, n=44) had used contraceptives before and 36% of the 44 respondents used the injection form. The reason for this choice was ease of use (41%, n=18).

Stephenson et al (2008:66-67) demonstrated that there is a relationship between the community one lives in and the available choice of methods. "Choice of contraceptive method follows racial stratification: Whites, who rely less on public family planning services, utilise a wider range of modern contraceptive methods, whereas the black and colored populations rely heavily on the injection, which accounts for 35% and 25%, respectively, of their method use," hence linking the injection to public facilities as the source of contraception. The study population was all black Africans from Umlazi township and the majority were dependent on Government grants hence their reliance on injectable method for family planning as the majority obtained the contraceptives from public facilities.

5.3 RECOMMENDATIONS

5.3.1 Recommendations for improving reproductive health services and contraception

Unintended pregnancy is a problem worldwide and is the primary reason for termination of pregnancies (Mqhayi et al 2004; Smith et al 2009:3). This is an area that, therefore, needs attention.

5.3.1.1 Improving access to facilities which offer reproductive health and contraception services

There is a need to improve access to Contraceptive service delivery in this community so as to address the unintended pregnancy problem especially among young women. According to Smith et al (2009:6), access to safe and voluntary family planning counselling and services significantly reduces unwanted pregnancy and rate of TOP.

5.3.1.2 Comprehensive health education on reproductive health and contraception

There is a need for comprehensive health education on reproductive health and contraception including emergency contraception in the study context. All learning institutions from lower primary school to higher education institutions should be included in reproductive health education in this township. The results show that the level of knowledge of the reproductive system and contraception is low. Persons at facilities that can assist with health education, like those from churches and clinics should be involved. Services of school health nurses who could do this kind of health education need to be re-introduced if not already in existence. Schools need to collaborate and work closely with community health workers who give reproductive health education.

5.3.1.3 Introduction of youth friendly reproductive health services

Despite all the efforts by the Department of Health to introduce youth friendly services, it is apparent from the findings of this study that these services are not meeting the needs of young women. The majority of TOP seekers in the community under investigation were young. There is a need for rescheduling of contraception and reproductive health services in this community so as to meet the needs of young women, for example, extending service hours or working on weekends. Extensive evidence has demonstrated that, when modern contraceptives are made available to women, their increased use over time replaces previous reliance on abortion and becomes the major factor associated with reduced abortion rate (Deschner & Cohen 2003:7).

5.3.1.4 Promotion of dual method

As in other parts of Africa, South African young women are at increased risk of contracting HIV infection. In this context, promotion of dual protection would play a critical role. It is believed that 50% of the Umlazi residents are HIV positive (Ecumenical and Interreligious Institute 2007). Other studies put the HIV prevalence at more than 50% (Bishop Farrell 2007).

Condoms must be made available in all learning institutions and other institutions visited regularly by young persons. According to the WHO (2004:1), in most settings, sexual activity begins during adolescence among many young people. At this stage, much of sexual activity is risky-contraception use is often erratic, and unwanted pregnancy and unsafe abortions are observed in many settings.

The majority of respondents in this study became sexually active after puberty. According to Biddlecom et al (2007:21), today, worldwide, adolescent reach puberty at a younger age than previous generations did because of improved nutrition, health and socioeconomic conditions. It is because of lack of knowledge or inadequate information about contraception that young women are at risk of falling pregnant and contracting the HIV infection.

5.3.1.5 Provision of long term or permanent contraception methods in public facilities

Previous research has shown that, in South Africa, a substantial number of women who use the injection form of contraception return late for re-injection (Crede et al 2012:197). Therefore, there is a need for consideration of long-term or permanent methods use in public health facilities, for example, IUDs, implants and sterilisation of both males and females. It is recommended that Primary Health Care (PHC) nurses be trained in IUD insertion as IUDs are predominantly inserted by the private sector (Osman 2011). Nor-plants implants-a sub-dermal implant designed to release levonorgestrel over a period of five years-also needed to be introduced in South Africa's government health facilities. Currently, nor-plant is not available in South Africa (Grobler 2003:98).

5.3.1.6 Use mass media to disseminate HIV/AIDS, reproductive health and contraceptive information

Most of the mass media campaigns are on use of condoms for the prevention of STIs and more specific HIV infection (for example Soul city, Love life, etc). Many of the billboards in Umlazi carry HIV/AIDS prevention messages. Mass media could be used to intensify campaigns on reproductive health too. Mass media campaigns should be presented in an integrated form, for example, include information on HIV, reproduction health and contraception. Integrated programs may have greater potential to meet women's overall reproductive health than stand-alone programs (Smith et al 2009:13).

5.3.1.7 Create demand for family planning

Creation of a family planning demand through education and behaviour change programs should be made a priority in this community. The programs should aim at increasing the understanding and acceptability of contraception and dispelling misconceptions about contraceptive methods (Smith et al 2009:21). The whole community should be involved, for example, churches, schools, etc.

5.3.2 Recommendation for further research

It is recommended that further research be conducted on the following topics:

- A similar study in the form of interviews to be conducted at the same hospital but this time to include the illiterate women.
- Determination of contraception level of knowledge among school-going young women.
- Determination of knowledge level of emergency contraception among learners in this community.
- Identification of whether the child support grant is a motivating factor for child birth in this community.
- Determination of nurses' attitudes as a major barrier to young women's access to reproductive services.

- Parental roles towards empowering girls with knowledge about sexual and reproductive health issues.
- Transactional sex as the determinant towards under-utilisation of contraceptives.

5.4 LIMITATIONS OF THE STUDY

5.4.1 Study context

The research was conducted at the TOP clinic of PMMH. Though data collection took place on alternate days, on two occasions, the researcher had clients from previous groups and cautioned them not to discuss any of their responses with the other clients.

5.4.2 Study design

This quantitative study used a non-experimental method in the form of a cross sectional survey. In a cross sectional survey, information is obtained at a single point in time. However, because large samples of clinical populations (as in this case TOP clients) could not be found easily, data collection took place between 20 August and 6 September 2012. Each respondent completed only one questionnaire.

5.4.3 Sampling

Because convenience sampling is a non-probability sampling technique, the sample's representativeness of the large population was decreased (Burns & Grove 2003:247). The study also excluded illiterate women, minors and those carrying fetuses with anomalies. This also decreased the representativeness of the large population in this community. However, it was assumed that respondents who met the inclusion criteria presented at the facility randomly making the sample representative of the large population of TOP clients (who would have met the inclusion criteria) in Umlazi township.

5.4.4 Data collecting instrument

The questionnaire was made available in Isizulu and English. The researcher advised respondents to ask for help if any of the questions or instructions were unclear. The

respondents did not find it difficult to follow instructions and answer the questions. All together 61 questionnaires were administered and only two were re-administered as respondents only answered demographic questions. Since the two respondents did not ask for help, the researcher concluded that they did not want to participate.

5.4.5 Ethics

Respondents were asked questions about their previous and current sexual activity. Despite using self-administered questionnaires to collect data, the researcher assumed that respondents did not reveal the actual extent of sexual activity because issues on sexual activity are sensitive and, are also considered to be personal and private. Hence this could have resulted in the low reported sexual prevalence among these women as most of them could have chosen not to review the real frequency of their sexual activities.

5.5 REFLECTION ON THE STUDY

The findings of this study showed that TOP clients' knowledge on contraception on the whole was very low. Sexual activity frequency was mostly once a month and only one client had sexual intercourse for financial gain. It is very surprising given that most of the clients were dependent on government grants, to discover that the majority decided to have sex for the first time because of love.

5.6 CONCLUSION

In conclusion, there is a need for policy makers to facilitate widespread access to modern contraception and promotion of its effectiveness in this community, and other disadvantaged communities in order to address the root cause of TOP-unintended pregnancy.

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Annexure A

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/5/2012

Date of meeting: 26 January 2012 Student No: 3276-940-7

Project Title: Knowledge, utilization of contraceptives and sexual activity among women who choose to terminate a pregnancy at Prince Mshiyeni Memorial Hospital.

Researcher: Charity Chipili Mazuba

Degree: Masters in Public Health Code: DIS4986

Supervisor: Mrs KA Maboe
Qualification: MA in Health Studies
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof E Potgieter
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B

Department of Health Studies
UNISA
Pretoria
18th October, 2011.

The Ethics Committee
KZN Department of Health
Head Office

Dear Sir/Madam

Ref:- Permission to use Prince Mshiyeni Memorial Hospital TOP clinic

A study on sexual activity and contraceptive knowledge and use among voluntary TOP seekers is currently been pursued as my project for the partial fulfillment of the master's degree in Public Health with the University of South Africa.

The aim of this study is to investigate sexual activity as well as contraceptive knowledge and use among TOP clients in Umlazi township. I therefore wish to formerly seek your approval to use the TOP clinic for the survey. A copy of the findings of this study will be made available upon completion of the study.

Thank you

Mrs CC Mazuba

Annexure C

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 102 Natalia Building, 330 Langalibalele Street,
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953186
Fax.: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : **HRKM 44/12**
Enquiries : **Mr X Xaba**
Tel : 033 – 395 2803

Dear Ms CC Mazuba

Subject: Approval of a Research Proposal

1. The research proposal titled '**Knowledge, utilization of contraceptives and sexual activity among clients who choose to terminate a pregnancy at Prince Mshiyeni Memorial Hospital**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Prince Mshiyeni Memorial Hospital. Data collection is scheduled for: April and May 2012.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2803.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 24/04/2012

Annexure D

QUESTIONNAIRE ON KNOWLEDGE, UTILIZATION OF CONTRACEPTIVES AND SEXUAL ACTIVITY AMONG WOMEN WHO CHOOSE TO TERMINATE A PREGNANCY AT PRINCE MSHIYENI MEMORIAL HOSPITAL.

Carefully read the questions and instructions in each section of this questionnaire and mark the most appropriate answer (s) with X in the provided space. where it says 'other' specify, please provide one word or short sentence answer; do not describe. All the information given in this questionnaire will be treated with due respect and confidentiality. Finally, do not include your name or any other details in this questionnaire.

SECTION A: DEMOGRAPHIC DATA

With an X, choose the most appropriate answer (s).

1. How old are you?

18 to 22 years ☐

23 to 27 years ☐

28 to 32 years ☐

33 to 37 years ☐

38 to 42 years ☐

43 and above ☐

2. Race

African ☐

Colored ☐

White ☐

Indian ☐

Other (specifiy)……

3. Religion

Islam ☐

Pentecostal ☐

Catholic ☐

Protestants ☐

African indigenous ☐

Other (specify)……

4. Marital status

Single/never married ☐

Married ☐

Divorced ☐

Widowed ☐

Other (specify)……..

5. Who do you live with?

Husband ☐

Both parents ☐

Single parent (specify father or mother) ☐

Boy friend ☐

Alone, on my own ☐

Other (specify)……

6. If married what type of your family are you living in?

I live alone without a husband ☐

Nuclear family (husband, wife and children only) ☐

Extended family (husband, wife, children and other family members like cousins, uncles, grandparents, in-laws, etc) ☐

Other (specify)……

7. Educational background of respondents

Never attended school ☐

Primary school but not completed ☐

Completed primary school ☐

Learner at high school ☐

Completed high school ☐

Student at tertiary level ☐

Completed tertiary education ☐

Other (specify)……

8. Source of income:-

Employed ☐

Self employed ☐

Government grant / pension ☐

Boy friend ☐

Other (specify)……

SECTION B: SEXUAL ACTIVITY

Please provide information on your history of sexual and related activities: either provide one word answer / or short sentence or tick with X the appropriate answer (s) in the provided space.

9. At what age did you start having periods? ☐

10. At what age did you first have sexual intercourse? ☐

11. Why did you decide to have sexual intercourse at this age?

Was married ☐

To keep my partner ☐

Financial gain ☐

Peer pressure ☐

Curiosity / experimentation ☐

Thought we would marry ☐

Romantic love ☐

Other specify……

12. What was the age of your first sexual partner?

Under 19 years ☐

20 – 24 years ☐

25 – 29 years ☐

30 – 34 years ☐

35 – 39 years ☐

40 years and above ☐

Current sexual activity

13. How often do you have sexual intercourse?

Less than once a week, but more than once a month ☐

Once a week ☐

Once a month ☐

More than once a week ☐

Other (specify)……

14. How many sexual partners do you have?

One ☐

More than one (specify how many) ☐

I currently have no sexual partners ☐

15. Have you been pregnant before?

Yes ☐

No (go to section C Q 19) ☐

16. If yes, how many times ☐

17. How many children do you have?

Living ☐

Dead ☐

SECTION C: CONTRACEPTION KNOWLEDGE.

Mark the most appropriate answer (s) . In some questions, you may give more than one answers. Any other information can be written on the blank space under the "other' specify.

18. Did you think that you could fall pregnant the first time you had sexual intercourse?

Yes ☐

No ☐

19. At which part of the menstrual cycle are women more fertile and therefore more at risk of pregnancy?

During a period ☐

Mid-cycle ☐

Just before a period ☐

Do not know ☐

20. Can you get pregnant during a period?

Yes ☐

No ☐

Do not know ☐

21. Have you ever heard of contraceptives or family planning?

Yes ☐

No (go to Q24) ☐

22. If yes, which method/s have you heard of?

Norplant ☐

Combined pills ☐

Condom ☐

Loop/coil ☐

Mini pills ☐

Injection ☐

Rhythm method ☐

Diaphragm/cap ☐

Calendar method ☐

Withdrawal method ☐

Permanent methods such as tying the tubes (sterilization) ☐

Body temperature method ☐

Cervical mucus change method ☐

Foam / jelly / spermicide ☐

Lactation amenorrhea method (LAM) ☐

Abstinence ☐

Other (specify)……...

23. Where did you hear or read about the method / s you ticked in Q 22?

My mom ☐

Sister ☐

Boy friend ☐

Girl friend ☐

Television / radio ☐

School / university ☐

Church / mosque ☐

Newspaper ☐

Magazines ☐

Posters ☐

Pamphlets ☐

Family planning clinic / well baby clinic ☐

Other (specify)……..

24. Have you ever heard of emergency contraceptive?

Yes ☐

No (if no go to Q29 and then Q30 in section D) ☐

25. Which of the following methods of emergency contraception have you heard of?

Loop ☐

Morning after pill ☐

Other describe……..

26. If you have unprotected sexual intercourse; up to how many hours do you have to take the emergency contraception pill?

Up to 12 hours ☐

Up to 48 hours ☐

Up to 24 hours ☐

Up to 72 hours ☐

Up to 1 week ☐

Do not know ☐

27. If you have unprotected sexual intercourse; up to how many hours or days do you have to get an emergency loop fitted?

Up to 24 hours ☐

Up to 72 hours ☐

Up to 5 days ☐

Up to 7 days ☐

Do not know ☐

28. How effective is emergency contraceptive in preventing pregnancy compared to other contraceptives?

Effective but less effective than other contraceptive methods ☐

The same as other contraceptive methods ☐

More effective than other contraceptive methods ☐

Not effective at all ☐

Do not know ☐

29. Which of the following contraceptive method also protects you from sexually transmitted infections?

Withdrawal method ☐

Loop ☐

Condoms ☐

Abstinence ☐

Injectables ☐

Contraceptive pills ☐

SECTION D: FACTORS INFLUENCING CONTRACEPTIVE USE.

Mark the most appropriate answer (s) with X and carefully follow the instructions given throughout this section.

30. Have you ever used any contraceptive before?

Yes ☐

No (go to Q 39) ☐

31. If yes, which method / s did you use?

Loop ☐

Cap / diaphragm ☐

Lactation amenorrhea ☐

Mini pill ☐

Combined pill ☐

Injection ☐

Norplant ☐

Cervical mucus method ☐

Body temperature method ☐

Abstinence ☐

Condom ☐

Rhythm ☐

Calendar ☐

Withdrawal method ☐

Foam / jelly / spermicide ☐

Other (specify)…….

32. What factor / s influenced your choice?

Cheaper ☐

My partner recommended the method ☐

Easy to use ☐

My friend advised me to use it ☐

A close friend / relative was using it ☐

Adverts of it ☐

Easily obtainable ☐

Did not affect my libido levels ☐

Experienced less or no side effects ☐

Other (specify)……

33. Where were you getting your contraceptive?

Private pharmacy ☐

Maternal and child health clinic (family planning clinic) ☐

My gynaecologist ☐

Other (specify)……

34. Were you using birth control at the time you fell pregnant?

Yes ☐

No (go to Q38) ☐

35. If yes to Q34, how did you fall pregnant?

Missed a pill or two ☐

My boy friend refused to use a condom on this day ☐

Missed my injection appointment ☐

Condom busted ☐

I was not using the condom consistently ☐

I run out supply ☐

Even if I took my contraceptive consistently, I fell pregnant ☐

Other (specify)……

36. Have you ever used a condom before?

Yes (go to Q 39) ☐

No ☐

37. If no, what is / are the reason / s for not using a condom?

My boy friend does not like them ☐

I have only one partner and I trust him ☐

I develop a rash which itches ☐

The sensation is reduced ☐

Condoms make noise during sexual intercourse ☐

Other (specify)……

38. If answer to Q 34 is no, what are the reasons for not using contraception?

I had no knowledge of contraception ☐

Had sexual intercourse infrequently hence did not see the need

of using contraception ☐

Thought contraception was for married couples ☐

My partner opposed use of contraception ☐

My religion does not allow modern methods of contraception ☐

Was concerned about the side effects and future fertility ☐

I did not know where to go for contraception ☐

Other (specify)……..

39. What would you like to know about contraception? List your responses in the provided space below:

……
……
……
……
……
……
……

THE END

THANK YOU VERY MUCH!!

ANNEXURE E

COVERING LETTER (informed written consent

Dear client

I, Mrs CC Mazuba, is conducting a research project entitled “knowledge of termination of pregnancy clients regarding contraception and sexual activity,” being a project submitted to the Department of Health, UNISA, in partial fulfilment of the requirement for the award of the Master of Public Health degree.

You as a TOP client is invited to participate in the study by completing the attached questionnaire. I realize that your time is important and I have tried to keep the need information as brief as possible. Therefore, this questionnaire will take approximately 15 minutes. Your participation is voluntary and you may withdraw from the study at any time without any consequences.

Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title or any other detail which could lead to your identification. Therefore, do not include your particulars on the questionnaire.

Finally by completing this questionnaire it means you have consented to be included in the study.

Thank you for your time and help.

Sincerely

Project director: Mrs CC Mazuba

Email: 0886009462@neomail.co.za

Phone:0314632085 (H); 0314605269 (W); 0716025109 (Cell)

6 St Augustine Crescent, Queensburgh,
4093,Durban, KZN.

ANNEXURE F

LYN VOIGT LITERARY SERVICES

Lyn Voigt: B. Mus. (Eng Hons) [Wits] H. Dip. Ed. [JCE]

P O Box 383

Ridge Terrace

2168

Tel/Fax: (011) 478 0634

EDITOR'S DECLARATION

I, Lynette Voigt, confirm that I edited the dissertation:

KNOWLEDGE, UTILIZATION OF CONTRACEPTIVES AND SEXUAL ACTIVITY AMONG CLIENTS WHO CHOOSE TO TERMINATE A PREGNANCY AT PRINCE MSHIYENI MEMORIAL HOSPITAL

by

CHARITY CHIPILI MAZUBA

L.Voigt

LE Voigt

Language practitioner

18 May 2013