

CHAPTER 4

Analysis and presentation of data

4.1 INTRODUCTION

This chapter discusses the data analysis and findings from 107 questionnaires completed by adolescent mothers who visited one of the two participating well-baby clinics in the Piet Retief (Mkhondo) area during 2004. The purpose of this study was to identify factors contributing to adolescent mothers' non-utilisation of contraceptives in the area.

The objectives of the study were to identify adolescent mothers'

- knowledge, attitudes and beliefs regarding contraceptives
- knowledge about reproductive issues prior to menarche
- knowledge about reproductive issues prior to their pregnancies
- reasons for non-utilisation of contraceptives
- requirements for using contraceptives effectively to prevent unplanned pregnancies
- individual perceptions, modifying factors and variables affecting their contraceptive utilisation

Questionnaires were given to adolescent mothers aged 19 or younger when their babies were born. After signing the consent form indicating their willingness to participate in the study, these adolescent mothers completed the questionnaires. The signed consent form was folded and put into a separate box from the anonymously completed questionnaires to ensure anonymity. In this way no signed consent form could be linked to any specific completed questionnaire.

A total of one hundred and seven (107) adolescent mothers completed questionnaires at the two participating well-baby clinics between 12 July 2004 and 3 September 2004.

The data from the questionnaires were statistically analysed by a statistician. The SPSS version 11 program was used for the data analysis. The findings are discussed according to the sections of the questionnaire and then with reference to the three components of the HBM. The four sections of the questionnaire were:

- Section A: Personal (biographical) data
- Section B: Sex education
- Section C: Knowledge of contraceptives
- Section D: Termination of pregnancy

The HBM was used to contextualize the literature review (see chapter 2). The three main components of the HBM, namely individual perceptions, modifying factors and variables affecting the likelihood of adolescent mothers' utilisation of contraceptives were used to summarise the findings (Onega 2001:271).

4.2 PERSONAL (BIOGRAPHIC) DATA

This section of the questionnaire covered the respondents' age, race, home language, highest school qualification and household monthly income. Though not central to the study, the personal data helped contextualise the findings and the formulation of appropriate recommendations to enable more adolescents to utilise contraceptives to prevent unplanned pregnancies.

4.2.1 Respondents' ages

The respondents were asked how old they were at their previous birthdays. Table 4.1 depicts the respondents' ages.

Table 4.1 Respondents' ages at the time of completing the questionnaires

AGE	FREQUENCY	PERCENTAGE
14 years	2	1,87
15 years	20	18,69
16 years	24	22,43
17 years	22	20,56
18 years	20	18,69
19 years	19	17,76
TOTAL	107	100,00

The adolescent mothers' ages ranged from 14 to 19, with the majority being 16 as 24 (22,43%) respondents were at this age. It should be borne in mind that adolescent mothers aged 14 probably became pregnant while they were only 13 years old, indicating that sex education and knowledge about contraceptives need to be attained by the age of 12 or even earlier.

4.2.2 Race

Of the 107 respondents, only one was Coloured, one was White and 105 were Black hence only Black adolescent mothers were well represented in the sample. This means that the research results might not be generalisable to adolescents of all racial groups in the Piet Retief (Mkhondo) area.

4.2.3 Home language

Of the respondents, 101 (94,39%) were Zulu-speaking. Only Zulu-speaking adolescents were well represented in the sample, which means that the research results might not be generalisable to adolescents with home languages other than Zulu. These findings correlate with the fact that almost all the respondents were Black. It also indicates that most of the Black adolescent mothers were Zulu-speaking, probably because the two participating clinics were in areas where predominantly

Zulu-speaking people live. The implication of this finding is that sex education and knowledge about contraceptives should be conveyed in Zulu to reach the majority of adolescent women.

4.2.4 Highest school qualification

Table 4.2 represents the highest level of school education that the adolescent mothers had obtained. Of the respondents, 59 (55,14%) had passed Grades 10 to 12 and only 2 (1,87%) had passed Grades 1 to 3, corresponding with the small number of adolescent mothers aged 14 (as indicated in table 4.1). This implies that with more knowledge and better accessibility to contraceptives, more adolescent mothers might have been able to complete their schooling prior to commencing childbearing.

Table 4.2 Highest school qualification

GRADE	FREQUENCY	PERCENTAGE
1-3	2	1,87
4-6	11	10,28
7-9	35	32,71
10-12	59	55,14
TOTAL	107	100,00

In a study of adolescent mothers' utilisation of reproductive health services in Gauteng Province, RSA, Ehlers et al (2000:46) reported that the majority had passed Grades 10 to 12. If the respondents had used contraceptives effectively, more could have completed their schooling (passed Grade 12) prior to becoming mothers. Having completed their schooling would have afforded the mothers more opportunities to continue with post-school education or training and earn better salaries. Better education would benefit not only the adolescent women but also their children.

4.2.5 Household income

The monthly household income revealed that 72 (67,29%) of the respondents were from low-income groups. Four (3,74%) respondents did not answer this question. Adolescent mothers can use contraceptives to prevent unplanned pregnancies and thus improve their educational and/or economic status prior to commencing with childrearing responsibilities. Hatcher et al (1997:2-22) emphasise that “family planning helps nations develop.

Table 4.3 Monthly household income

RANDS	FREQUENCY	PERCENTAGE
R0-R999	72	67,29
R1 000-R1 999	14	13,08
R2 000-R2 999	7	6,54
R3 000-R3 999	3	2,80
R4 000-R4 999	3	2,80
R5 000-R5 999	2	1,87
R6 000 and more	2	1,87
No response	4	3,74
TOTAL	103	100,00

In countries where women are having far fewer children than their mothers did, people’s economic situations are improving faster than in most other countries.” Although contraceptives are available free of charge at clinics in the Piet Retief (Mkhondo) area, the adolescent mothers could still require funds for transport costs should the clinics not be within walking distance from their homes.

4.2.6 Summary of personal data

Section A revealed the respondents’ age distribution, racial group, home languages, highest school qualification, and monthly (30 days) household income. Most of the respondents were 16 years old (22,43%), mostly African (98,13%), Zulu-speaking (94,39%), had passed Grades 10 to 12 (55,14%) and had a low monthly household income (67,29%).

4.3 SEX EDUCATION

This section consisted of six questions about sex education received by the participating adolescent mothers at different stages of their lives, in relation to potentially significant events in their lives, such as their age at their first sex encounter (sometimes referred to as “sexual debut” in the literature review).

4.3.1 Age at first sexual encounter

This question was asked to identify whether or not the respondents had received sex education prior to their sexual debut.

Table 4.4 Age at first sexual encounter

AGE	FREQUENCY	PERCENTAGE
12	3	2,80
13	9	8,41
14	20	18,69
15	29	27,10
16	25	23,36
17	16	14,95
18	4	3,74
19	1	0,93

Knowing the age at which they had their sexual debuts should indicate before what age sex education as well as contraceptive information should be provided. This is important to enable adolescent women to make informed decisions prior to embarking on sexual intercourse. Learning about contraceptives only after becoming pregnant might deprive many young women of the opportunity to make informed decisions about their own and their children’s futures.

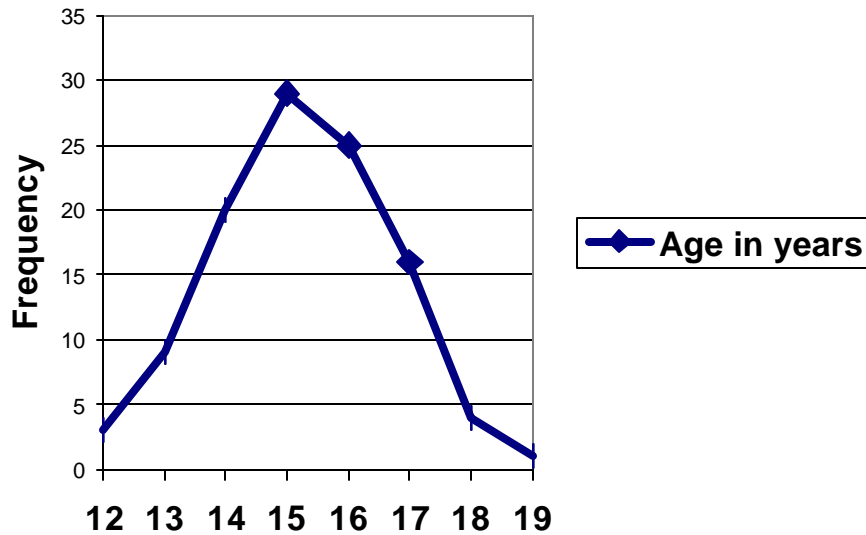


Figure 4.1
Age at first sexual encounter

Table 4.4 and figure 4.1 reveal that of the 107 adolescent mothers, 102 (95,33%) had engaged in sexual intercourse by the time they reached the age of 17. It is important to study the age at first sexual intercourse to identify adolescents at risk before they engage in unprotected sexual intercourse. Measures could then be taken to prevent or delay pregnancy through education about sexual intercourse, pregnancy and contraception, before the age of 12. From tables 4.1 and 4.4 there appears to be a correlation between “age at time of data collection” and “age at time of first sexual encounter”. The modal age when they had sex for the first time was 15 (table 4.4) and the modal age of the respondents at their previous birthdays was 16 (table 4.1). These findings could mean that there are possibly factors contributing to adolescent mothers’ non-utilisation of contraceptives at their sexual debut.

4.3.2 Reasons for sex for the first time

This question aimed to identify reasons why the respondents engaged in sexual intercourse for the first time. Four reasons and a space for other reasons, which respondents could specify, were

provided. Only one respondent did not reply to this question but the other 106 chose from the reasons provided as depicted in table 4.5.

Table 4.5 Reasons for respondents' sexual debut

REASON	FREQUENCY	PERCENTAGE
Did not know	62	57,94
Loved partner	32	29,91
Requested by partner	4	3,74
Peer pressure	8	7,48
No response	1	0,93
TOTAL	107	100,00

Although the 62 (57,94%) respondents who indicated that they did not know why they had sex for the first time did not elaborate on this, it can be assumed that sex education and contraceptive knowledge might have enabled them to make better informed choices about their own and their children's futures, by either using contraceptives effectively themselves or insisting that their partners use condoms effectively – avoiding both unplanned pregnancies and STIs.

4.3.3 Number of children the respondents had

The respondents were asked to indicate how many children they had. Figure 4.2 represents the number of children. Of the respondents, 96 (89,72%) had one child and 11 (10,28%) had two children. Being an adolescent mother aged 19 or younger with one child could be a challenge, but with two children it could become a major challenge to cope physically, emotionally and financially. The finding that 11 adolescent mothers had two children indicates the urgent need to continue to

provide health education and contraceptive information to adolescent mothers – even after the birth of their babies.

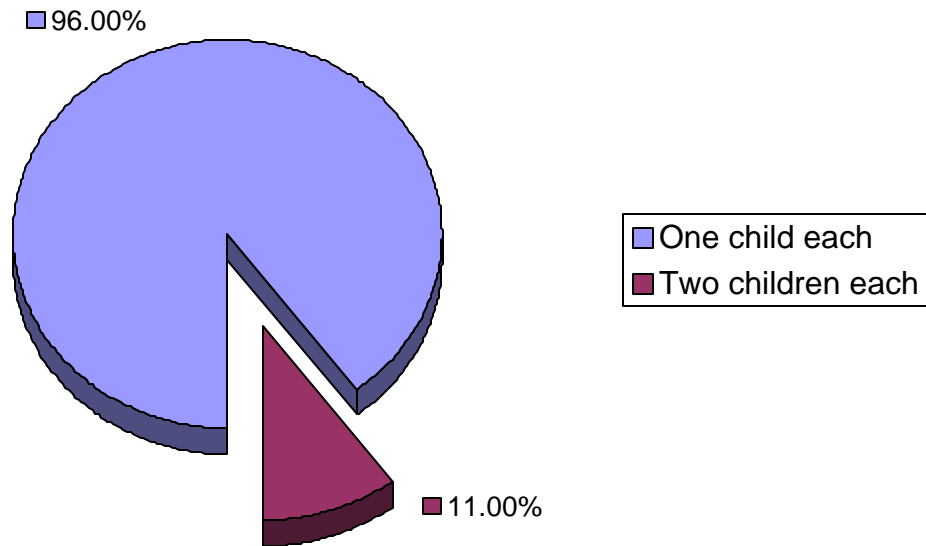


Figure 4.2
Number of children each adolescent mother had

4.3.4 Age at birth of first child

The respondents were asked how old they were when their first child was born. The modal age was 17 (n=41; 38,32%). These findings seem to correlate with those portrayed in table 4.4, which indicates that they were 15 and 16 at their sexual debut (see bimodal distribution in table 4.4).

Table 4.6 Respondents' ages when their first children were born

AGE	FREQUENCY	PERCENTAGE
Up to 14	4	3,74
15	16	14,95
16	24	22,43
17	41	38,32

18	13	12,15
19	8	7,48
No response	1	0,93
TOTAL	107	100,00

The implication of this finding is that at the age of 17 the respondents could not have progressed beyond Grade 10 or 11 in their schooling. If they could have been empowered to postpone their childbearing for one or two years, should they have desired to do so, they might have successfully completed their schooling (passed Grade 12) thereby enhancing the possibility of finding gainful employment and perhaps pursuing post-secondary education pursuits – even after the birth of their children. However, an incomplete school career may imply greater hardship for adolescent mothers and their children than a successfully completed school career.

Figure 4.3 presents a comparison of the respondents' ages at their previous birthdays, their sexual debut and the birth of their first child. Ages 15 and 17 seem to be significant in the lives of these adolescent mothers. This supports Stanhope and Lancaster's (2001:810) finding that many pregnant teenagers fell into the 15 to 17 years old age group.

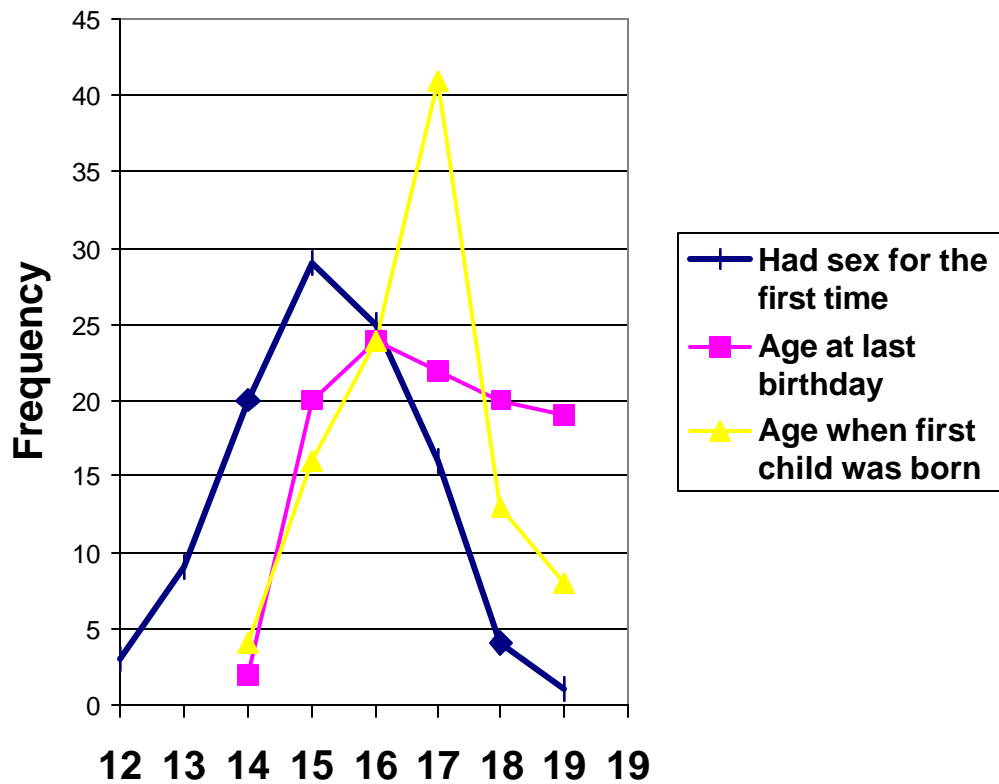


Figure 4.3

Adolescent mothers' significant ages

(Combination of facts from tables 4.4, 4.1 and 4.6).

4.3.5 Age at which sex education was provided

Table 4.7 depicts the ages at which the respondents received information about menstruation, sexual intercourse, conception (pregnancy) and contraceptives.

Table 4.7 Age at which information was received about menstruation, sexual intercourse, pregnancy and contraceptives

AGE IN YEARS	MENSTRUATION		SEXUAL INTERCOURSE		PREGNANCY		CONTRACEPTIVES	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
up to 12	26	24,30	11	10,28	13	12,15	7	6,54
13	20	18,69	8	7,48	2	1,87	2	1,87
14	21	19,63	28	26,71	13	12,15	8	7,48
15	16	14,95	16	14,95	20	18,69	18	16,82
16	10	9,35	17	15,89	26	24,30	21	19,63
17	4	3,74	12	11,21	14	13,08	15	14,02
18	1	0,93	3	2,80	4	3,74	7	6,54
19	-	-	-	-	2	1,87	4	3,74
No response	9	8,41	12	11,21	13	12,15	25	23,36

	MENSTRUATION		SEXUAL INTERCOURSE		PREGNANCY		CONTRACEPTIVES	
TOTAL	107	100,00	107	100,00	107	100,00	107	100,00

Table 4.7 as well as figure 4.4 indicate that of the respondents, 21 (19,63%) received information about menstruation at 14; 28 (26,71%) on sexual intercourse at 14; 26 (24,30%) about pregnancy at 16; and 21 (19,63%) on contraceptives at 16 years of age. Figure 4.4 indicates that very few adolescent girls knew about sexual intercourse, pregnancy or contraceptives if they started menstruating at the age of 12. Although most respondents were reportedly informed about sexual intercourse at the age of 14, few were informed about pregnancy and even fewer about contraceptives. In order to make informed decisions adolescent girls seem to need information about menstruation, sexual intercourse, pregnancy and contraceptives before they reach the age of 12. Thereafter this information might need to be provided at repeated intervals in order to enhance their knowledge and understanding about sexual issues and thus their capability to make informed decisions affecting their own lives but also the lives of their families and their children.

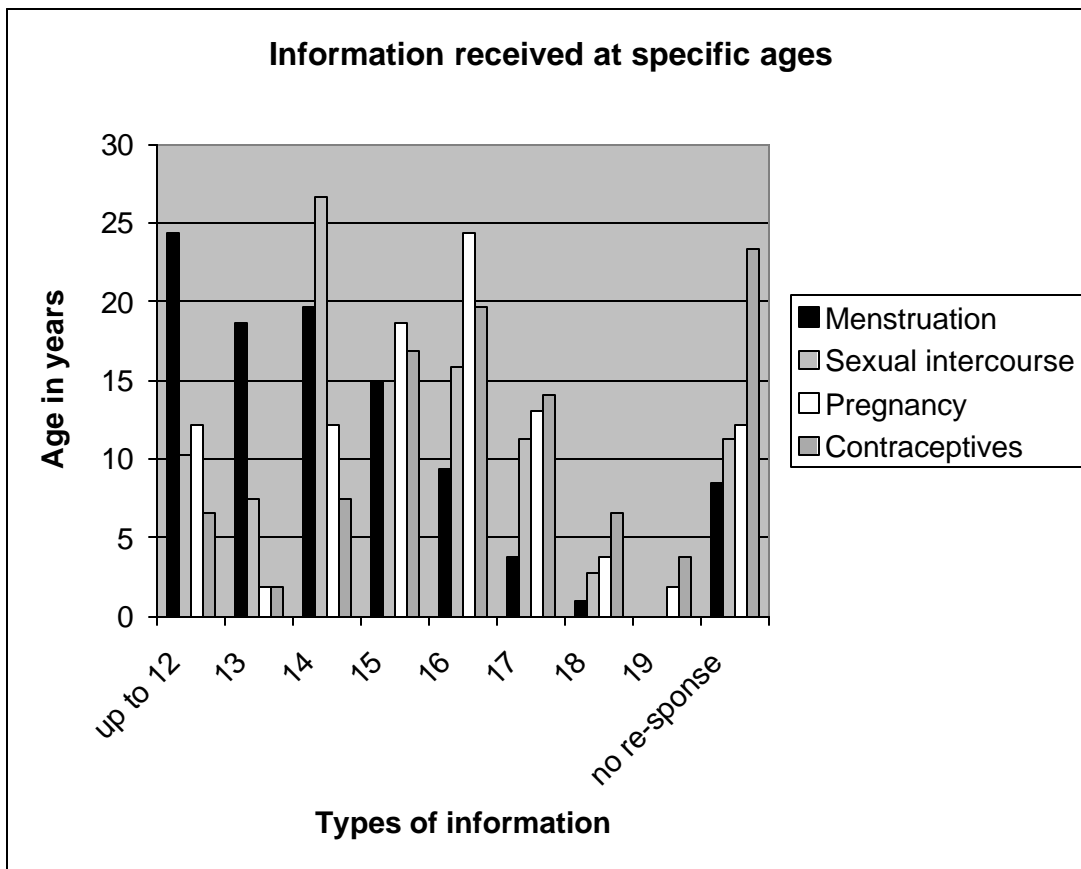


Figure 4.4

Ages at which adolescent mothers received specific types of sexual information

4.3.6 Sources providing sex education

The respondents indicated that they received information about menstruation, sexual intercourse, pregnancy and contraceptives from the sources/persons specified in table 4.8.

Of the respondents, 80 (74,77%) received information from their mothers. Other sources in order of frequency were clinic nurses, friends, teachers, magazines/newspapers, television, radio, fathers and sisters. This question allowed the respondents to indicate more than one source and to specify other sources that were not on the list. However, only two specified "other: sister" as indicated in table 4.8.

Table 4.8 Sources providing sex education

SOURCE OF INFORMATION	FREQUENCY	PERCENTAGE
Mother	80	74,77
Father	7	6,54
Teacher	18	16,84
Friend	20	18,69
Clinic nurse	25	23,36
Television	14	13,08
Radio	12	11,21
Magazine/newspaper	16	14,95
Other: sister	2	1,87

Although information about menstruation, sexual intercourse, pregnancy and contraceptives was received mostly by the time they had reached 14 to 16 years of age, all the respondents fell pregnant. From the findings, then, sex education failed to prevent the adolescents from engaging in unprotected sexual intercourse. This is shown in table 4.4 where 29 (27,10%) of the respondents had had sex for the first time at the age of 15. Of the respondents, 28 (26,71%) received information on sexual intercourse at 14 years old as illustrated in figure 4.8, indicating that many of

the respondents had received sex education prior to their sexual debut, yet failed to use effective contraceptives effectively. As the majority of the adolescent mothers received sex education from their mothers, it might be worthwhile to update the mothers' knowledge about contraceptives for them to impart knowledge to their daughters about the effective utilisation of contraceptives to prevent unplanned pregnancies. This may be a constructive and valuable effort to help adolescents to make better informed decisions about preventing unplanned pregnancies.

4.3.7 Ways in which sex education was presented

Respondents could indicate that they received sex education in different ways. As each respondent could tick a number of presentations, these totals do not add up to 107.

Table 4.9 Sex education presentations

SOURCE OF INFORMATION	FREQUENCY	PERCENTAGE
Book	14	13,08
Video	6	5,61
Lecture	25	23,36
Personal discussion	78	72,90
Other: no response	107	100,00

Table 4.9 reveals that 78 (72,90%) of the respondents received information about menstruation, sexual intercourse, pregnancy and contraceptives through personal discussion. Personal discussion makes the adolescent feel comfortable about asking questions and encourages participation in such discussions. However, as the majority of the respondents received this sex education from their mothers, some information about the effective utilisation of contraceptives to prevent unplanned pregnancies may have been lacking, because all these adolescents became mothers despite sex education from their mothers.

4.3.8 Summary of sex education

The results in section B indicate that of the respondents, 29 (27,10%) had had sex for the first time at the age of 15, 62 (57,94%) did not provide specific reasons for their sexual debut, 96 (89,72%) had one child, and 41 (38,32%) gave birth to their first child at the age of 17. Information about menstruation, sexual intercourse, pregnancy and contraceptives was mostly received at the age of 14 to 16 and chiefly from mothers through personal discussion. The findings indicate that there may be a lack of accurate contraceptive information/knowledge to enable adolescent women to use contraceptives to delay childrearing should they so wish.

4.4 KNOWLEDGE OF CONTRACEPTIVES

This section of the questionnaire consisted of 26 questions on contraceptive knowledge. Most of the questions were closed items requiring the respondents to reply "yes" or "no", but spaces were provided for them to specify, explain or state reasons in their own words should they wish to do so.

4.4.1 Clinic visits for contraceptives

The respondents were asked whether they ever visited a clinic to acquire contraceptives.

Table 4.10 Clinic visits for contraceptives

RESPONSE	FREQUENCY	PERCENTAGE
Yes	50	46,73
No	56	52,34
No response	1	0,93
TOTAL	107	100,00

Of the respondents, 50 (46,73%) had visited clinics for contraceptives, 56 (52,34%) had never done so and only one did not reply to this item. Adolescents would appear to need more information about contraceptives and clinics providing contraceptives free of charge in the Piet Retief (Mkhondo) area. However, as 50 (46,73%) of the respondents reported visiting clinics for contraceptives, and nevertheless fell pregnant, the services and health education actually provided to adolescents at these clinics might be suspect of failing to provide effective contraceptive services and education.

Every adolescent who visits a clinic is entitled to receive health education and contraceptives free of charge. If this were the case, and if the respondents had used the contraceptives effectively, then they should not have fallen pregnant. Furthermore, if the services and health education provided at the clinics had been effective, the pregnant adolescents should have been able to access and utilise ECs and/or TOP services should they have wished to do so in order to postpone their childbearing until they had completed their schooling or until deciding to have children.

4.4.2 Utilisation of contraceptives

The respondents were asked to indicate whether or not they had ever used contraceptives.

Table 4.11 Utilisation of contraceptives

RESPONSE	FREQUENCY	PERCENTAGE
Yes	54	50,47
No	53	49,53
TOTAL	107	100,00

From tables 4.10 and 4.11 it appears that 50 (46,73%) of the respondents had visited clinics to obtain contraceptives, but 54 (50,47%) had, in fact, used contraceptives. The fact that three of the respondents reported that they had never visited a clinic for contraceptives and one did not answer the question, but had used contraceptives could mean that the contraceptives were obtained from their friends, mothers or private sources, such as pharmacies. However, the last possibility might be unfeasible in view of the low monthly family household incomes reported by the respondents, making it unlikely that they would be able to afford to pay for contraceptives provided by private suppliers.

4.4.3 Contraceptives used

Table 4.12 presents the contraceptive methods used.

Table 4.12 Contraceptives used

CONTRACEPTIVE METHOD	FREQUENCY	PERCENTAGE
Pills	6	5,61
Injections	28	26,71
Intra-uterine contraceptive device	-	-
Condoms	32	29,91
Other methods (unspecified)	1	0,93
Multiple methods	2	1,87
No response	38	35,51
TOTAL	107	100,00

Of the respondents, 32 (29,91%) used condoms, 28 (26,17%) used injections, 6 (5,61%) used contraceptive pills, 0 indicated using an IUCD, and 38 (35,51%) did not reply to this question, which could indicate their non-utilisation of contraceptives. No reasons for making limited use of contraceptive pills and no use of IUCDs could be derived from the questionnaires.

4.4.4 Choice of contraceptive methods at clinics

The respondents were asked whether they were allowed to choose a contraceptive method at their clinics.

It could not be determined why 32 (29,91%) of the respondents reported not being able to choose a contraceptive method at their clinics. Such a choice should be encouraged, as the same method might not necessarily be suitable for all adolescents.

Table 4.13 Ability to choose a contraceptive method at clinics

RESPONSE	FREQUENCY	PERCENTAGE
Yes	68	63,55
No	32	29,91
No response	7	6,54

TOTAL	107	100,00
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Of the respondents, 68 (63,55%) reported that they were allowed to choose a contraceptive method at their clinics and 7 (6,54%) failed to reply to this question, probably because they did not know whether or not their clinics allowed a choice of contraceptive methods. Despite the adolescent mothers' ability to choose a contraceptive method, they failed to use contraceptives effectively and still had children. It was noted that 54 (50,47%) of the respondents (see table 4.11) indicated that they had ever used contraceptives, while 68 (63,55%) reported that they would be allowed to choose a contraceptive method at their clinics. These numbers might indicate that some of the respondents were aware that they would be allowed to choose a contraceptive method at their clinics, even if they themselves had never used contraceptives. They may have obtained such information from their peers.

4.4.5 Utilisation of traditional contraceptives

The respondents were asked whether they had used any traditional contraceptive methods.

Table 4.14 Use of traditional contraceptive methods

RESPONSE	FREQUENCY	PERCENTAGE
Yes	9	8,41
No	95	88,79
No response	3	2,80
TOTAL	107	100,00

Table 4.14 indicates that 95 (88,79%) of the respondents had reportedly never used traditional contraceptive methods, while 9 (8,41%) had used traditional methods such as tying a rope around the waist, mixing medicines with menstrual blood, drinking traditional medicines. Only one respondent specified a traditional contraceptive method that was not listed, namely "double bay". Table 4.15 illustrates the traditional methods used.

Table 4.15 Types of traditional contraceptives used

TRADITIONAL METHOD USED	FREQUENCY	PERCENTAGE
Tying a rope around the waist	2	1,87
Mixing medicines with menstrual blood	1	0,93
Drinking traditional medicines	7	6,54
Other methods	6	5,61
Specified other: double bay	1	0,93
No response	90	85,05
TOTAL	107	100,00

Table 4.15 reveals that 17 (15,89%) of the respondents used traditional methods and this could have contributed to their pregnancies since the effectiveness of these methods has not been scientifically proven. This argument could not be supported nor refuted from the information available from the completed questionnaires because an unknown number of adolescents might have successfully avoided pregnancies by using traditional contraceptive methods, who would thus not be adolescent mothers and who would thus be excluded from participation in this study. Moreover, the other 90 respondents, who did not report that they had used traditional contraceptives, also became pregnant. It could not be explained why in table 4.14, 95 respondents said they had not used traditional contraceptive methods, while in table 4.14 only 90 claimed this to be the case. However, the respondents might have encountered some difficulty in understanding all the questions, and the alternative answers supplied as they completed the questionnaires by themselves. If the respondents could have been traced for follow-up interviews, then this apparent discrepancy might have been resolved. However, as the questionnaires were completed anonymously such follow-up investigations could not be done and the data had to be accepted as indicated by the respondents on the questionnaires. A possible explanation might be that some adolescent mothers might have been unfamiliar with the term "traditional contraceptives".

4.4.6 Problems with receiving contraceptives or information

The respondents were asked whether they experienced any problems with receiving contraceptives and/or family planning information.

Table 4.16 Problems with receiving contraceptives or information

RESPONSE	FREQUENCY	PERCENTAGE
Yes	10	9,35
No	84	78,50
No response	13	12,15
TOTAL	107	100,00

Table 4.16 indicates that of the respondents, 84 (78,50%) did not experience problems with obtaining contraceptives or family planning information. The respondents were asked to explain any problems they encountered with receiving contraceptives or family planning information.

Table 4.17 Description of problems with receiving contraceptives or information

PROBLEMS	FREQUENCY	PERCENTAGE
Draining water per vagina	1	10,0
Prolonged menstruation	5	50,0
Varicose veins	1	10,0
Swollen legs	1	10,0
Lower abdominal pains	1	10,0
No explanation of problem	1	10,0
TOTAL	10	100,0

From table 4.17 it is clear that the problems stated by 10 (9,35%) of the respondents were not related to receiving contraceptives or information per se but were due to side effects of some contraceptives. The respondents may have misunderstood this question.

4.4.7 Knowledge about contraceptives before pregnancy

The respondents were asked whether they had known about contraceptives/family planning before they started menstruating, had sexual intercourse or became pregnant.

Table 4.18 Knowledge about contraceptives before pregnancy

CONTRACEPTIVE METHOD	MENSTRUATION		SEXUAL INTERCOURSE		PREGNANCY	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
Emergency contraceptives	19	17,76	74	69,14	14	13,08
Oral contraceptives	23	21,50	55	51,40	29	27,10
Injections: Depo-provera	34	31,78	47	43,93	26	24,30
Nur-Isterate	28	26,17	52	48,60	27	25,23
Intra-uterine contraceptive device	14	13,08	61	57,10	32	29,91
Condoms	57	53,27	22	20,56	28	26,17

From table 4.18 it is evident that the respondents had known about a number of different contraceptives/family planning methods before they became pregnant. The data in table 4.19 about contraceptives used does not correlate with data in table 4.18 because knowledge about contraceptives did not result in the respondents' utilisation of contraceptives to prevent unplanned pregnancies. Factors other than knowledge may have contributed to the respondents' non-utilisation of contraceptives prior to their pregnancies. Table 4.18 indicates that 57 (53,27%) of the respondents had knowledge about condoms before they started menstruating. However, they did not use condoms because they had children despite their knowledge. Similar results about other contraceptive methods are found in table 4.19, which indicates that although the respondents knew about different contraceptives, they failed to use contraceptives effectively to prevent unplanned pregnancies.

4.4.8 Contraceptive use before pregnancy

The respondents were asked whether they had actually used contraceptives before becoming pregnant.

Table 4.19 Contraceptive use before pregnancy

RESPONSE	FREQUENCY	PERCENTAGE
Yes	17	15,89
No	88	82,24
No response	2	1,87
TOTAL	107	100,00

Although most of the respondents knew about different contraceptives prior to their pregnancies, only 17 (15,89%) had actually used contraceptives prior to conception. The respondents were asked to indicate what contraceptive method was used.

Table 4.20 Contraceptive method used before pregnancy

CONTRACEPTIVE USED	FREQUENCY	PERCENTAGE
Emergency contraceptive	2	11,76
Oral contraceptives (pills)	1	5,88
Condoms	10	58,82
Multiple methods	4	23,53
TOTAL	17	100,00

From tables 4.19 and 4.20 it is evident that only 17 (15,89%) of the respondents used contraceptives before pregnancy and that the contraceptive methods used were condoms, ECs and oral contraceptives. No further deductions could be made about the four respondents who reported using multiple methods. It is not known whether they used different methods at different times or concurrently. Although 10 of the respondents reported having used condoms before their pregnancies, they nonetheless became pregnant, which might indicate that the condoms had not been used properly or that they had insufficient knowledge about condom usage. However, if condoms had been used effectively, the 10 respondents may have been able to postpone their pregnancies until they had completed their schooling. The two respondents who used ECs did not indicate what methods were used or why the ECs did not prevent the pregnancies. Further

exploration of adolescents' actual knowledge about ECs and condoms might help to reduce the number of unplanned adolescent pregnancies in the Piet Retief (Mkhondo) area in future.

Of the respondents, 88 (82,24%) indicated that they did not use contraceptives before pregnancy (see table 4.19). However, it should be borne in mind that there may be perceived benefits of the non-utilisation of contraceptives (see chapter 2, section 2.4), such as enhanced sexual pleasure by not using condoms. The few adolescent mothers who actually reported using contraceptives prior to their pregnancies might have discontinued such use because they encountered side-effects.

4.4.9 Side effects of contraceptives

The respondents were asked whether they had experienced any side effects when they used contraceptives.

Table 4.21 Side effects of contraceptives used

SIDE EFFECTS	FREQUENCY	PERCENTAGE
Headaches	1	5,88
Weight gain	1	5,88
Amenorrhoea (absence of menstruation)	3	17,65
Multiple side effects	4	23,53
No response	8	47,06
TOTAL	17	100,00

Table 4.21 indicates that all 17 respondents who had used contraceptives experienced side effects. These side effects may have caused them to discontinue using contraceptives since they subsequently fell pregnant and gave birth. If contraceptive methods have known side effects, clients need to be informed about these side effects before they choose a contraceptive method and if a method hardly ever has any side effects or complications, then clients need to know that too (Hatcher et al 1997:3-5). Adolescents need to know about all the side effects of all contraceptive methods available in order to be satisfied and continue using contraceptives and reduce the

number of adolescent mothers. However, merely knowing about potential side effects might not be sufficient to let women persevere with any specific method. Contraceptive users need to have recourse to clinic staff should they encounter side effects. The clients need to have open communication lines to raise any concerns with appropriately qualified staff members. However, all clients should be educated never to discontinue a contraceptive method when they encounter side effects, as that would make them vulnerable to unplanned pregnancies. Should any side effect be encountered, then they should consult clinic staff, and perhaps change their contraceptive method but they should be duly warned about any unsafe contraceptive period with such changes.

4.4.10 Reasons for discontinuing contraceptive methods

The respondents were asked to state the reasons for stopping to use contraceptives. The following reasons were given:

- Do not know; no specific reason for stopping contraceptives. (10)
- Dislike using contraceptives. (10)
- Had general, non-specific side effects. (3)
- Boyfriends did not want them to use contraceptives. (3)
- There was peer pressure. (3)
- Had amenorrhoea as a specific side effect. (2)
- Lacked knowledge. (1)
- It was a mistake to use contraceptives. (1)

From the reasons given for having discontinued contraceptive use, it may be assumed that their sexual education did not deal with the effects of adolescent pregnancy for the adolescent mother, adolescent father and child as well as the adolescents' own families. These reasons were some of the factors that contributed to the respondents' non-utilisation of contraceptives and led to their pregnancies. According to the respondents, peer pressure, side effects of contraceptives, lack of

knowledge, boyfriends'/sexual partners' disapproval, and their dislike of contraceptives contributed to their non-utilisation of contraceptives, leading to their adolescent motherhood.

4.4.11 Contraceptive use after babies' births

The respondents were asked whether they had used contraceptives since their babies' births.

Comparing contraceptive use in table 4.22 with table 4.19, there was an increase in contraceptive use from before pregnancy (15,89%; n=17) to after their babies' births (59,81%; n=64). However, the fact that only 59,81% of these adolescent mothers used contraceptives after their babies' births implied that the other 40,19% might have been susceptible to further pregnancies within the foreseeable future. The adolescent mothers did not indicate why did or did not use contraceptives after the birth of their babies. The respondents were asked to indicate the contraceptive method used after their babies' births.

Table 4.22 Contraceptive use after babies' births

RESPONSE	FREQUENCY	PERCENTAGE
Yes	64	59,81
No	39	36,45
No response	4	3,74
TOTAL	107	100,00

Table 4.23 Contraceptive methods used after babies' births

CONTRACEPTIVE METHOD	FREQUENCY	PERCENTAGE
Emergency contraceptives	1	1,56
Oral contraceptives (pills)	3	4,69
Injections: Depo-Provera	20	31,25
Nur-isterate	9	14,06
Condoms	17	26,56
Multiple methods	14	21,88
TOTAL	64	100,00

According to table 4.23, the 64 (59,81%) respondents who indicated using contraceptives after their babies' births used the following methods:

- depo provera (20)
- condoms (17)
- multiple methods (14)
- nur-isterate (9)
- oral contraceptives/pills (3)
- emergency contraceptives (1)

It could not be determined why only 64 of the respondents were using contraceptives and why the other 43 apparently used no contraceptives, thereby risking further pregnancies and possibly jeopardising their own and their children's chances of a more secure future to an even greater extent than in the case of their first pregnancies. Concerted education drives should be directed at adolescent mothers to enable them to make informed decisions about their own and their children's futures. The 17 respondents who reported using condoms as a contraceptive method may have been in particular need of education about the effective use of condoms as 10 of them had reported using condoms prior to their pregnancies. If they could not prevent pregnancy using condoms prior to their pregnancies, it would seem doubtful whether they could do so after their babies' births. ECs should not be seen as a contraceptive method, but should only be used in cases of unprotected sexual intercourse to prevent unplanned pregnancies. It can be generally accepted that any woman who requires an EC should, in fact, use contraceptives regularly and effectively subsequent to the utilisation of the EC.

4.4.12 Knowledge about side effects of contraceptives

The respondents were asked whether they had received any information about the side effects of contraceptives.

Table 4.24 Knowledge about side effects of contraceptives

RESPONSE	FREQUENCY	PERCENTAGE
Yes	50	46,73
No	54	50,47
No response	3	2,80
TOTAL	107	100,00

Of the respondents, 54 (50,47%) indicated that they had not received information about contraceptives' side effects (see table 4.24) although 64 (59,81%) indicated that they had used contraceptives (see table 4.23). Some of the respondents apparently used contraceptives without knowing about their side effects. This could be a particularly serious situation as some of the respondents indicated side effects as the reason for discontinuing contraceptive use (see section 4.4.10). Information about contraceptives' side effects should be provided to adolescents in order to increase their knowledge, thus improve contraceptive compliance. However, they should also know what to do and where to seek help should any side effects be encountered. Above all, they should be informed never to discontinue any contraceptive without consulting the clinic staff, and that should they decide to change to another contraceptive, there might be an unsafe period during which they could become pregnant even if they had no break in contraceptive use. During this period, condoms should be used in addition to any other contraceptives to avoid unplanned pregnancy.

4.4.13 Sources of information about side effects

The respondents were asked to indicate who provided information about contraceptives' side effects.

Table 4.25 Sources of information about contraceptives' side effects

SOURCE OF INFORMATION	FREQUENCY	PERCENTAGE
Mother	11	22,00

Father	1	2,00
Teacher	2	4,00
Friend	10	20,00
Clinic nurse	12	24,00
Television	1	2,00
More than one	12	24,00
No response	1	2,00
TOTAL	50	100,00

Of the 50 (46,73%) respondents who knew about side effects, 12 obtained this information mostly from the clinic nurses, 11 from their mothers, 10 from their friends, 12 from more than one source, 1 from her father, 1 from television, 2 from a teacher, and 1 did not reply to the question. It could not be determined why the 50 respondents who knew about contraceptives' side effects, failed to use contraceptives effectively to prevent unplanned pregnancies. Again, it appeared that knowledge alone did not enable the respondents to postpone their pregnancies until they had completed their schooling. It might be valuable to find out what clinic nurses and mothers actually tell adolescents about contraceptives' side effects in order to provide them with further information, should that be indicated by research results.

4.4.14 Availability of contraceptives

The respondents were asked about the availability of contraceptives at their clinics.

Table 4.26 Availability of contraceptives

AVAILABILITY	FREQUENCY	PERCENTAGE
Always	68	63,55
Sometimes	33	30,84
Unknown	5	4,67
No response	1	0,93
TOTAL	107	100,00

From table 4.26 it appears that contraceptives were only “always” available to 68 (63,55%) of the respondents. This question was asked to evaluate whether the unavailability of contraceptives was one of the factors contributing to adolescent mothers’ non-utilisation of contraceptives in the Piet Retief (Mkhondo) area. Contraceptive services should always be available at all health facilities so that adolescents can access contraceptives when needed. In a study on the accessibility of adolescent health services, adolescents indicated that the service should be available throughout the week, including Saturdays (Richter 2000:81).

4.4.15 Advice received at clinics

The respondents were asked to indicate what advice they had received at their clinics visited for contraceptives. According to table 4.27, most of the respondents received advice about condoms and/or HIV/AIDS.

Table 4.27 Advice received at clinics

ADVICE	FREQUENCY	PERCENTAGE
Condoms	83	77,57
HIV/AIDS	64	59,81
Other	9	8,41

The respondents had to indicate all the advice received and each respondent could indicate more than one, hence the total frequency exceeded 107. Of the respondents, 83 (77,57%) received advice about condoms, and 64 (59,81%) about HIV/AIDS. Table 4.27 indicates that 77,57% of the respondents were advised about condom usage, correlating with table 4.20 where 58,82% of the respondents indicated condom use, and table 4.18 where 53,27% indicated knowing about condoms. More extensive condom use should be promoted, especially for adolescents since condoms protect against both pregnancy and STIs, including HIV/AIDS. However, something may

be lacking with regard to condom use as all these respondents became pregnant in spite of this knowledge, and 10 had used condoms prior to their pregnancies.

4.4.16 Distance from home to the nearest clinic

The respondents were asked to estimate the distance from their homes to the nearest clinic.

Table 4.28 Distance from home to the nearest clinic

DISTANCE	FREQUENCY	PERCENTAGE
0-5 km	73	68,22
5-10 km	20	18,69
10-20 km	10	9,35
20 km and more	1	0,93
No response	3	2,80
TOTAL	107	100,00

Of the respondents, 73 (68,22%) travelled less than 5 km from their homes to their nearest clinic, which meant that these clinics should have been within the respondents' geographical reach. However, the geographical accessibility of living up to 5 km from clinics did not prevent the 73 respondents from becoming pregnant. The 10 (9,35%) respondents who had to travel more than 10 km could experience problems of accessibility. Only 3 (2,80%) respondents did not reply to this question.

4.4.17 Type of clinic visited by respondents

The respondents were asked to indicate the type of clinic used. Table 4.30 indicates that of the respondents, 73 (68,22%) used fixed clinics that operate from 07:00 to 16:00, 20 (18,69%) used mobile clinics visiting their areas once a month and 10 (10,28%) used community health centres. Only one respondent (0,93%) did not reply to this question.

Table 4.29 Type of clinic

TYPE OF CLINIC	FREQUENCY	PERCENTAGE
Fixed clinic (07:00-16:00)	73	68,22
Mobile clinic (once a month)	20	18,69
Community health centre (24 hours)	10	9,35
No response	1	0,93
TOTAL	107	100,00

From table 4.29 it is clear that contraceptive services are available to 99,07% of the respondents because they indicated a type of health service used. However, the distance the respondents have to travel may influence the type of health service used since 73 (66,22%) of the respondents travel less than 5 km to the nearest clinic as indicated in table 4.28. Hence for the majority of the respondents, utilisation could not be affected by accessibility in terms of geographical distance from their homes to the nearest clinic.

4.4.18 Clinic operating days

The respondents were asked to indicate their clinic operating days.

Table 4.30 Clinics' operating days

DAY	FREQUENCY	PERCENTAGE
Monday	103	96,26
Tuesday	102	95,33
Wednesday	102	95,33
Thursday	105	98,13
Friday	34	31,78
Saturday	1	0,93

Of the respondents, 105 (98,13%) indicated clinic operating day on Thursdays because contraceptive services were previously offered on Thursdays although contraceptive services had been available from Monday to Friday (from 07:00 to 16:00) in the Piet Retief (Mkhondo) area for months prior to the current study. This aspect needs to be stressed during health education sessions with adolescents so that they know about contraceptive services' availability at the fixed clinics and daily (24 hours) at community health centres. Only 34 (78,0%) respondents indicated that contraceptive clinics operated on Fridays, implying that 72 believed contraceptive services were not available on Fridays. This perception might have been attributable to past clinic operations in the Piet Retief (Mkhondo) area, when Fridays were used only for administration and in-service duties, and not for providing services to clients. Although this has changed, and services are available to clients on Fridays, some respondents did not perceive Fridays as clinic days.

4.4.19 Clinic operating times

The respondents were asked to indicate the times during which contraceptive services were available from their clinics.

Table 4.31 Clinic operating times

OPERATING TIMES	FREQUENCY	PERCENTAGE
All the time	63	58,88
On specific days	35	32,71
At specific times	5	4,67
No response	4	3,74
TOTAL	107	100,00

Table 4.31 indicates that only 63 (58,88%) of the respondents reported that contraceptive services were available at all times while the clinics were open. This could mean that the respondents' perceptions were that they could not access contraceptive services at all times, even if these services were, in fact, available. Merely extending the consulting hours and days did not succeed

in enhancing adolescents' accessibility nor utilisation of the services because they lacked the appropriate knowledge.

When comparing tables 4.30 and 4.31, it is evident that contraceptive services were not perceived to be available every day when the clinic was open. These perceptions might have impacted negatively on the perceived accessibility of contraceptives, compromising their decision-making on whether or not to become pregnant. Accessibility seems to have been compromised when comparing tables 4.31, 4.30 and 4.28.

Of the respondents, 98,13% accessed clinics only on Thursdays, 68,22% travelled less than 5 km to the clinics and 58,88% could access their clinics for contraceptive services at all times. (Table 4.30 indicates that some adolescents continued to believe [erroneously] that contraceptive services were offered only on Thursdays.) Only 1 (0,93%) respondent could access contraceptive services on Saturdays and travel more than 20 km to their clinics. The findings indicate that accessibility could contribute to the respondents' non-utilisation of contraceptives. More information about longer clinic hours and about the availability of contraceptives at clinics on all weekdays in the Piet Retief (Mkhondo) area might help adolescents, including adolescent mothers, to make better informed decisions about the utilisation of contraceptives. Moreover, merely extending the clinic hours and days for providing contraceptives did not seem to benefit the adolescent mothers who were apparently uninformed about these changes that could have benefited them.

4.4.20 Clinic staff's attitudes towards adolescent clients

The respondents were asked to rate their clinic staff's attitudes towards adolescent clients.

Table 4.32 Clinic staff's friendliness towards adolescent clients

FRIENDLINESS	FREQUENCY	PERCENTAGE
Very friendly	37	34,58
Friendly	51	47,66
Unfriendly	9	8,41
Extremely unfriendly	4	3,74
No response	6	5,61
TOTAL	107	100,00

Table 4.32 indicates that of the respondents, 51 (47,66%) found clinic staff members friendly, 37 (34,58%) found them very friendly, but 9 (8,41%) found them unfriendly and 4 (3,74%) indicated that clinic staff members were extremely unfriendly.

The respondents were asked to rate the clinic staff members' respect towards adolescents at clinics when they requested contraceptives.

Table 4.33 Clinic staff's respect towards adolescent clients

RESPONSE	FREQUENCY	PERCENTAGE
Yes	83	77,57
No	18	16,82
No response	6	5,61
TOTAL	107	100,00

Tables 4.32 and 4.33 indicate that clinic staff members were mostly perceived to show respect and to be friendly towards their adolescent clients. There was a similarity between tables 4.32 and 4.33 because 6 (5,61%) respondents did not respond to both questions. The positive responses to tables 4.33 and 4.34 indicated that 82,24% of the adolescent mothers perceived clinic staff to be friendly and 77,57% to show respect to the adolescent clients. This data did not indicate that lack of friendliness or respect from clinic staff members could be regarded as factors contributing to the respondents' non-utilisation of contraceptives.

4.4.21 Beliefs about contraceptives

The respondents were asked to state their beliefs about contraceptives and stated the following:

- Contraceptives prevent pregnancy (45,79%; n=49)
- Condoms protect from both pregnancy and STIs (13,08%; n=14)
- Contraceptives stop menstruation pains (0,93%; n=1)
- Weight gain occurs when contraceptives are used (0,93%; n=1).

Of the respondents, 42 (39,25%) did not indicate their beliefs about contraceptives. This could mean that they lacked knowledge about contraceptives. Of the 65 (61.75%) respondents who responded, 49 (45,79%) believed contraceptives do prevent pregnancies; 14 (13,08%) believed that condoms do prevent both pregnancies and STIs, and two (1,89%) believed that contraceptives caused side-effects of weight gain and amenorrhoea, respectively. Whether or not these two adolescent mothers also believed that contraceptives prevent unplanned pregnancies could not be ascertained from the available data.

4.4.22 Summary of contraceptive knowledge

In section C the adolescent mothers responded to 26 questions on their knowledge about contraceptives. The findings in this section indicate that knowledge about contraceptives, side effects and accessibility could contribute to the adolescent mothers' non-utilisation of contraceptives.

4.5 TERMINATION OF PREGNANCY SERVICES (TOPs)

This section consisted of eight questions on termination of pregnancy and one last part where adolescent mothers could provide comments or state contraceptive problems in their own words.

4.5.1 Termination of pregnancies (TOPs)

The respondents were asked whether they had heard about legally available TOP services.

Table 4.34 Knowledge about termination of pregnancy (TOP) services

RESPONSE	FREQUENCY	PERCENTAGE
Yes	25	23,36
No	78	72,90
No response	4	3,74
TOTAL	107	100,00

Of the respondents, 78 (72,90%) indicated that they had not and 25 (23,36%) had heard about TOPs while 4 (3,74%) did not reply to this question. It could be surmised that if more of the respondents had known about TOP services in their areas, and if they could have accessed these services, fewer of them might have been adolescent mothers at the time of collecting data for this study.

4.5.2 Knowledge about termination of pregnancy services (TOPs)

The respondents stated that they knew that TOPs

- were legal in South Africa (8,41%; n=9)
- were dangerous (4,67%; n=5)
- implied killing babies (1,87%; n=2)
- constituted a sin before God (0,93%; n=1)

As only 8 (7.48%) respondents reported negative perceptions of TOPs, it could not be established why the others had failed to obtain TOP services and became adolescent mothers, assuming that the other 99 respondents did not harbour similar negative attitudes towards TOPs. However, as

only 25 (23,36%) of the respondents indicated that they knew about TOP services in the Piet Retief (Mkhondo) area, this aspect might deserve greater attention from the health educators in this area.

4.5.3 Utilisation of termination of pregnancy services (TOPs)

The respondents were asked whether they had ever undergone an abortion or utilised TOP services.

Table 4.35 Previous abortions (TOPs)

RESPONSE	FREQUENCY	PERCENTAGE
Yes	4	3,74
No	97	90,65
No response	6	5,61
TOTAL	107	100,00

Of the respondents, 97 (90,65%) reported that they had never used TOPs or undergone abortions. Only 4 (3,74%) respondents had had abortions while 6 (5,61%) did not reply to this question. It is not known whether the 4 adolescent mothers had used TOPs prior to or after the birth of their babies, nor whether the TOP had failed for some reason.

4.5.4 Reasons for abortions/TOPs

The reasons given by the 4 respondents for using TOPs were poverty (2), rape (1) and not being ready to bear and raise a child (1). Regular information regarding TOPs should be provided for adolescents to enable pregnant adolescent women to make informed decisions on whether or not to use the service in the first twelve weeks of conception. Only two of the respondents procured TOPs at a hospital or from a doctor, while one did so at home and the other one failed to indicate where she obtained TOPs. Although only 4 respondents responded to this item, it might indicate that TOPs are not freely accessible to adolescents at clinics in the Piet Retief (Mkhondo) area. Such non-accessibility of TOPs could be a factor influencing the respondents' and other adolescent

mothers' non-utilisation of TOPs, contributing to the number of unplanned adolescent pregnancies in the area.

4.5.5 Willingness to use TOPs

The respondents were asked whether they would use TOPs if they could access them. Of the respondents, 82 (76,64%) indicated that they would not use TOPs even if they could access them; 11 (10,28%) indicated that they would use TOPs and 14 (13,08%) did not respond to this question. More factual information could be provided to adolescents on TOP issues, procedures and legal aspects. Although many of the respondents would refrain from using TOPs, only 2 had experienced problems with these services. One these respondents explained her problem as feeling guilty and like a murderer after the TOP. Thus her problem concerned her own psychological experiences, rather than the TOPs as such.

These results supported those of Myburgh et al (1998:18) who found that adolescents experienced psychological pain and were depressed subsequent to procuring TOPs. Myburgh et al (1998:19) stress that counselling should focus on the girl's termination of pregnancy as a long-term issue, possibly incorporating spiritual and psychological pain. The finding that a few respondents would use TOPs indicates a need for more abortion clarification workshops and awareness campaigns.

4.5.6 Comments or problems

The questionnaire concluded with an open question requiring the respondents to comment on contraceptives. The following responses were received:

- The questionnaire should be re-administered at a later stage as they enjoyed completing it (8)
- They had no problems with clinic staff (7)

- Adolescents should be taught to use condoms effectively as condoms prevent both pregnancy and STIs (5)
- Clinic staff members do not treat adolescents well (2)
- Adolescents should use contraceptives and not TOPs (1)
- It was a mistake to have a child (1)
- Stronger condoms should be supplied as they “burst” (1)
- Young people, not adults, should be appointed to teach and render contraceptive service to adolescents (1)

The respondents' comments may not be generalisable because of the small number of responses. However, their concerns about condoms should be dealt with to enable more adolescents to prevent unplanned pregnancies in the Piet Retief (Mkhondo) area.

4.5.7 Summary of TOPs

Section D covered nine questions on TOPs. Of the 107 respondents, 78 (72,90%) indicated that they had not heard about TOPs and only 9 knew that TOPs were legal in South Africa. This information may indicate that adolescents require more information about TOPs.

4.6 FINDINGS IN TERMS OF THE HEALTH BELIEF MODEL (HBM)

The researcher used the HBM to contextualise factors contributing to the adolescent mothers' non-utilisation of contraceptives. According to Onega (2001:271), the HBM provides a framework for understanding why some people (in this study, adolescent mothers) take specific actions to avoid illness (in this study, pregnancy instead of illness), whereas others fail to protect themselves (in this case, become adolescent mothers). The findings are discussed in terms of the three main components of the HBM, namely individual perceptions, modifying factors, and variables affecting initiating action.

4.6.1 Individual perceptions

The study found that of the adolescent mothers, 74 (69,14%) did not know about emergency contraceptives and 88 (82,24%) did not use any contraceptives prior to their pregnancies. Negative perceptions about TOPs may have prevented them from procuring these services to terminate unplanned pregnancies. Perceptions that contraceptives cause weight gain may have been a deterrent to using contraceptives.

4.6.2 Modifying factors

The adolescent mothers were aged between 14 and 19 years of age. The majority (94,39%) were Zulu- speaking. Of the respondents, 72 (67,29%) were from a low social class as the household monthly income was below R1 000,00.

4.6.3 Variables affecting the initiation of actions

Although the respondents knew about contraceptives, namely condoms, injections, oral pills, ECs and IUCDs, this knowledge did not enable them to use contraceptives effectively to prevent their pregnancies. Of the respondents, 88 (82,24%) did not use contraceptives before pregnancy, 17 (15,89%) used contraceptives before pregnancy and 2 (1,87%) did not reply to this question.

The adolescent mothers in this study indicated the following perceived barriers to contraceptive use:

- prolonged menstruation due to contraceptives
- accessibility of contraceptive services was more limited than the actual accessibility as a large number of respondents were unaware of the extended clinic hours and days during which contraceptives can be obtained in the Piet Retief (Mkhondo) area
- lack of knowledge about contraceptives, ECs and TOPs.

4.7 CONCLUSION

This chapter discussed the data analysis and interpretation with reference to the literature review. The aim of this study was to identify factors contributing to adolescent mothers' non-utilisation of contraceptives. The main findings of the investigation were summarised in each section.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for practice and further research.