

**ADOLESCENTS' KNOWLEDGE OF CONTRACEPTION IN A  
SELECTED AREA IN ANGOLA**

by

**ENGRÁCIA DA GLÓRIA GOMES DE FREITAS**

submitted in partial fulfilment of the requirements

for the degree of

**MASTER OF ARTS**

in the subject

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

**SUPERVISOR: MRS JE TJALLINKS**

**JOINT SUPERVISORS:  
PROF MC BEZUIDENHOUT AND MRS E SOARES**

**JUNE 2007**

Student number: 3412-595-7

## DECLARATION

I declare that the study on **ADOLESCENTS' KNOWLEDGE OF CONTRACEPTION IN A SELECTED AREA IN ANGOLA** is my own work and that all the sources consulted, used or quoted are reliable sources and that this work has not been submitted previously in any other institution.

SIGNATURE

(E da GG de Freitas)

DATE .....

# **ADOLESCENTS' KNOWLEDGE OF CONTRACEPTION IN A SELECTED AREA IN ANGOLA**

STUDENT NUMBER: 3412-595-7  
STUDENT: E DA GG DE FREITAS  
DEGREE: MASTER OF ARTS  
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA  
SUPERVISOR: MRS JE TJALLINKS  
JOINT SUPERVISORS: PROF MC BEZUIDENHOUT AND MRS E SOARES

## **ABSTRACT**

Adolescent pregnancy is a worldwide problem. This study attempted to describe and explore the knowledge of female adolescents in Angola's knowledge with regard to contraception.

The research results, obtained from interview schedules, revealed that the respondents lacked knowledge about themselves as adolescents as well as a lack of knowledge of their reproductive health and development. Furthermore, the results portrayed a lack of knowledge of contraceptives.

The study findings may assist health care providers to identify educational programmes on contraception at schools, markets and in the community.

## **KEY TERMS**

Adolescent; contraception; emergency contraception; knowledge; reproductive health; termination of pregnancy.

## **ACKNOWLEDGEMENTS**

- Having completed this work I thank
- All Mighty God who gave me life, strength, vision and enlightenment during the development of this work
- The Ministry of Health for the initiative taken in terms of enabling a Masters' degree in nursing in Angola
- The Rectorate of the University Agostinho Neto for the support during this degree
- To SANTED for having financed the project through the Embassy of Norway without which this Master's degree would not have been possible
- The University of South Africa (UNISA) for consenting and authorizing the training of Angola Nurses in this area
- The tireless and immeasurable support and guidance provided by Mrs JE Tjallinks is forever registered in my mind and in my heart, for the way in which she knew how to pass on her knowledge throughout this course as well as throughout the development of the research study
- To Mrs Elizabete Soares, for the hard work involved in the translation of assignments, exams as well the making of this work

At this moment in time, I lack the appropriate words to express my sincere thanks to:

- All my colleagues who directly or indirectly contributed to making this work a reality
- All adolescents who were willing to partake in this study, and without whom this would not have been possible

## *Dedication*

*I dedicate this work  
to my mother, to my husband, my children, brothers and sisters,  
for their tolerance throughout these long five years of study,  
with them I learnt to have doubts and not to lose the capability to dream.*

## Chapter 1

### Orientation to the study

1.1	INTRODUCTION .....	1
1.2	BACKGROUND TO THE STUDY .....	1
1.2.1	Demographic background of Angola .....	1
1.2.1.1	Language .....	1
1.2.1.2	Population .....	1
1.2.1.3	Socio-religious aspects .....	2
1.2.1.4	Independence of Angola .....	2
1.2.1.5	Life expectancy .....	2
1.2.2	Introduction and background of the problem .....	2
1.2.3	Pregnancy in adolescence .....	5
1.2.3.1	Biological factors .....	5
1.2.3.2	Family factors .....	6
1.2.3.3	Social factors .....	6
1.2.3.4	Psychological factors and contraception .....	6
1.2.4	Sexually transmissible infections amongst adolescents .....	6
1.2.5	Contraception in adolescence .....	7
1.3	PROBLEM STATEMENT .....	7
1.4	AIM AND PURPOSE FO THE STUDY .....	8
1.5	OBJECTIVES OF THE STUDY .....	8
1.6	RESEARCH QUESTION .....	8
1.7	SIGNIFICANCE OF THE STUDY .....	9
1.8	RESEARCH DESIGN AND METHOD .....	10
1.8.1	Research design .....	10
1.8.2	Setting of the study .....	10
1.8.3	Population and sample .....	11
1.8.3.1	Population .....	11
1.8.3.2	Sampling technique .....	11
1.8.4	Data collection instrument .....	12
1.8.5	Data analysis .....	12
1.8.6	Generalisability .....	12
1.8.7	Ethical considerations .....	12
1.9	LIMITATIONS OF THE STUDY .....	13
1.10	OPERATIONAL DEFINITIONS .....	13

Table of contents	Page
1.11 ORGANISATION OF THE REPORT .....	15
1.12 ABBREVIATIONS .....	16
1.13 CONCLUSION .....	16
 <b>Chapter 2</b>	
<b>Literature review</b>	
2.1 INTRODUCTION .....	17
2.2 REASON FOR THE LITERATURE REVIEW .....	17
2.3 CONCEPTS RELATED TO ADOLESCENTS' KNOWLEDGE OF CONTRACEPTION IDENTIFIED IN THE LITERATURE.....	18
2.3.1 Knowledge.....	18
2.3.1.1 Defining knowledge .....	19
2.3.1.2 Domains of knowledge .....	19
2.4 ADOLESCENCE .....	21
2.4.1 Changes in the behaviour of the adolescent .....	21
2.4.2 Physical development in adolescence.....	22
2.4.3 Hypersensitivity in adolescence .....	23
2.4.4 Psychosocial development during adolescence.....	23
2.4.5 Factors which may influence female adolescents' usage of contraceptives.....	24
2.4.6 Factors that could influence adolescents' use of contraceptives.....	26
2.5 SEXUAL AND REPRODUCTIVE HEALTH .....	32
2.5.1 National Health System in Angola .....	33
2.5.2 Institutions and specialised services .....	34
2.6 SEXUALITY.....	36
2.6.1 Stages of sexuality in the adolescent .....	36
2.7 CONTRACEPTION .....	38
2.7.1 Organisation of services.....	38
2.7.2 Objectives of contraception .....	39
2.7.3 Family planning .....	39
2.7.4 Promotion of contraceptive health by counselling .....	40
2.7.5 Contraception for adolescents.....	40
2.7.6 Evaluation and diagnosis.....	41
2.7.7 Counselling.....	44
2.7.7.1 Pre-conception counselling .....	44
2.7.7.2 Basic principles of counselling.....	45

Table of contents	Page
2.7.8 Benefits of contraception .....	45
2.7.9 Contraceptive methods appropriate for adolescents .....	46
2.8 SEXUALLY TRANSMITTED INFECTIONS (STIs) .....	69
2.9 CONCLUSION.....	71

## Chapter 3

### Research methodology

3.1 INTRODUCTION .....	72
3.2 AIM AND PURPOSE OF THE STUDY .....	72
3.2.1 Objectives of the study .....	72
3.3 RESEARCH QUESTION .....	73
3.4 RESEARCH SETTING .....	73
3.5 RESEARCH DESIGN .....	74
3.5.1 Quantitative research design.....	74
3.5.2 Descriptive research design .....	76
3.5.3 Exploratory research design.....	76
3.6 TARGET POPULATION .....	76
3.6.1 Inclusion criteria.....	77
3.6.2 Exclusion criteria .....	77
3.7 SAMPLE DESIGN AND PROCEDURES .....	77
3.7.1 Sampling site .....	78
3.7.2 Sampling of respondents .....	78
3.7.2.1 Convenience sampling .....	78
3.7.3 Sample size .....	78
3.8 DATA COLLECTION .....	79
3.8.1 Data-collection instrument .....	79
3.8.2 Conducting the interviews.....	80
3.8.2.1 Advantages of structured interviews.....	80
3.8.2.2 Disadvantages of structured interviews .....	81
3.8.3 Pre-testing of instrument .....	81



Table of contents	Page
3.9	VALIDITY AND RELIABILITY ..... 81
3.9.1	Validity ..... 82
3.9.2	Threats to internal and external validity ..... 83
3.9.2.1	Internal validity ..... 83
3.9.2.2	External validity ..... 84
3.9.3	Reliability ..... 84
3.9.3.1	Pre-test ..... 84
3.10	ETHICAL CONSIDERATIONS ..... 85
3.10.1	Permission to conduct the study ..... 85
3.10.2	Respect for persons as autonomous individuals ..... 86
3.10.3	Confidentiality and anonymity ..... 86
3.10.4	Privacy and dignity ..... 86
3.10.5	Avoiding harm ..... 87
3.10.6	Justice ..... 87
3.10.7	Informed consent ..... 87
3.10.8	Right to withdraw from the study ..... 87
3.10.9	Disclosure of results ..... 88
3.11	DATA ANALYSIS ..... 88
3.12	CONCLUSION ..... 88

## Chapter 4

### Data analysis and interpretation

4.1	INTRODUCTION ..... 90
4.1.1	Data presentation ..... 91
4.2	SECTION A: DEMOGRAPHIC DATA ..... 92
4.2.1	Age of respondents (item 1) ..... 92
4.2.2	School attendance of respondents (item 2) ..... 93
4.2.3	Highest grade passed (item 3) ..... 94
4.2.4	Activity of respondents not attending school (item 4) ..... 94
4.2.5	Reasons for not attending school (item 5) ..... 94
4.2.6	Ethnic group (item 6) ..... 95
4.2.7	Religious affiliation (item 7) ..... 96
4.2.8	Language spoken (item 8) ..... 97
4.2.9	Family structure (item 9) ..... 97
4.2.10	Sex discussion with the family (item 10) ..... 98

# Table of contents

# Page

4.2.11	Information on discussion about sex with the family (item 11).....	99
4.2.12	Reasons for not discussing sex with the family (item 12).....	100
4.2.13	Relationship with a family member (item 13).....	100
4.2.14	Discussing sex with friends (item 14).....	101
4.2.15	Reasons for discussing sex with friends (item 15).....	102
4.2.16	Reasons for not discussing sex with friends (item 16).....	103
4.2.17	Menstrual cycle (item 17).....	103
4.3	SECTION B: ADOLESCENCE.....	105
4.3.1	Understanding of the term "adolescence" (item 18).....	105
4.3.2	Age at which adolescence begins (item 19).....	106
4.3.3	Physical changes in adolescence (item 20).....	107
4.3.4	Physical changes experienced by adolescents (item 21).....	108
4.3.5	Emotional changes expected during adolescence (item 22).....	109
4.3.6	Discussing sex with the mother (item 23).....	110
4.3.7	Topics discussed with mothers about sex (item 24).....	112
4.4	SECTION C: SEXUALITY.....	113
4.4.1	Sexual behaviours which are part of your orientation (item 25).....	113
4.4.2	Sexual intercourse (item 26).....	114
4.4.3	Age when first started having sexual intercourse (item 27).....	114
4.4.4	Reasons for having sexual intercourse (item 28).....	115
4.4.5	Consequences of having unprotected sex (item 29).....	116
4.4.6	Contraceptive methods used (item 30).....	117
4.4.7	Abortion (item 31).....	118
4.4.8	Where was the abortion done? (item 32).....	119
4.4.9	Age at the time of the abortion (item 33).....	119
4.5	SECTION D: CONTRACEPTION.....	119
4.5.1	Knowledge of contraception (item 34).....	119
4.5.2	Meaning of contraception (item 35).....	120
4.5.3	Source of Information (item 36).....	121
4.5.4	Belief in the use of condoms (item 37).....	122
4.5.5	Beliefs with regard to condom use (item 38).....	123
4.5.6	Use of condoms as a contraceptive (item 39).....	123
4.5.7	Acquisition of contraceptives (item 40).....	124
4.5.8	Type of contraceptive used (item 41).....	125
4.5.9	Information received about vaginal contraceptives (item 42).....	126
4.5.10	Partner's agreement with guidance received about vaginal contraception (item 43).....	126
4.5.11	Method used to prevent unwanted pregnancy (item 44).....	127
4.5.12	How do spermicides work? (item 45).....	128
4.5.13	How do diaphragms and cervical caps work? (item 46).....	128
4.5.14	Information received about oral contraceptives (item 47).....	129
4.5.15	How do oral contraceptives work? (item 48).....	129
4.5.16	Information about injectable contraceptives (item 49).....	130
4.5.17	How does injectable contraception work? (item 50).....	131
4.5.18	Have you ever heard of emergency contraception? (item 51).....	131
4.5.19	Meaning of emergency contraception (item 52).....	132
4.5.20	Reason for using emergency contraception (item 53).....	133
4.5.21	Source of emergency contraception (item 54).....	133

## Table of contents

## Page

4.6	SECTION E: SEXUALLY TRANSMITTED INFECTIONS (STIs).....	134
4.6.1	Definition of AIDS (item 55) .....	134
4.6.2	Definition of HIV (item 56).....	135
4.6.3	HIV transmission (item 57) .....	136
4.6.4	HIV prevention (item 58).....	137
4.6.5	Have you ever heard of Sexually Transmitted Infections (STIs)? (item 59).....	138
4.6.6	Meaning of STIs (item 60) .....	139
4.6.7	STI diseases (item 61).....	140
4.6.8	STI transmission (item 62).....	141
4.6.9	Have you been raped before? (item 63) .....	142
4.6.10	Socio-cultural taboos about the use of artificial contraception (item 66).....	142
4.6.11	Decisions about contraception (item 68) .....	143
4.6.12	Children seen as proof of ... (item 69).....	144
4.6.13	Cultural preferences with regard to a particular gender (item 70).....	145
4.6.14	Preferred gender (item 71) .....	146
4.6.15	Menstrual blood considered as "polluting" (item 73).....	147
4.6.16	Acceptance of contraceptives (item 74).....	148
4.6.17	Beliefs about female anatomy related to the acceptance of IUCD'S (item 75) .....	149
4.6.18	Description of beliefs (item 76) .....	150
4.7	CONCLUSION.....	150

## Chapter 5

### Results, conclusions and recommendations

5.1	INTRODUCTION .....	151
5.2	OBJECTIVES .....	151
5.3	RESULTS .....	151
5.3.1	Section A: Demographic data .....	152
5.3.2	Section B: Adolescence.....	152
5.3.3	Section C: Sexuality .....	154
5.3.4	Section D: Contraception.....	154
5.3.5	Section E: Sexually transmitted infections (STIs) .....	157
5.4	CONCLUSIONS .....	159
5.4.1	Section A: Demographic data .....	159
5.4.2	Section B: Adolescence.....	159
5.4.3	Section C: Sexuality .....	160
5.4.4	Section D: Contraception.....	160
5.4.5	Section E: Sexually transmitted infections (STIs) .....	161
5.5	RECOMMENDATIONS .....	162
5.5.1	Improved knowledge of contraception through the family.....	162
5.5.2	Improving knowledge with regard to contraception for female adolescents .....	163
5.5.3	The Ministry of Education .....	165

Table of contents	Page
5.5.4 The Health Centres .....	165
5.5.5 The Ministry of Health.....	165
5.5.6 The media.....	166
5.6 RECOMMENDATIONS FOR ADDITIONAL RESEARCH .....	166
5.7 LIMITATIONS OF THE STUDY.....	167
5.8 CONCLUDING REMARKS.....	168
5.9 CONCLUSION.....	168
BIBLIOGRAPHY .....	169

List of tables	Page
Table 4.1	Age of respondents (N=100) ..... 92
Table 4.2	Activities if not attending school (N=20) ..... 94
Table 4.3	Reasons that led respondents to not continuing attending school (N=100) ..... 95
Table 4.4	Ethnic group (N=100) ..... 96
Table 4.5	Religious affiliation (N=99) ..... 96
Table 4.6	Language spoken (N=100) ..... 97
Table 4.7	Reasons why respondents do not discuss sex with their families (N=100) ..... 100
Table 4.8	Age at which adolescence begins (N=100) ..... 107
Table 4.9	Sexual intercourse (N=100) ..... 114
Table 4.10	Have you ever had an abortion (N=100) ..... 118
Table 4.11	Belief in the use of condoms as a contraceptive (N=77) ..... 122
Table 4.12	Information received about vaginal contraceptives (N=100) ..... 126
Table 4.13	Partner's agreement with guidance received about vaginal contraception (N=100) ..... 127
Table 4.14	Method used to prevent undesired pregnancy (N=100) ..... 127
Table 4.15	How spermicides work (N=100) ..... 128
Table 4.16	How diaphragms and cervical caps work (N=100) ..... 128
Table 4.17	Information received about oral contraceptives (N=100) ..... 129
Table 4.18	How oral contraceptives work (N=100) ..... 130
Table 4.19	Information on injectable contraceptives (N=100) ..... 130
Table 4.20	How injectable contraception works (N=100) ..... 131
Table 4.21	Have you ever heard of emergency contraception? (N=100) ..... 131
Table 4.22	Meaning of emergency contraception (N=100) ..... 132
Table 4.23	Reason for using emergency contraception (N=100) ..... 133
Table 4.24	Source of emergency contraception (N=100) ..... 134
Table 4.25	Relates to the issue of rape (N=100) ..... 142
Table 4.26	Decisions about contraception (N=100) ..... 144
Table 4.27	Acceptance of contraceptives (N=100) ..... 149

## List of figures

## Page

Figure 1.1	Map of Angola .....	10
Figure 2.1	Cairo Conference Population and Development .....	33
Figure 2.2	Benefits of contraception.....	46
Figure 4.1	School attendance of respondents (N=99).....	93
Figure 4.2	Family structure (N=100).....	98
Figure 4.3	Sex discussion with the family (N=100).....	99
Figure 4.4	Relationship between the respondents and family members (N=97) .....	101
Figure 4.5	Discussing sex with friends (N=100) .....	102
Figure 4.6	Reasons why respondents can discuss sex with their friends (N=100).....	103
Figure 4.7	Understanding of the menstrual cycle (N=100) .....	104
Figure 4.8	Understanding of the term “adolescence” (N=100) .....	106
Figure 4.9	Physical changes in adolescence (N=100) .....	108
Figure 4.10	Physical changes experienced by adolescents (N=100) .....	109
Figure 4.11	Emotional changes expected during adolescence (N=55) .....	110
Figure 4.12	Discussing sex with the mother (N=99).....	111
Figure 4.13	Topics discussed with mothers about sex (N=100).....	112
Figure 4.14	Sexual behaviours which are part of your orientation (N=100).....	113
Figure 4.15	Age when started having sexual intercourse (N=100).....	115
Figure 4.16	Reasons for having sexual intercourse (N=100) .....	116
Figure 4.17	Consequences of having unprotected sex (N=100) .....	117
Figure 4.18	Contraceptive methods used (N=100).....	118
Figure 4.19	Knowledge of contraception (N=99) .....	120
Figure 4.20	Meaning of contraception (N=100) .....	121
Figure 4.21	Source of information on contraception (N=100).....	122
Figure 4.22	Beliefs with regard to condom use (N=100) .....	123
Figure 4.23	Use of contraceptives (N=98).....	124
Figure 4.24	Acquisition of contraceptives (N=100).....	125
Figure 4.25	Type of contraceptive used (N=100) .....	125

List of figures	Page
Figure 4.26	Definition of AIDS (N=100) ..... 135
Figure 4.27	Definition of HIV (N=100) ..... 136
Figure 4.28	HIV transmission (N=100) ..... 137
Figure 4.29	Prevention of HIV (N=100) ..... 138
Figure 4.30	Have you ever heard of Sexually Transmitted Infections (STIs)? (N=100)..... 139
Figure 4.31	Meaning of STIs (N=100) ..... 140
Figure 4.32	STI diseases (N=100)..... 141
Figure 4.33	Transmission of STIs (N=100)..... 142
Figure 4.34	Socio-cultural taboos about the use of artificial contraception (N=100) ..... 143
Figure 4.35	Children as proof of ... (N=100) ..... 145
Figure 4.36	Cultural preferences with regard to gender (N=100) ..... 146
Figure 4.37	Preferred gender (N=100) ..... 147
Figure 4.38	Menstrual blood considered as "polluting" (N=100)..... 148
Figure 4.39	Beliefs about female anatomy related to the acceptance of IUCDs (N=100) ..... 149

## List of annexures

---

Annexure A	Permission requested to conduct a research study
Annexure B	Permission granted to conduct a research study
Annexure C	Consent form
Annexure D	Interview schedule
Annexure E	Clearance certificate



# **Chapter 1**

## **Orientation to the study**

### **1.1 INTRODUCTION**

This chapter is an introduction to the study. It gives an outline of the study, describes the background to the problem, formulates the problem statement and discusses the significance of the study. It also includes the research questions and objectives. The researcher also briefly discusses the methodology and the research design, the population and the sample, the setting, the techniques for data collection, the reliability and validity of the study and ethical considerations.

### **1.2 BACKGROUND TO THE STUDY**

#### **1.2.1 Demographic background of Angola**

Angola is a country situated on the west coast of Africa, bordered on the north by the Democratic Republic of Congo, on the northeast by the Republic of Congo, on the east by Zambia, on the south by Namibia and on the west by the Atlantic ocean, with an area of 1 276 700 km<sup>2</sup>. It has a population of 13,5 million inhabitants and 18 provinces (AIDS Network 2005:1). The capital of the country is Luanda, with an estimated population of 5 million inhabitants divided into nine (9) municipalities; the Municipality of Cazenga is the most populated, with a population estimated to be 1 500 000 inhabitants, of which 290 034 are at a reproductive age (Provincial Director of Health, Luanda 2004:2).

##### **1.2.1.1 *Language***

The official spoken language is Portuguese, followed by various local languages, with the main ones being Kimbundo, Umbundo and Kikongo.

##### **1.2.1.2 *Population***

The rural population is 58% and the urban population is 42%, 60% of whom live below the poverty line, and lack access to health services (Angola 2004c:12).

### **1.2.1.3 Socio-religious aspects**

With regard to religious beliefs, 38% of the population is Catholic, 15% Protestant and 47% practise traditional religions. Angola is a country with a high potential for development, with oil reserves, abundant mineral resources, capacity for electrical energy, great potential in agriculture and cattle breeding, fisheries and forestry. Owing to the war situation, it has suffered major damage and the economy in general is the aspect most affected. (AIDS Network 2005:3).

### **1.2.1.4 Independence of Angola**

Angola became independent from the Portuguese Government in 1975 and independence was followed by a war which lasted more than 20 years (AIDS Network 2005:3), a conflict which had as a consequence approximately 4,2 million refugees and a myriad of social, economic, political and health problems, with the maternal mortality rates being the highest in the world (1 850/100 000 live births), and 1 in every 5 live births not surviving past infancy (Lemba 2002:1).

### **1.2.1.5 Life expectancy**

For those who managed to survive, life expectancy is on average 42,4 years, being 40 years for men and 45 years for women (MICS (Multi Inquiry Cluster Survey) 2003:12). According to the National Directorate of Public Health (Direcção Nacional de Saúde Pública) (Angola 2004c:21), the fertility rate is 7,1% per woman.

## **1.2.2 Introduction and background of the problem**

Education about life skills, which includes sex education and contraception, is first learned from parents who have the primary responsibility for providing sex education for their children. As a child starts primary and secondary schooling, the responsibility for sex education expands to engage teachers.

Sex education, as part of life skills education on sexual behaviour for adolescents, should form part of a total health-care strategy. The lack of information about sexual

behaviour and contraception leads to sexual dysfunction, teenage pregnancy, sexual abuse and sexually transmitted diseases (Williams & Mavundla 1999:58-59). Life skills education, which includes education on contraception, is supported in many schools, but it is not allowed in many others. Many life skill educators are hesitant and do not have the personal confidence to discuss sexuality and contraception with the adolescents. These educators feel more comfortable teaching the basic anatomy and physiology, from fear of the controversy regarding sexual issues (Miller 1992:352).

Currently, emphasis is placed on maternal and child health care services in Angola. The health authorities target groups such as expectant mothers, and children under the age of five years. As a result the health care services rendered to adolescents are insufficient, which results in unplanned pregnancies and back-street abortions. Many of the adolescents have a dual role, both attending school and being mothers.

Sexuality is a lifelong process that encompasses the biological, emotional, psychological and social domains, and is a natural and healthy part of living. Appropriate sex education assists the youth and adolescents in acquiring an understanding of what sexuality is, engendering a positive view of sexuality and helping them make responsible decisions regarding their sexual health (Fraser, Cooper & Nolte 2006:353-354).

According to the World Health Organization (WHO 2005:1) there were more than 5 million new cases of Human Immunodeficiency Virus (HIV) infections registered at world level in 2005 occurring among the 15-24-year-olds. Approximately 17 million girls younger than 20 years give birth each year in developing countries (Silberschmidt & Rasch 2001:1815-1816). In Angola, according to MICS (2003:27), by 18 years of age, one in three young girls have already given birth, and at 20 years of age, 68% are already mothers.

Substantial numbers of teenagers are still engaging in high-risk sexual practices such as unprotected sexual intercourse. A recent WHO global review of research exploring sexual practices concluded that the most successful approaches are those which do not focus exclusively on the cognitive processes of the individual, but also take into account the social world in which the behaviour happens.

Unwanted or unexpected pregnancies and sexually transmitted infections (STIs) among the youth are the result of engaging in unprotected sexual behaviour. It could be assumed that the lack of knowledge about the use of condoms or contraceptives, and the effects of HIV and other STIs contribute to unprotected sexual behaviour. According to Ehlers (2003:19-20), adolescent mothers in a survey in South Africa provided reasons for not using contraceptives such as: ignorance about contraceptives; fear of going to the clinic; fear of picking up weight; and opposition of their boyfriends regarding the use of contraceptives. A similar problem was identified amongst adolescents in Texas, in the United States (USA). Adolescents on the pill or using injectable hormonal contraceptives worried about gaining weight. Factors that impede the use of condoms by the youth in South Africa included lack of perceived risk; peer norms; condom unavailability; adult attitudes to condoms and sex; and gender power relationships (Ehlers 2003:20).

According to MICS (2003:27), in Angola, 37% of the population falls between the ages of 10 and 24, which constitutes a group of 5,2 million individuals with a specific need for sexual and reproductive health education. As predicted in 2005 by AIDS Network (2005:1), in Angola the number of new AIDS cases would increase from 21 000 in 2001 to between 45 000 and 49 000 in 2005. The prevalence of the virus could have increased from 5,7% in 2001 to 9,96% in 2005 and could reach 18,8% in 2010. The number of HIV positive individuals could go from 344 000 in 2001 to 749 000 in 2005, reaching 1,6 million in 2010. According to the Public Health Directorate (Angola 2004c:21) 8,9% of sexually transmissible infections constitute the main problem of morbidity among women.

Many countries such as Australia, the USA and South Africa have national life skills programmes in place. But despite these programmes a large number of adolescents still engage in unprotected sexual intercourse with casual partners (Fraser et al 2006:668).

In some countries like Lesotho, life skills education is taboo and there are in that country a large number of teenagers (13–19 years of age) who are sexually active.

In Angola life skills education programmes do not exist, or what exists is minimal because of the past war situation in the country and the total breakdown of social behaviour of the people. Thus, when sexual activity begins, most adolescents lack accurate knowledge about reproduction, sexuality and contraception.

### **1.2.3 Pregnancy in adolescence**

According to Vitalle and Amâncio (2005:2), the consequences of early sexual activity have as undesirable immediate consequences an increase in the number of sexually transmitted infections (STIs), and, often, undesired pregnancies which can end up in abortions which in turn give rise to delayed and long-term consequences for the adolescent. The adolescent could have growth and development problems, and emotional, behavioural, educational and learning problems due to complications during pregnancy and labour.

Vitalle and Amâncio (2005:1) further explain that pregnancy in adolescence is multicausal and its aetiology is related to various factors.

In a study on the impact of sex education on health beliefs of teenage mothers in Umtata, Transkei, South Africa, it was pointed out that adolescent mothers are not specifically targeted by health services, because the emphasis is on maternal (adult) and child health. Adolescents lack adequate access to health care (Cronje & Grobler 2003:665).

#### **1.2.3.1 Biological factors**

More and more adolescents fall pregnant and at earlier ages. Young teenage mothers tend to present late for antenatal care and are disproportionately likely to have some risk factors associated with poor antenatal health. In South Africa there is an increase in mortality and morbidity amongst teenage mothers due to the increased risk and severity of gestational proteinuric hypertension. In teenagers under 16 years, an incompletely developed pelvis may be responsible for higher rates of cephalopelvic disproportion which might result in obstructed labour and increase the caesarean section rate (Fraser et al 2006:22).

### **1.2.3.2 Family factors**

Adolescents who engage in early sexual activities or fall pregnant during that time usually come from families where the mothers also engaged in early sexual activities or fell pregnant during adolescence (Fraser et al 2006:22).

### **1.2.3.3 Social factors**

Society has undergone profound changes in its structure, including greater acceptance of sexuality in adolescence, sex before marriage and pregnancy in adolescence. For many young mothers, however, pregnancy and parenthood mean an early conclusion to their education with consequently reduced career opportunities and increased likelihood that they will find themselves socially excluded and living in poverty (Fraser et al 2006:72).

### **1.2.3.4 Psychological factors and contraception**

The use of contraceptive methods is not followed effectively during adolescence, and this is related to psychological factors inherent to that age. The adolescent denies the possibility of falling pregnant and that denial is higher the younger the adolescent.

In Angola abortion is not legalised. Moura (2005:8) refers to a statistical study carried out at the Lucrecia Paim Maternity in Luanda, Angola, a national referral institution, based on 2 445 cases of induced abortions, and reveals that 67,8% were illegal abortions, of which 61% were on single women and 32,2% were done at the hospital. The legal abortions done at the maternity were for medical reasons: cardiopathy and severe hypertension.

## **1.2.4 Sexually transmissible infections amongst adolescents**

According to the National Directorate of Public Health (Direcção Nacional de Saúde Pública) (Angola 2004c:21), 8,9% of STIs constitute the main problem of morbidity amongst women.

HIV/AIDS is preventing the growth and development of the youth, and this pandemic is more evident in the African countries south of the Sahara, where approximately 60% of HIV-positive individuals are females and are between 15 and 24 years of age (Bellamy 2005:70).

### **1.2.5 Contraception in adolescence**

Fraser et al (2006:655) indicates that for decades in sub-Saharan Africa, family planning has been perceived merely as an imposed means to control the population numbers.

In sub-Saharan Africa, family planning services are normally considered as priority. Yet family planning is often perceived by families and communities as a method to reduce their fertility, rather than being an intervention in terms of health. In the city of Luanda the availability of family planning services is still very limited.

According to the report submitted by the Coordination of Obstetric Services in Luanda (Angola 2004b), in the province of Luanda there are 45 services for family planning and in 2004, 28 053.00 adolescents were attended to for the first time. The Cazenga Municipality has five health centres which provide family planning consultation to adolescents that visited the health centre for the first time (Angola 2004c:21).

## **1.3 PROBLEM STATEMENT**

Despite the limited family planning programmes introduced in Luanda, indications are that teenage pregnancies and numbers of STIs and HIV cases continue growing at an alarming rate (MICS 2003:27).

Unwanted/unplanned pregnancies pose problems for women throughout the world, including Angola. Amongst 5,2 million adolescents, 68% of unwanted pregnancies continue to be terminated legally or illegally (MICS 2003:27). These unwanted/unplanned pregnancies, complications due to abortions, sexually transmitted diseases (STDs) especially the high incidence of HIV/AIDS (160 000 infected people), as well as the incidence of illiteracy amongst adolescents, place the country at a disadvantage in

terms of reproductive health and education, and thus perpetuate the cycle of poverty, increasing the rates of maternal (1 850 per 100 000 live births) and child mortality.

As adolescents are considered as the priority group for intervention, due to the critical phase they are undergoing in that age bracket, it becomes evident that there is an urgent need for a serious and uncompromising policy for intervention.

The research problem is to identify the knowledge adolescents have of contraception in order to prevent unplanned pregnancies. If the knowledge gaps are identified, recommendations can be made to enable more adolescents to gain sufficient life skills to lead a quality life.

#### **1.4 AIM AND PURPOSE OF THE STUDY**

The aim of the study was to propose strategies to promote health education programmes on life skills for adolescents, including contraceptive use by adolescents, to reduce unwanted pregnancies. The purpose of the study was to explore the knowledge that female adolescents have of contraception.

#### **1.5 OBJECTIVES OF THE STUDY**

The objective of the study encompasses the aims or goals that the researcher intends to reach with the research (LoBiondo-Wood & Haber 2001:42). The objectives of this study were to

- analyse the knowledge of adolescents about contraception
- determine the sources of information on the use of contraception methods
- make recommendations for educational programmes on contraception

#### **1.6 RESEARCH QUESTION**

Burns and Grove (2005:10) describe the research question as a concise and interrogative statement expressed in the present tense and generally with one or more variables.



The study sets out to answer the following question:

- What is the knowledge of adolescents in Angola with regard to contraception?

## **1.7 SIGNIFICANCE OF THE STUDY**

The study will provide information to health care practitioners regarding the knowledge that female adolescents in Luanda, Angola have on contraception. The study will further help health care practitioners in the preparation of female adolescents on matters relating to contraception and the prevention of unwanted pregnancies. Health care practitioners can use the information gained to render client-centred care and counselling.

This study is considered significant for the following reasons:

- This research on the knowledge of adolescents in Angola with regard to contraception could contribute to making parents, educators and the health authorities aware of the importance of an effective life-skills education in preventing unplanned pregnancies. The better adolescents are prepared in terms of sexual education, the better their preparation in terms of personal, social, community and especially family life can be established.
- This could contribute to building a system of values, attitudes and behaviour with regard to sexuality amongst adolescents in the community.
- Life-skills education which includes contraception could empower the adolescent female to further her education and to fulfil her role in society.
- The integration of family planning in health services and in other non-health services, such as education, the private sector and the environment, is essential.
- The study could be used to plan health education programmes for adolescents, midwives and nurses to improve the quality of assistance and education when developing school curricula for teachers.

The results could assist the Ministries of Education and Health in Angola to introduce measures and reinforce policies and strategies on health programmes for adolescents.

## 1.8 RESEARCH DESIGN AND METHOD

### 1.8.1 Research design

A non-experimental, descriptive, exploratory research design was used for the study to obtain more information regarding the knowledge of adolescents in a selected area in Luanda, Angola, regarding contraception. The purpose of such a design is to provide an explicit description of the phenomenon explored so that it can be addressed (Burns & Grove 2005:211).

### 1.8.2 Setting of the study

This study was carried out in the Republic of Angola, Province of Luanda, capital of the country, in the Municipality of Cazenga. This is the most populated municipality in Luanda, with 1 500 000 inhabitants. In Angola, 2 363 368 females are of reproductive age. The birth rate is 45,14 births/1 000 population (Provincial Director of Health, Luanda 2004:2).



**Figure 1.1**

**Map of Angola**

(<http://pt.wikipedia.org/wiki/Angola>, 26-04-2007)

● **LUANDA - Capital of Angola**

### **1.8.3 Population and sample**

#### **1.8.3.1 Population**

A population is a well-defined group that has certain specific characteristics. A population can consist of people, animals, objects or events. The terms of the population provide the basis for criteria of eligibility which must be evident in the sample, that is, the characteristics of the population and the sample must be coherent (LoBiondo-Wood & Haber 2001:141).

The chosen population consisted of adolescents who used the services of a Health Centre in the Cazenga Municipality in the Province of Luanda. The accessible population of the study was adolescents who use a Health Centre in the Cazenga Municipality. These adolescents are between the ages of 13 and 19 years, in the Cazenga Municipality in Luanda, Angola.

#### **1.8.3.2 Sampling technique**

Sampling is a process of selecting a portion of the designated population to represent the whole population (LoBiondo-Wood & Haber 2001:144). The researcher went to the health centres and interviewed respondents who were present and were willing to participate in the study on the days of the visit (Burns & Grove 2005:342). To prevent bias, the researcher selected subjects who met the inclusion criteria (refer to chapter 3).

Convenience sampling was used to select the respondents for the study at the Health Centre in Cazenga Municipality in Luanda, Angola. The size of the sample comprised 100 female adolescents between the ages of 13 and 19 years, who sought the services of the Asa Branca Health Centre in the Cazenga Municipality in Luanda, Angola. Participants had to be willing to participate in the study voluntarily and willing to provide informed consent.

#### **1.8.4 Data collection instrument**

Data were collected using a structured pre-tested interview schedule. The researcher administered the interview schedule. Chapter 3 contains more information about the research methodology adopted to gather data for this study.

#### **1.8.5 Data analysis**

Data were encoded and computerised by using the Statistical Package for Social Sciences (SPSS) Version 13.0 by a statistician at Unisa. Statistics which were used in the data analysis and summaries included descriptive statistics, frequencies and percentages.

#### **1.8.6 Generalisability**

Respondents from the Health Centre in Cazenga Municipality, Luanda, Angola were interviewed on the phenomenon of interest. The respondents were conveniently selected. The findings will therefore not be able to be generalised to the population under study.

#### **1.8.7 Ethical considerations**

Ethical considerations in the conduct of research were followed to prevent ethical dilemmas. To ensure ethical conduct of the study, permission to conduct this study was obtained through an official letter by the researcher addressed to the Director of the Health Centre in the Cazenga Municipality, and from the Research and Ethics Committee at the Department of Health Studies, Unisa. Informed consent was obtained from each research participant. To ensure confidentiality and anonymity, neither the name of the participant nor that of the institution involved were requested on the questionnaires. No physical or psychological risks were involved as the study was non-experimental. The lists of participants' names for sampling purposes were kept safe to ensure confidentiality and anonymity (Polit & Beck 2004:161).

More discussions on ethical considerations pertaining to this research will follow in chapter 3, section 3.3.

## 1.9 LIMITATIONS OF THE STUDY

Interviews using a structured interview schedule were conducted with 100 participants at a health centre in the Cazenga Municipality in Luanda, Angola. Although similar results might be obtained in other geographical areas, it might not be possible to generalise this study beyond the geographical area where the research was conducted.

Burns and Grove (2005:39) describe limitations as restrictions to a study which can reduce the generalisation of the results. There are two types of limitations: conceptual and methodological.

The conceptual limitations limit the abstract generalisation of the results. The methodological limitations limit the population to which the results can be generalised (Burns & Grove 2005:40). With regard to this study, the information was obtained or provided by Angolan adolescents in the area, thus limiting the transferability of the results.

## 1.10 OPERATIONAL DEFINITIONS

The concepts used throughout this study are defined so that readers can share the researcher's interpretation of these key terms.

- Adolescent
- Conception
- Pregnancy
- Contraception
- Contraceptives
- Traditional contraceptive methods
- Modern contraceptive methods
- Termination of pregnancy
- Reproductive health
- Sex education

**Adolescent.** An adolescent is defined as an individual between the ages of 10 and 19 (Nodin 2001:36). This study refers only to females between 13 and 19 years of age who use the services of a Health Centre in the Cazenga Municipality in Luanda, Angola.

**Conception.** The union of an ovum or egg cell with a sperm cell is known as conception or fertilisation, which is the beginning of a pregnancy (Fraser et al 2006:137).

**Pregnancy.** Fraser et al (2006:196) describe pregnancy as the condition of a female from conception until the birth of the baby.

**Contraception** implies the prevention of conception at impregnation. Contraception may be achieved by using traditional and/or modern contraceptive methods (Cronje & Grobler 2003:114).

**Contraceptives.** Cronje and Grobler (2003:16) define contraceptives as agents such as pills, condoms, intra-uterine devices, diaphragms and injections, used to temporarily prevent the occurrence of conception.

**Traditional contraceptive methods** are contraceptives which are prescribed and/or supplied by traditional healers to prevent unwanted pregnancies, or methods used traditionally in specific cultures without any prescriptions (Helman 2007:179).

**Modern contraceptive methods** refer to contraceptives which are frequently used in Westernised health care services, including oral contraceptives and injections. In Angola these may be prescribed by specialised midwives or sexual reproductive health nurses trained for that purpose (Cronje & Grobler 2003:115).

**Termination of pregnancy (TOP).** The termination of pregnancy refers to the act of bringing a pregnancy to a final end, preventing the birth of a live baby. The manual vacuum aspiration (MVA) technique is the legally approved method used to terminate most pregnancies in South Africa (Cronje & Grobler 2003:117). Pills can also be used to effect pregnancy termination, depending on the policy of the specific health care institution.

**Reproductive health (RH).** “Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters

related to the reproductive system and its functions and processes” (WHO 1998:1). In this study reproductive health (RH) services refer to contraceptive, ante-natal, obstetric and post-natal services provided in Cazenga Municipal area, Luanda, Angola.

**Sex education.** The process of sex education refers to a socialising process, formal and informal, which includes instruction and training in all aspects which may help to form normal and wholesome attitudes, values and ideas in relation to sex (Fraser et al 2006:22). In this study, sex education includes providing information that makes adolescents aware of their bodies, including reproductive anatomy and physiology, but emphasising contraceptives and adolescents’ abilities to make informed decisions about their own and their children’s futures.

## **1.11 ORGANISATION OF THE REPORT**

The report of the study is organised as follows:

**Chapter 1** presents the introduction and background of the study. It includes the problem statement, purpose of the study, significance of the study and the research question. It introduces the methodology for the study, scope and limitations, ethical considerations, definition of terms used in the study and an outline of the study.

**Chapter 2** reviews relevant literature pertaining to the knowledge of adolescents regarding contraception.

**Chapter 3** outlines the research methodology used in the study.

**Chapter 4** presents a discussion of the data analysis and findings obtained from the completed questionnaires.

**Chapter 5** provides the summary and conclusion, recommendations and implications of the findings for further research.

The bibliography presents a list of references used throughout the dissertation as well as works consulted during the course of the study to which no specific references were made. This is followed by appendices referred to in the report.

## 1.12 ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CAJ	Centro de Apoio aos Jovens <i>[Centre for Support of the Youth]</i>
CAOL	Coordenação do Atendimento Obstétrico de Luanda <i>[Coordination of Obstetric Assistance of Luanda]</i>
EC	Emergency Contraception
HIV	Human Immuno-deficiency Virus
MICS	Multiple Inquiry Cluster Survey
RH	Reproductive Health
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
TOP	Termination of Pregnancy
WHO	World Health Organization
USA	United States of America

## 1.13 CONCLUSION

Chapter 1 introduced the background to the study on the knowledge of adolescents in Luanda, Angola, on contraception. It also provided an overview of the study; its design, purpose and limitations.

The review of the literature is presented in Chapter 2.



## **Chapter 2**

### **Literature review**

#### **2.1 INTRODUCTION**

Chapter 2 deals with the search for, and review of, literature relevant to the research topic: adolescents' knowledge of contraception and related issues. It contains information on and methodological issues pertaining to the research topic. Burns and Grove (2005:93-94) state that a literature review is an extensive and systematic examination of books, publications and articles relevant to the research.

#### **2.2 REASON FOR THE LITERATURE REVIEW**

The purpose of a literature review is to gain knowledge about the research topic per se and about studies already conducted by other researchers or similar topics. Findings from previous studies assist researchers in refining parts of their studies, especially with regard to the problem statement, design and data analysis process. It also assists in forming a basis for comparison when interpreting findings of a current study.

The review of literature about adolescents' knowledge of contraception also assisted the present researcher to bring the problem into focus, and to formulate an appropriate research question. The latter is stated in section 1.6 of this study.

In addition, the researcher was able to obtain clues as to the methodology and instruments used by other researchers. This information provided the researcher with knowledge as to what had been tried, and what shortcomings might have been identified in approaches and methods used during previous research into adolescents' knowledge regarding contraception (Polit & Beck 2004:125).

The discussion that follows focuses mainly on literature related to the research topic, i.e. adolescents' knowledge of contraception in a selected area in Angola.

## **2.3 CONCEPTS RELATED TO ADOLESCENTS' KNOWLEDGE OF CONTRACEPTION IDENTIFIED IN THE LITERATURE**

The review of the literature revealed the following significant concepts related to the topic: adolescents' knowledge of contraception, which could individually or in combination be reflected in the study:

- Knowledge
- Adolescence
- Sexual and Reproductive Health
- Contraception
- Sexuality
- Sexually Transmitted Diseases

A discussion of each of these terms follows. As far as possible these discussions refer pertinently to the definitions, characteristics, roles involved and outcomes of these phenomena.

### **2.3.1 Knowledge**

Knowledge is the act or consequence of knowing, or the activity of knowing, carried out through reasoning and/or experience. According to Houaiss and Salles (2001:802), knowledge is the act or consequence of intellectual learning, of understanding a fact or a truth, cognition, understanding, perception, discernment, theoretical or practical mastery of a subject, art or a science.

According to Houaiss and Salles (2001:803), the first knowledge is the myth (a symbolic reporting passed on from generation to generation within a group; it explains the origin of a specific phenomenon). The second factor which enables knowledge is memory or recollection; its function is to preserve and remember what has already been within reach of sensible intuition. Memory is the place where images are preserved within the intellect. The third factor in acquiring knowledge is based on experience, the coordinated synthesis of the content of sensible intentions, of memory recollection and the basis for more elaborate knowledge, such as arts and sciences. Science and arts come from men through experience. Hence the fact that rational knowledge tends to

discriminate between what is right and wrong, what is adjusted and not adjusted, good and evil, what is false and true (Houaiss & Salles 2001:802)

### **2.3.1.1 Defining knowledge**

According to the Teachers' Pedagogical Guide (2000:3), the theory of various philosophers is based on the principle that knowledge is a process of having and being. It is a process of maturing; it changes the individual in qualitative terms according to the world vision that surrounds him or her and is divided into various domains.

### **2.3.1.2 Domains of knowledge**

#### **Cognitive domain**

Within the cognitive domain, knowledge is processed through memorisation. In addition, each human being has personal values which are formed through the family and through society.

#### **Capabilities domain (sensory-motor)**

Within the domain of capabilities the cognitive and affective domains are implicit; skills enable the individual to perform something effectively and efficiently.

#### **Intuition domain**

Intuition is the immediate awareness or knowledge which enables the individual to guess what is or what must be (a "feeling" or "hunch"). According to LoBiondo-Wood and Haber (2001:76), knowledge is the awareness or the perception of reality acquired by means of insight, learning or research, and is expressed in a way that can be shared and can be developed within the context of conviction.

Some avenues of knowledge are very structured and generally are linked by process-defined or method-defined rules, such as research, critical thinking and logical reasoning. Other sources are less structured and have fewer process-defined or method-defined rules, for example intuition.

In every aspect of life people cope better when they have knowledge, and the same happens with regard to sex. Knowledge is the only way in which the adolescent can confront sexual myths which could ruin her life. It is known that parents do not easily discuss sex-related issues with their children.

According to Tiba (1994:110), in girls, physical, psychological and emotional changes start quite early, around 9 years of age, and have as a key point sexual desire. Thus it is extremely important to identify the adolescents' knowledge with regard to contraception. Sex is good and gives pleasure, but it is necessary to use it armed with knowledge, to prevent it from having the opposite effect because of such risks as becoming addicted, early pregnancy and contracting of sexually transmitted infections (STIs). It is extremely important that young girls during the adolescent phase know about such risks, so that they can protect their physical health as well as enjoy pleasure, thus preserving psychological health.

Initially in Europe and then in other regions of the world, that during the last two decades first menstruation has appeared at a younger and younger age, with a corresponding increase in fertility, and an increase in the percentage of women who start having sexual intercourse quite early, well before 20 years of age.

According to the WHO (2001:1), the inter-generation armed conflict in Angola contributed to weakening the family structure and cohesion, leaving adolescents with a breakdown of family structure, disorganised social support systems and ever-increasing poverty, giving rise to crime, the consumption of drugs, violence, rape and commercial sex. Side-effects of this are early pregnancies, illegal abortions, and sexually transmitted infections.

There are approximately 1 700 million adolescents in the world, of which 86% live in developing countries and approximately 33% live in Africa. Among these adolescent girls there is a high rate of maternal mortality (40% of the total number of maternal deaths), due to lack of access to family planning and reproductive health services, including counselling. This contributes to the high rate of post-partum complications, characteristic of poor countries (WHO 2001:1-2).

According to AIDS Network (2005:12) the Angolan population is young; approximately 50% of the youth are younger than 15 years of age. Angola is considered to have an adolescent population.

## **2.4 ADOLESCENCE**

Afonso and Lucas ([s.a.]:2) define adolescence as a period in the life of the individual that is not well-defined, a stage in which society does not yet recognise the individual as an adult but in which he or she is also no longer considered as a child. Adolescence can be divided into two periods:

The first, which is called puberty or pubertal adolescence, starts approximately between 10 and 12 years of age for girls and between 12 and 14 years of age for boys. It is characterised by major physical and psychological changes. For young girls it starts with the first menstrual period and for boys with the first ejaculation.

During the second period of adolescence, approximately from 15 to 20 years of age, the aspects of psycho-social development prevail. This period is characterised essentially by personal affirmation and the need to belong to a group.

Afonso and Lucas ([s.a.]:3-5) point out that adolescence starts with puberty and is characterised by multiple morphological and psychological changes, which are as follows:

### **2.4.1 Changes in the behaviour of the adolescent**

Nodin (2001:37) points out that adolescence is a period of major changes at various levels: family, social, emotional, personal and physical levels. It is during this phase that the adolescent girl becomes an individual, tries to become autonomous and tries to understand her position in the world, and define her own existence. This is also a period of great ideas, when the adolescent is able to become involved in situations which she would find difficult to do in other stages of her life. The emotional and physical changes are the changes that particularly concern her. The body undergoes a lot of changes, gradually acquires adult characteristics and loses childhood traits, and unfamiliar reactions appear: boys find that the bed is wet in the morning, girls find that the first

menstruation appears and strange sensations appear when sexually excited. These changes happen to both genders, and concern, disturb and astonish them.

The male adolescent is more vulnerable to disabilities and mortality as a result of risks undertaken, intentionally or not, which result for example in road accidents, violence and suicide. Female adolescents often have to endure the impact of an undesired pregnancy (WHO 2001:1).

The adolescent is vulnerable at various levels, such as age, gender, nutritional status, marital status, school attendance and the nature of the public places where the adolescent spends the majority of his or her free time. In addition to the usual difficulties and traumas of adolescence, many adolescents in Angola live under extremely difficult conditions: the disabled, orphans, street children, those infected by HIV/AIDS and the ones who live as refugees or displaced people (WHO 2001:2).

#### **2.4.2 Physical development in adolescence**

When puberty starts there are complex processes which take place and stimulate the anterior hypothalamus, generating gonadotrophic hormones. These, in turn, stimulate maturation resulting from the activity of the gonads, which are the ovaries and testicles, which in turn will secrete steroid hormones (testosterone through the testicles and oestrogen through the ovaries) which lead to the appearance of secondary characteristics in the adolescent.

In young girls the first signs of puberty are the beginning of development of the mammary tissue and the subareola, growth of hair in the pubic area and armpits, and menstruation, on average at age 12. However, from the first menstrual period the possibility of pregnancy exists. One can observe the development and changes in the quantity and distribution of the fatty tissue, with a tendency to shape around the hips and the thighs.

In young boys the puberty signs are an increase in the size of testicles, of the penis and of the scrotal bags, as well as the appearance of pubic and auxiliary hair. Later, there is the appearance of hair in other areas of the body, such as the face. Other changes start

occurring at this age, such as the appearance of acne and seborrhoea, and in boys the change in voice, which becomes deeper, and the beginning of ejaculation.

### **2.4.3 Hypersensitivity in adolescence**

Owing to the many physical and psychological changes in adolescence, there is a hypersensitivity towards their own body and it may result in some manifestations such as anorexia, bulimia, obesity, allergies, chronic headaches, and dyspnoea. Changes in behaviour might present irritability, hypersensitivity, feelings of guilt, isolation and depression.

### **2.4.4 Psychosocial development during adolescence**

Simultaneously with the physical development, a deep and lasting psychological and social change comes into being. Forced to leave the closed and protected world of childhood to become part of a society which they have to discover, adolescents will react and behave in terms of their temperament, personal history, family environment and family's attitude towards them. This process of transformation is designated by various authors as the "crisis of adolescence". This is characterised by two poles: the need for autonomy and independence, versus dependency and the manifest need for protection.

Adolescence is not marked only by difficulties, crisis, ill-being and anguish. When one abandons the childish attitude and becomes part of an adult world, there are various psychological developments. The intellect, for example, becomes more effective, faster and capable of more complex reasoning, there may be an increase in concentration and better selection of information, memory acquires a better retention and recall capability, language becomes more complete and complex, with an increase in vocabulary and expression. These developments in the global performance of the adolescent produce a typical 'blowing up' of the ego – they feel they can do anything.

The article entitled "The place of the female..." quotes the World Health Organization (WHO 2005:5) as saying that there are no specific delimitations with regard to the adolescence period; its social classification varies both in terms of its composition and

its implications. However, it considers the period of adolescence as lasting from 10 to 20 years of age, characterised by the development of the individual in various aspects:

- Physical: secondary sexual characteristics develop to sexual maturity.
- Psychological: the forms of identification evolve from the initial phase to the adult stage.
- Dependency: total economic dependency changes to relative independence.

Adolescence therefore corresponds to a period in which:

- The individual moves from the point of initial development of the secondary sexual characteristics to sexual maturity.
- The psychological characteristics of the individual and the forms of identification change from the childish phase to the adult phase.
- Transition occurs from the state of total economic dependence to one of relative independence.

Within the change from childhood dependency to the adult phase inter-dependency, along a process of progressive maturity, there is a significant psycho-social development, particularly in the emotional, intellectual and spiritual aspects ("The place of the female..." (Chagas 2005:8)).

#### **2.4.5 Factors which may influence female adolescents' usage of contraceptives**

Some female adolescents might perceive contraceptives to be irrelevant or even harmful and these perceptions could result in unplanned pregnancies. Unplanned pregnancies could have serious implications for the physical, psychological and social well-being of adolescents and even for their nuclear and extended families. Adolescents should therefore be knowledgeable about contraception and different contraceptives, to enable them to make informed decisions about their own and their children's futures. Adequate information about contraceptives could help adolescents to realise that effective utilisation of contraceptives can successfully postpone pregnancies until they have completed their schooling and/or are financially capable of caring for their children. Numerous factors could contribute to the many adolescent pregnancies in Angola.



However, adolescents require knowledge to be able to make informed decisions and to evaluate their attitudes towards and beliefs about contraceptives.

In a study in South Africa, Mwaba (2000:32) found that 23% of the adolescents indicated that pregnancy was caused by girls seeking to prove their fertility. This perception might encourage adolescents to engage in unprotected sexual intercourse and avoid using contraceptives so as to prove their fertility.

Watt (2001:226) found that the belief that condoms are difficult to use and interfere with sexual pleasure was perceived as a barrier to the use of condoms. Adolescents should be educated about contraceptives, including condoms, in a manner that addresses these beliefs. According to Mwaba (2000:33), 50% of the adolescents were ashamed to use contraceptives, 49% feared parental reaction should their contraceptive use be discovered and 43% did not trust contraceptives. Thus adolescents' attitudes of shame about using contraceptives, fear of parental disapproval and distrust in the efficacy of contraceptives all pose possible barriers to adolescent girls' utilisation of contraceptives to prevent unplanned pregnancies.

Cronje and Grobler (2005:115) found a low level of awareness about emergency contraceptives (ECs). In their study in the Gauteng Province of South Africa, Ehlers et al (2000:48) indicated that 68% of the adolescent mothers did not know about the availability of ECs. This means that in order to improve contraceptive use by adolescents, awareness campaigns, pamphlets and education should be used to inform adolescents about the availability of all methods of contraception, including ECs. Although ECs cannot replace the effective use of contraceptives, they could help to reduce the number of unplanned pregnancies and the demand for abortions.

In a study in the USA, Paikoff (1990:480) found that although all the participants had heard about contraception, 77% stated that they did not know about contraceptives before their pregnancies, and only 20% were informed about contraceptives at the clinics during their pregnancies. Lack of knowledge was found to be an obstacle to the use of contraceptives. In Uganda, Hulton, Cullen and Khalokho (2000:35) found that adolescents' perceptions of the risks of sexual activity and their consequences indicated a lack of knowledge on contraceptives. In Punjab, Pakistan, Casterline, Sathar and Haque (2001:95) reported lack of knowledge as an obstacle to contraceptive use.

Adolescents should be knowledgeable about different methods of contraception before becoming pregnant in order to feel safe in deciding to use them effectively. This knowledge might help to reduce the number of adolescent mothers. Buga, Amoko and Ncayiyana (1996:526) analysed sexual behaviour and contraceptive practices among school adolescents in a rural area of the Transkei region of the RSA and found that only 23,5% of sexually experienced girls had ever used any modern method of contraception. According to Ehlers (2003:7), out of 250 respondents in the RSA, 85 (34%) did not know about contraceptives before their pregnancies. In the Kriel area of Mpumalanga, 31,34% and in the Gauteng Province, 24,23% did not know about contraceptives although contraceptives were available free of charge at the clinics in all these areas throughout the RSA (Ehlers 2003:20; Ehlers, Maja, Sellers & Gololo 2000:48).

#### **2.4.6 Factors that could influence adolescents' use of contraceptives**

The factors that could influence female adolescents' usage of contraceptives include demographic factors, such as age, gender and educational status, and cultural/traditional beliefs and/or practices.

##### **Age**

The ages of adolescent mothers could be important in identifying the high-risk age groups in order to make concerted efforts to provide such age groups with appropriate health education opportunities. Adolescents might not use contraceptives out of ignorance and the unavailability of contraceptives, for example (Buga et al 1996:523). The adolescents' ages might influence their decisions to engage in sexual intercourse and contraceptive non-utilisation. Belfield (1998:31) maintains that if sexual and relationship education is started at an early age, prior to teenagers' sexual debut, such knowledge could help adolescents to delay their first sexual encounters. Adolescents need knowledge about contraceptives before sexual activities commence in order to prevent unplanned pregnancies and reduce the number of adolescent mothers, or at least postpone the birth of the first child. While an adolescent mother aged 19 might be able to care for a newborn infant, an adolescent aged 16 or younger might be less able to do so. Thus postponing childbirth could help adolescent women to improve the quality of their own and their children's lives.

## **Gender**

Although gender cultures lay down norms of sexual behaviour for each of the sexes, there are many variations cross-culturally as to what those norms are. For example, ethnographic studies indicate that there is much variation between societies in the degree of heterosexual activity permitted before marriage, outside of marriage and even within marriage itself (Helman 2007:160).

Patterns of sexual behaviour are important in the transmission of several diseases. Where promiscuity and extramarital sex are common within a society, there is a greater likelihood of the spread of STDs (Helman 2007:160).

Membership of a particular gender culture does not always coincide with sexual behaviour. There are vast variations worldwide in whether societies are tolerant of some forms of sexual behaviour, such as homosexuality (both male and female), that transgress the usual norms of a gender culture (Helman 2007:118).

There might be gender differences in sexual knowledge, attitudes and behaviour among adolescents. Adolescent males might be willing to participate in reproductive choices but could be at a disadvantage compared to their female peers. Adolescent girls and boys might need interventions that could improve their sexual knowledge and skills, clarify attitudes and beliefs, and enhance discussions and negotiation skills (Watt 2001:227). Adolescent males and females should receive the same information about contraceptives and reproduction. Male adolescents should also be able to control reproductive opportunities by using male condoms to prevent unwanted pregnancies. However, the present study focused only on female adolescents.

## **Educational status**

Adolescents who lack general education might lack knowledge about contraceptives because they might not be able to understand the relationship between menstruation, coitus, fertility and conception (Mwaba 2000:31). Information about sexual and reproductive issues presented in pamphlets and posters might be read and understood only by educated adolescents. Poverty, lack of education, and inadequate family support could contribute to a lack of adequate prenatal care, which might account for

some of the negative health outcomes of adolescent mothers and their children (Mbambo, Ehlers & Monareng 2006:27-28). Lack of education could impede adolescents' comprehension of important information. Health care providers should help adolescent clients to understand and personalise information about reproductive health issues, including contraception (Hatcher, Rhinehart, Blackburn, Geller & Shelton 1997:3-2). People's levels of education affect their ability to make informed decisions, and lack of education could impact negatively on their awareness of their rights and choices, affecting not only their own but also their children's future.

### **Socio-psychological issues**

Social values, beliefs and practices influence decision making about the use of contraception. Some beliefs are beneficial and others are not. Adolescents are influenced by socio-psychological variables in deciding about initiating sexual relations and contraceptive use, possibly allowing their individual perceptions to be greatly influenced by their peers' influence and expectations.

Adolescence is a time of increased need for acceptance and support from others. The qualities that make up an adolescent should be improved through education. According to Mbambo et al (2006:29), communication programmes should aim to increase adolescents' self-efficacy, particularly in terms of their perceived ability to convince partners to use condoms and use them correctly. According to the Adolescent Sexual and Reproductive Health Rights document (RHRU 2000:44-46), adolescents should be fully informed about their sexual and reproductive health rights. The guidelines (RHRU 2000:44-46) stipulate that adolescents are entitled to the right to

- a full range of accessible and affordable SRH services
- privacy during service delivery
- be treated with dignity and respect during service delivery
- be assured that personal information will remain confidential
- be given an explanation of the processes that they will go through during service delivery
- be treated by people who are trained and knowledgeable about what they do
- continuity of services
- be treated by a named health care provider

- express views on the services provided and complain about unsatisfactory health services
- a healthy and safe environment
- gender equality
- sexual orientation, experience and pleasure, implying the right to
  - make their own decisions about sex
  - express themselves in their own way
  - enjoy sex
  - abstain from sex
  - choose to marry or not to marry
  - choose whether or not to have children
  - be accepted and respected for who they are (RHRU 2000:46)

Given these rights, adolescents should have strong personalities and be responsible, take pride in their abilities, and make informed decisions on sexual and reproductive issues, including the decision to use contraceptives effectively to avoid unplanned pregnancies.

### **Cultural/traditional factors**

The acceptability of contraceptive techniques depends on cultural beliefs about the body, particularly the female reproductive system. Women in many cultures, for instance, see menstrual blood as “polluting” or “poisonous” and fear the effects of a decreased menstrual flow, when more of the “poison” will remain within their bodies. This is one of the reasons why the contraceptive pill, which may cause lighter menses or even their cessation, has been rejected by many women worldwide.

Similarly, cultural attitudes can influence whether the intrauterine contraceptive device is acceptable or not. Some cultures reject the IUCD, based on folk models of the female anatomy (Helman 2007:430).

Ethnic background, socio-economic class, educational level, religious affiliation and local community standards are interdependent and interrelated factors in shaping adolescents’ sexual ideas and behaviours (Helman 2007:160). Adolescents from

different cultural backgrounds or traditions might be influenced by different factors, or by the same factors but to a different extent, not to use contraceptives.

According to Mwaba (2000:32), educated girls tend to fetch greater bridal wealth (known as *lobola* in many South African traditional cultures), which may encourage parents to support their daughters' schooling, and perhaps their return to school following childbirth. However, encouraging their daughters to use contraceptives in order to complete their schooling prior to childbearing could be problematic for many parents, especially those living in traditional communities.

Cultural/traditional factors could pose a hindrance to adolescents' utilisation of contraceptives, and lead to unplanned pregnancies. Culturally, Zulu women are expected to have as many children as possible. Williams and Mavundla (1999:59) state that parents are in a dilemma between upholding the traditional and cultural values and respecting their daughters' rights to access and utilise contraceptives in order to postpone childbearing. Adolescents might share the same conflict in many traditional societies between cultural/traditional factors requiring them to have as many children as possible, and their right to use contraceptives in order to postpone childbearing until they have completed their schooling and/or become sufficiently financially independent to care for their children.

Hulton et al (2000:37) maintains that for many sub-Saharan Africa (SSA) communities, negative attitudes towards condom use are based on cultural factors, including the desire for more children; female sexual compliance; to enhance their economic status; and/or increase the parents' perceived social security for their old age (by having many children to care for them when they are old).

### **Economic factors**

The status of women in African societies varies from culture to culture and even from village to village. Women of inferior status cannot and do not make decisions affecting their own lives.

Therefore, uneducated poor women, dependent on their husbands for their livelihood, cannot oppose their husband's wishes concerning the number of children, being at risk

of losing their only source of financial support for themselves and their children (Ehlers 2003:18). Because adolescent mothers are still dependent on their parents, they are also affected by the same socio-economic considerations as their mothers, possibly contributing to the non-utilisation of contraceptives by adolescent women.

According to Buga et al (1996:526), in many rural settings in South Africa, adolescent pregnancies might be generally accepted, tolerated and even connived at by society. Lack of housing and recreational facilities in villages could cause adolescents to channel time and energy into sexual activities rather than into sports and recreation as adolescents from other socio-economic groups do (Williams & Mavundla 1999:59).

Couples with fewer children are better able to provide them with enough food, clothing, housing and schooling (Hatcher et al 1997:2-21). Adolescents from large families, with low levels of education, who engage in sexual activities without using effective contraceptives, perpetuate the cycle of poor families, limited education, overcrowding and adolescent pregnancies. Adolescent girls with sufficient knowledge, parental support and access to contraceptives can ensure a better future for themselves and their children.

Adolescents feel comfortable with their peers, on whom they can rely and whose judgements they respect. Many adolescents are unable to resist peer pressure because of the need to conform and belong to a group. Adolescents need help to develop skills in deciding whether to follow their own or a group's choices, as well as ways to cope with the consequences of their choices (Hatcher et al 1997:15).

According to Onega (2000:270), teenagers are more likely to be sexually active if their friends are sexually active. Both young men and women might think that being pregnant validates an adolescent girl's love for and commitment to her male partner or boyfriend. Williams and Mavundla (1999:59) state that some teenage mothers are intimidated and told that if they do not engage in sexual intercourse they will become sick or crazy. Gmeiner, Van Wyk and Mpshe (2002:15) state that friends play an important role in adolescents' sexual behaviours.

Health education should stress the consequences of adolescent sexuality and childbearing in order to empower them to resist peer pressure if it encourages

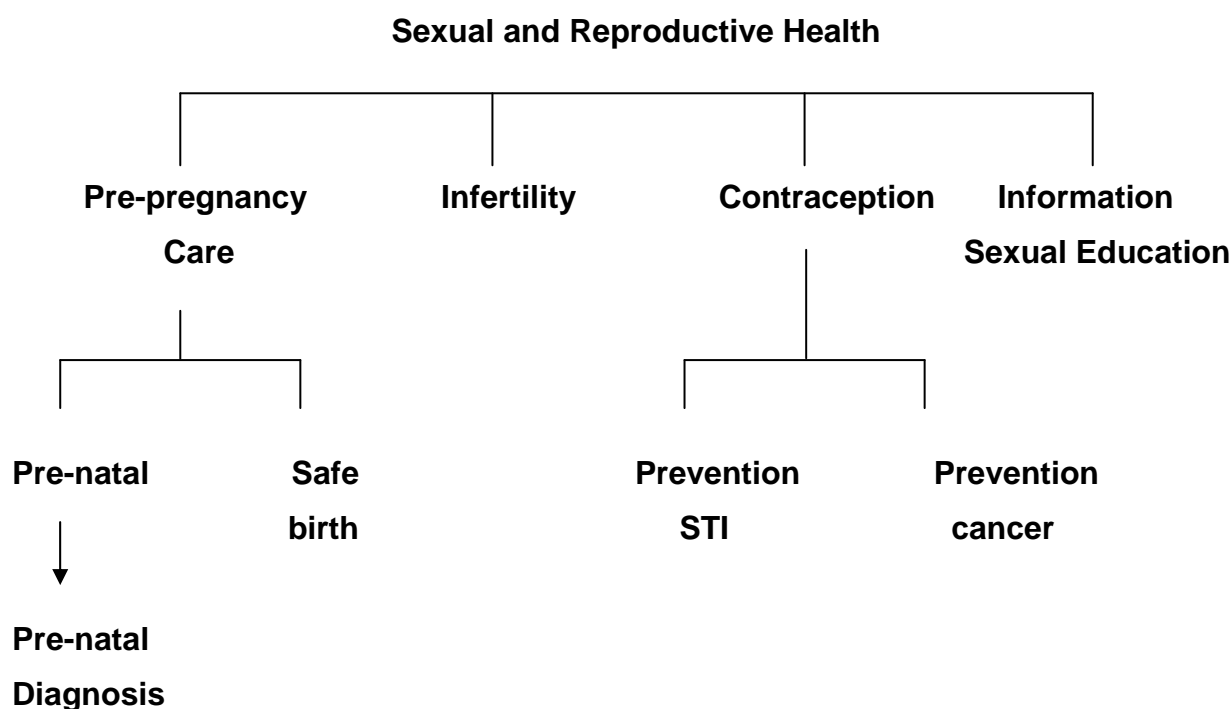
unprotected sexual activities and results in adolescent pregnancies. Even if adolescents should decide to engage in sexual activities, they should be knowledgeable about and have access to contraceptive services and contraceptives of their choice. Adolescents, like adults, should be enabled to decide if and when they should have children and be empowered to avoid unplanned pregnancies by effectively utilising contraceptives.

## **2.5 SEXUAL AND REPRODUCTIVE HEALTH**

According to Fraser et al (2006:175), reproductive health implies that people can have a satisfactory and safe sexual life and are able to reproduce and decide if, when, and how frequently they engage in sexual intercourse.

In 1995, at the Cairo Conference on Population and Development, a unique concept was put forward of Sexual and Reproductive Health (SRH), with a set of measures which presuppose the right of men and women to be informed and to have access to safe, effective and acceptable methods of family planning of their choice, as well as access to adequate health services which enable women to have safe pregnancies and labour and offer the couples the best opportunities to have healthy children. This also encompasses the sexual right as a fundamental right of life and of personal inter-relations; sexual relations must be safe, so as to enable a better control of fertility and prevention of STDs, with positive consequences in terms of sexuality, freedom from unwanted pregnancies, pre-natal vigilance, safe labour, and health and survival of children.





**Figure 2.1**

***Cairo Conference Population and Development***

(United Nations International Conference on Population and Development (ICPD) 1994)

According to the *Policies and norms for the provision of services in sexual health* (Rita, Feio & Fagundes 2004:15-16) sexual and reproductive health is a state of complete physical, mental and social well-being and not only the absence of disease or illness in all aspects related to the reproduction system, its function and activity. Besides being an individual state, reproductive health is also considered as a basic right, the right of women, men and adolescents to freely choose the size of the family, the timing and method of contraception, and the right to be informed on all aspects of reproductive and sexual health. In order that those rights be realised, the user must be guaranteed access to cost-effective services within his or her economic capabilities.

### **2.5.1 National Health System in Angola**

It is the duty of the State to guarantee and promote health care to all its citizens. According to the General Regulation for Health Units of the National Health Service (Angola 2002, article 2:2) the National Health System is organised in levels of attendance:

- Primary level, Secondary Level and Tertiary Level
- Primary level includes primary health care and is structured as follows:

**Table 2.1 National Health System in Angola**

Levels	Health unit	Geographic area	Number of beds	Services rendered
Primary	Health Post	20 000.00/inhabitants	-	Promotion of Health Prevention of Disease Ambulatory Service/Shifts Nursing Care
	Health Centre	75 000.00/inhabitants	-	Diagnosis Treatment Nursing Care / Shifts Prevention of Disease
	Referral Health Centre	-	30 beds	Diagnosis Medical Treatment 24 hr Service and Emergencies Nursing Care Promotion of Health Prevention of Disease Admissions
	Municipal Hospital	-	More than 30 beds	Same functions as the Referral Centre
Secondary (Referral Hospitals)	General Hospital	-	Physical space – exclusively for health purposes	Diagnosis Treatment Admissions Medical Health Staff Nursing Health Staff
	Central Hospital	-	National Network referral hospital	Highly Specialised Services
Tertiary	Specialised	-	-	Special institutions and services

### 2.5.2 Institutions and specialised services

These are specialised institutions that provide assistance or preventive services at all levels.

Owing to the poor conditions of reproductive health in the country, shown in the high levels of maternal and neonatal mortality, the Angolan Government created Act no. 21-B/92 of 28 August, which establishes the Policies and Norms for the Provision of Services in Reproductive and Sexual Health (Angola 2000:8-9).

The Reproductive and Sexual Health Services are organised as indicated below. According to the Ministry of Health (Angola 2000:8-9) reproductive health services are organised in three levels:

- **Community level**

The community level includes the trained traditional midwives, rural health promoters, community organisations and activists, teachers, community leaders, churches and private entities.

### **Health posts and health centres**

Health posts and health centres include community support, home deliveries with professional assistance, contraception, and prevention and treatment of sexually transmitted diseases (STDs).

### **Municipal hospitals**

The municipal hospitals have units for obstetric emergencies. Provincial Hospitals/Maternities are institutions which provide specialised radiology, cytopathology and histopathology services. Central Hospitals/Maternities provide specialised radiology, cytopathology, histopathology oncology, endocrinology services, treatment of infertility, training and research.

The Government of Angola is a signatory to the Action Programme for the International Conference on Population and Development (ICPD) in Cairo, which acknowledged the need for norms for sexual and reproductive health for women and men as basic requirements for human and social development. It has a strategy to reduce poverty and implement immediate initiatives to reduce maternal-child morbidity and mortality.

Ghouayel (2001:45; 46) states that international consensus has repeatedly agreed that health and reproductive and sexual options are human rights which must be protected and respected. This protects the rights of children, especially female children, so as to ensure that their rights in the future, as adults, do not lose their content, and that they

achieve the highest levels of reproductive and sexual health as well as taking decisions with regard to reproductive and sexual health without fear of discrimination, coercion or violence. Furthermore, people must have a satisfactory and safe sexual life. It is therefore necessary and important that men and women receive information about the issue and have access to contraceptive methods of their choice.

## **2.6 SEXUALITY**

Garcia (2005:1-5) describes sexuality as the group of special external or internal characteristics determined by the gender of the individual. Sexuality connotes not only the activities and the pleasure which depend on the functioning of the genital system, but a whole series of stimuli and activities present since childhood, which provide an universal pleasure to satisfy a fundamental physiological need which is normally satisfied by sexual love.

Sexuality does not begin during adolescence, as stated by many sources, or in the change into adulthood. It starts in the child, in the childish attitudes and curiosity which demand erotic and affective gratification. Younger children are interested in knowing how things work with regard to sexuality, through what they learn from school friends, family, television programmes, magazines and erotic movies.

During adolescence, after the period of latency, the curiosity and interest in one's own body and the bodies of other young people of the same age again reappears.

On the other hand, the risks related to sexually transmitted diseases (STDs), early pregnancy, early sexual initiation, affective disillusionment, and unpleasant or traumatic experiences in sexual relations, could also form part of the experiences of the growing child (Garcia 2005:1-5).

### **2.6.1 Stages of sexuality in the adolescent**

#### **Pre-adolescence**

- low physical and mental investment in "sexuality"
- obtaining information and myths from friends, school and family

- pre-puberty physical appearance

### **Early stage of adolescence – from 10 to 14 years of age**

- physical puberty maturation starts
- extreme interest and curiosity about own body and bodies similar to his or hers
- frequent sexual fantasies, which could become a reason for guilt
- masturbation starts at this age and can be accompanied by a feeling of guilt
- relations are usually platonic, without physical contact, such as chats over the telephone

### **Middle stage – from 14 to 17 years of age**

- full puberty development with the first menstrual period in girls and semenarche for males
- high level of sexual energy, with higher emphasis in physical contact
- sexual behaviour of an exploratory and selfish nature, trying to take advantage of relationships
- setting up meetings, fondling and casual sexual relations together with genital relations
- denial of the consequences of sexual behaviour

### **Late adolescence**

- full physical maturity
- more expressive and less exploratory sexual behaviour
- more intimate and sharing relations (Garcia 2005:1-5)

According to Garcia (2005:4), sexuality is an area of great importance in the development of individuals, as it refers to the manner in which each one relates to himself or herself and with others, searching for love, contact and intimacy.

According to Lowdermilk, Perry and Bobak (2002:35-36), sexuality has an influence on feelings, behaviours and interactions, and can also affect the physical and mental health

of individuals. Sexuality is not easy to define. It is present in what we are, in our human condition.

Furlani (2000:2-4) points out that human sexuality is an integral part of a person, which does not necessarily imply its reproductive aspect. Sexual values and life styles differ from person to person. It is necessary to respect those of others and to understand that in a plural society holding his or her own values and beliefs is the right of each citizen. What is necessary is to make the young think of the responsibilities associated with sexual practices.

## **2.7 CONTRACEPTION**

In the last few years, keeping pace with worldwide developments marked by various International Conferences, countries have witnessed the growth of the concept of contraception, which has evolved, from a previously limited concept related to the initial limitation or spacing of births and prevention of undesired pregnancy, to sexual education, which will enable a better control of fertility and prevention of sexually transmitted diseases (STDs), with positive consequences for sexuality, pre-natal alertness, safe labour, and health and survival of children, and avoidance of undesired pregnancy and infertility. Education and the responsibility for contraception must be shared by the couple. Contraception constitutes a fundamental component of the activities for providing care in reproductive health for adolescents.

Besides the normal needs of human health care, the woman has exclusive and special characteristics related to her reproductive capability. The need for the promotion of health and preventive care, as part of the lifelong care provided to the woman, must be recognised (Lowdermilk et al 2002:136).

### **2.7.1 Organisation of services**

Contraception-related activities constitute an integral part of primary health care in order to meet the needs of the female adolescent and the family. These must be organised in each health centre in such a way that they can meet the needs of the population. All health centres must have a multi-professional team able to render quality assistance and ensure the following:

- immediate assistance and referral
- consideration of adolescents as the target and priority population of all contraception-related activities (offering them a flexible timetable and assistance free from bureaucracy)
- creation of conditions that facilitate access by their partners (Angola 1998:1)

### **2.7.2 Objectives of contraception**

According to the National Directorate for Public Health (Angola 1998:1), contraception has the following objectives: to

- promote the experience of sexuality in a healthy and safe manner
- regulate fertility according to the wishes of the couple
- prepare for responsible parenting
- reduce the incidence of sexually transmitted infections (STIs) and their consequences
- improve the health and well-being of the woman

### **2.7.3 Family planning**

The objectives of family planning are to:

- clarify the advantages of regulating fertility in terms of age
- explain the advantages of adequate spacing of pregnancies
- clarify the consequences of undesired pregnancy
- inform about reproductive anatomy and physiology
- provide complete free information on and scientific explanation of all contraceptive methods
- carry out clinic follow-ups, irrespective of the contraceptive method chosen
- identify and provide guidance to couples with infertility problems
- handle the prevention, diagnosis and treatment of sexually transmitted infections
- trace cancer of the cervix, uterus and breast (Angola 1998:1)

#### **2.7.4 Promotion of reproductive health by counselling**

The concept of health promotion is applicable to contraception in terms of counselling on contraceptive techniques suitable to the multiple and specific health needs of adolescents. Education is the key to encourage these adolescents to be:

- informed about the advantages of regulating fertility in terms of age
- informed about the consequences of undesired pregnancy
- informed about the advantages of adequate spacing of pregnancies
- provided with complete free information on and scientific explanation of all contraceptive methods
- advised to carry out clinic follow-ups, irrespective of the contraceptive method chosen
- informed about prevention, diagnosis and treatment of sexually transmitted infections (STIs)

The promotion of pre-pregnancy health provides women and their partners with the information necessary to decide on their reproductive future. It is extremely important to have pre-pregnancy counselling, which provides guidance to couples on how to prevent undesired pregnancies, explains to them the control of risks and identifies healthy behaviour and lifestyles which promote the well-being of the woman and her potential foetus. These principles must constitute the key to improved health for the next generation. Young couples also need to be informed with regard to physiology, the connection between coitus and pregnancy, and the truth, myths or beliefs (Lowdermik et al 2002:57).

#### **2.7.5 Contraception for adolescents**

As has already been discussed, during adolescence the development of the genital organs takes place; this is when the anterior hypophysis starts functioning, thus freeing the gonadotrophic hormones to produce hormones (oestrogen and progesterone). These stimulate the growth and development of the adult sexual characteristics. It is during this period that adolescents start showing an interest in the opposite sex, which often leads to sexual contact without protection, which brings with it risks such as early pregnancy, induced abortion, complications during pregnancy and delivery, infertility



and exposure to sexually transmitted infections including HIV/AIDS (Lowdermik et al 2002:86).

There are various contraceptive methods which are ideal, safe and effective and can positively affect the future health of the adolescent (Angola 1999:79-80).

### **2.7.6 Evaluation and diagnosis**

Besides the usual needs in terms of health care, the woman has exclusive health characteristics related to her reproductive capability. In view of this Lowdermilk et al (2002:136) recommend that the reproductive life plan for the woman must be followed when providing assistance services, taking into account the following: history, physical examination, pelvic examination, lab tests, care and counselling.

#### **History**

- identification data
- main complaints
- history of present disease
- previous medical history
- present state of health
- family history
- social history

**Background of systems:** general, skin, head, lymphatic glands, eyes, nose, cheeks, throat, neck, breasts, respiratory, cardiac, gastrointestinal, genital urinary, vascular, endocrine, haematological, muscular-skeletal and neurological systems. With regard to adolescents, one should pay special attention to behaviour, eating disorders and depression. Contact must be made in the presence of a family member, a partner or a friend, and the questions must be done with sensitivity, in a delicate manner and without criticism.

## Physical examination

The physical examination includes a general statement about the state of health and is a good starting point. The results are described in detail:

**General appearance:** age, race, gender, state of health, height, development, clothing, hygiene, temperament, alertness, responsiveness, cooperation and communication skills

**Vital signs:** temperature, pulse, breathing, blood pressure, height and weight

**Skin:** colour, whether the skin is broken, texture, moisture, temperature, oedema, excessive perspiration, unusual odour, existence and description of lesions, texture and distribution of hair, shape of nails; colour, texture, signs of whitening

**Head:** size, format, trauma, scars, rashes, scaling; symmetry of the face, presence of oedema

**Eyes:** size of the pupils, shape, reaction, visual reactivity, icterus in the white of the eye, sclerotic icterus, deep papilledema, haemorrhage, eyelids, extraocular movement, visual field and visual acuity

**Ears:** shape/symmetry, sensitivity, secretion, external channel and tympanic membranes; hearing: the Weber must be in the middle line (the pitch of the sound must be the same in both ears), and the Rinne must be negative (without conductive or sensorineural hearing loss); must be able to hear a whisper at a distance of 1 meter

**Nose:** symmetry, sensitivity, secretion, mucous, turbinate inflammation, front sinuosity, axillary; differentiation of odours

**Mouth, throat:** hygiene, condition of the teeth, denture, appearance of the lips, tongue and oral mucous, erythema, oedema, swelling of tonsils, palate, uvula, regurgitation reflex or ulcers

**Neck:** mobility, lumps, variation of movement, tracheal deviation, size of the thyroid, carotid bruit

**Lymphatic system:** cervical, intra-clavicle, axillary, inguinal adenopathy; size, form, sensitivity and consistency

**Breasts:** Changes in the skin, depression, symmetry, scars, secretion or lumps; characteristics of the nipples and areolas

**Heart:** cardiac frequency, rhythm, murmurs, attrition, gallop, clicks, precordial movements

**Peripheral vascular:** jugular vein distension, oedema, swelling, distension of the veins, Homan's sign or sensitivity of the limbs.

**Lungs:** symmetry of thorax with breathing, wheezing, stertor, snoring, vocal quivering, vocal choking, diaphragmatic percussion or excursion; similar and clear breathing on both sides

**Abdomen:** format, scar, intestinal noises, consistency, sensitivity, reflux, lumps, defensiveness, organomegaly, palpation of the liver, percussion (tympanism, deviation, hardness) sensitivity of the costo-vertebral angle.

**Limbs:** oedema, ulceration, sensitivity, varicosity, erythema, tremors or deformities

**Genital-urinary:** external genitals, perineum, vaginal mucous, cervix, inflammation, sensitivity, secretion, bleeding, ulcers, nodes, lumps, internal vaginal support, bimanual; examination of the cervix, uterus and joined organs.

**Rectal:** tone of the sphincter, lumps, haemorrhoids, contour of rectal wall, sensitivity and blood in the faeces.

**Muscular and skeletal:** posture, symmetry of muscular mass, muscular atrophy, weakness, joints, sensitivity or crepitating, variation of articulation movements, instability, redness, swelling or deviation of the vertebra

**Neurological:** mental state, nerve orientation, memory, humour, speaking clarity and understanding, cranial nerves, strength, reflexes of the deep and superficial sinews, deambulation, balance and coordination with alternate rapid movements

## Tests

With regard to the genital-urinary system it is of extreme importance to have a gynaecological examination which will enable carrying out the following tests:

**Cytological examination:** collection of samples to diagnose infections caused by *Candida albicans*, *trichomonas vaginalis*, bacterial vaginitis, streptococci B-haemolytic, *Neisseria gonorrhoeae*, *chlamydia trachomatis* and herpes simplex virus

**Pap smear:** to detect potential carcinogenic conditions.

**Laboratory examinations:** the following are requested: haemoglobin, full blood, cholesterol, fasting glucose, urine test, syphilis serology (VDRL), mammography. For HIV testing, informed consent is advised.

## Tests required in Angola according to Sexual and Reproductive Health norms

The Family Planning Manual in Angola (1999:84) proposes the following tests:

- Haemogram, presence of sugar in the blood, syphilis serology (VDRL), HIV/AIDS with user consent, cytology, colposcopy and urine.

### 2.7.7 Counselling

Counselling on contraceptives is crucial for all adolescents who use contraception. It enables them to make an informed choice of method, based on an objective clarification, and aimed at the specific needs of the person, thus facilitating a higher level of usage of contraception and more continuity in the use of the chosen method (Lowdermilk et al 2002:57, 60-137).

#### 2.7.7.1 Pre-conception counselling

In order to start using contraception it is vital to have informed consent; this constitutes the vital component in the education of adolescents. One must provide information on this subject, clarify erroneous information and ensure that adolescents talk about and

understand available contraceptive methods, alternatives, benefits and failure rates, and use of methods. Give them an opportunity to decide and ask questions.

Lowdermilk et al (2002:57, 60-137) indicate that the ideal contraceptive method must be available, must be inexpensive, acceptable, simple to use, and easily reversible. For example, the use of condoms prevents HIV infection; combined oral anti-contraceptives can provide some protection against the later development of ovarian and endometrial cancer; the barrier methods reduce the occurrence of sexually transmitted infections (STIs) which can become pelvic inflammation diseases, thus affecting the future reproductive capability.

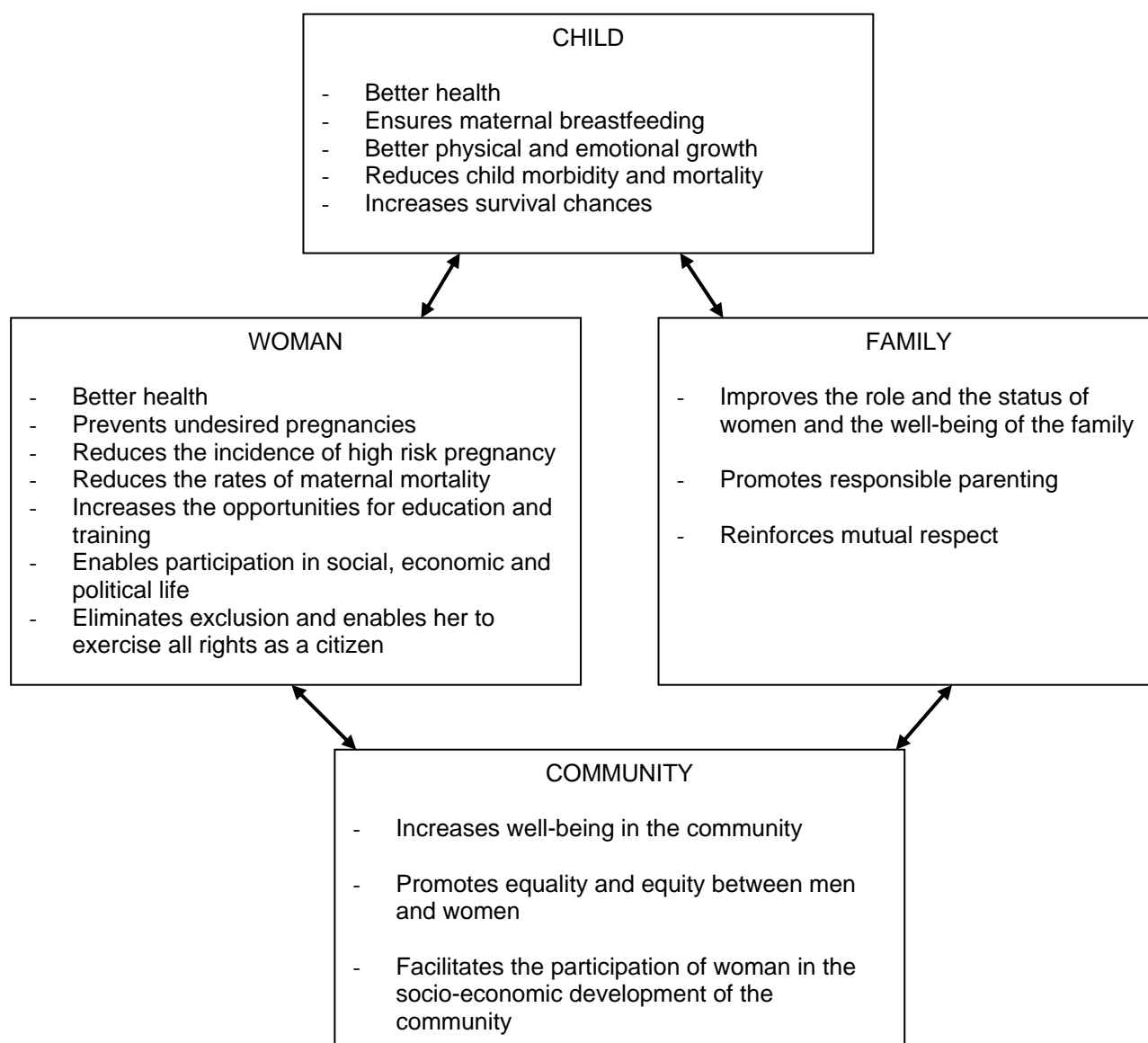
#### **2.7.7.2 Basic principles of counselling**

According to the National Directorate for Health (Angola 1998:4), the basic principles of counselling are to:

- **Create empathy**, know how to listen and establish an environment of trust.
- **Interact**, to encourage the person to speak and to ask questions.
- **Adapt the information to the needs of the adolescent in question**, know how to listen and to understand the specific needs of each situation.
- **Avoid excessive information**; excessive information does not enable the person to retain only what is essential, and reduces the time necessary to discuss and clarify doubts.
- **Provide the chosen method**; should there be no relative or absolute contra-indications, the method must be chosen by the user. Counselling must start with the chosen method, and then with the other methods.
- **Ensure that the information was retained**; point out the most important aspects, and provide, whenever possible, information material.

#### **2.7.8 Benefits of contraception**

According to the Ministry of Health (Angola 1999:7) contraception has health benefits for the child, the woman, the family and the community.



**Figure 2.2**  
**Benefits of contraception**  
 (Angola 1999:7)

### **2.7.9 Contraceptive methods appropriate for adolescents**

The most appropriate methods for adolescents are as follows:

## **Barrier methods**

These are those that prevent the penetration of spermatozooids in the cervix, acting as a physical and or chemical barrier (condoms, spermicides and diaphragm).

### ➤ **Spermicides**

The vaginal spermicide is a physical barrier placed in the vagina which kills or prevents the penetration or movement of the spermatozooids up to the cervix. The most commonly used are monoxinol-9 and octoxinol-9. The chemical barriers such as nonoxinal-9 have demonstrated that they protect against *Neisseria gonorrhoeae*, *Chlamydia* and the Human Immune Deficiency Virus (HIV) (Cronje & Grobler 2003:118).

### **Type of action**

Spermicides provide a physical and chemical barrier which prevents the sperm from entering the cervix. The effect is localised inside the vagina. The spermicide is placed deep in the vagina, in contact with the cervix, every time before having sexual intercourse.

### **Types of spermicide**

According to Lowdermik et al (2002:141), spermicides are sold in the form of aerosol foam, foaming tablets, suppositories, creams, films and gels.

### **Rate of failure**

Typical rate of failure: 5% to 50%

### **Advantages**

- Easy to apply
- Safe
- Low cost
- Available without prescription or prior medical examination

- Does not harm the vaginal mucous, unless the woman is allergic to a specific product
- Helps to lubricate vagina
- Alternative for mothers who are breastfeeding (does not interfere with breastfeeding)
- Alternative for pre-menopause
- Resource for the woman who forgot to take the oral contraceptive
- Increases the efficiency of contraceptives and other types of contraception

### **Protection against STIs**

Spermicides such as monoxinal-9 provide some protection against STIs through the bacteriostatic effect, but need to be used with the condom.

### **Disadvantages**

- The maximum spermicide efficiency generally does not last for longer than one hour
- If sexual intercourse is repeated, this must be preceded by the reapplication of the additional spermicide
- Some users complain that the spermicide is messy, and complain about the effervescence and unpleasant taste
- An allergic reaction or irritation of the vaginal or perineal tissue may occur
- Possible reduction of touch sensitivity

### **Nursing points to consider**

Guidelines for the adolescent:

- Wash the hands before and after using.
- The package must be shaken so the spermicide foam can spread before being used.
- Tablets and suppositories take between 10 and 30 minutes to dissolve.
- Vaginal douches should be avoided at least 6 hours before sexual intercourse.



For counsellor:

- Encourage open communication between sexual partners to discuss vaginal contraception.
- Enable them to view and handle various models.
- Provide an anatomical model to practise how to insert into the vagina (Fraser et al 2006:353).

### **How to use**

Introduce the spermicide deeply into the vagina. The interval between the application of the spermicide and the sexual intercourse can be up to 60 minutes.

Whenever there is sexual intercourse, no vaginal douche should take place. Some spermicides, especially cones or suppositories, must be kept in cool places (Angola 1998:28).

### **➤ Male condom**

The male condom is an anti-conception method for male use. It consists of a fine stretchable cover which covers the penis. Condoms covered with spermicide enable the swift immobilisation of ejaculated sperm, thus increasing their contraceptive effectiveness (Lowdermik et al 2002:141).

### **How it works**

Lowdermik et al (2002:143) point out that during sexual intercourse, it retains the ejaculated sperm, preventing the sperm from staying in the vagina. The condom is placed over the erect penis before the penis enters the vagina or before the loss of pre-ejaculation semen drops. If used correctly, the condom prevents the sperm from entering the cervix.

## **Composition**

Ninety-five percent (95%) are made of latex, and some are lubricated with a wet gel or a dry powder, and contain spermicides (0,5gde monoxinnol-9) in the internal and external surfaces. This addition not only increases the contraceptive effectiveness, but also the protection against sexually transmissible diseases (STIs) including HIV/AIDS.

## **Effectiveness**

5 – 10 pregnancies in 100 women/year

## **Rate of failure**

Regular condom users 17%  
(Fraser et al 2006:360)

## **Advantages**

- Safe
- Without side effects
- Easily available
- Pre-malignant changes in the cervix can be prevented or improved in women whose partners use condoms
- Non-surgical method for male contraception

## **Disadvantages**

- Intercourse has to be interrupted in order to place the condom.
- Sensitivity might be affected.
- If used incorrectly, leaking of sperm may result in pregnancy.
- Occasionally, the condom might tear during intercourse.

## **Protection against STIs**

- If a condom is used during intercourse and there is no unprotected contact with the woman's genitals, the latex virus-proof condom can be used as a protector against STIs. Adding monoxinal-9 increases the protection against the STIs, including HIV.

## **Nursing points to consider**

Provide guidelines for the adolescents with regard to the following:

The condom enables both male and female adolescents to cooperate in preventing pregnancy and STIs because the responsibility is not only that of the female adolescent but also the male adolescent (Family Planning Manual 1999:80).

- Use a new condom (check the date of validity) every time you have sexual intercourse.
- Open the package carefully so as to not damage the condom.
- Place the condom over the erect penis and before intimate contact.
- Place the condom over the tip of the penis, ensuring that there is no air inside the condom; unroll the condom over the shaft of the penis all the way.
- Remove immediately after ejaculation, knot the open tip of the condom and throw away in an appropriate place.
- Use only once.
- Condoms must be stored in a cool place away from heat and humidity.

## **Mechanical barrier methods** (Female condom or femidon and diaphragm)

### ➤ **Female Condom**

Lowdermik et al (2002:143) state that the female condom or femidon is a mechanical barrier method made of polyurethane and has flexible rings at both ends. The closed extremity is inserted into the vagina (Lowdermik et al 2002:142).

## **Efficacy**

Approximately 10 pregnancies in 100 women/year.

## **Rate of failure**

The typical rate of failure is 21% during the first year of use.

## **Advantages**

- Protects against STIs and respective consequences.
- Does not have systemic effects.
- Can be placed at any time before penetration with the penis.
- It is not necessary to withdraw the penis after ejaculation.
- It is more resistant than the male condom.

## **Disadvantages**

- Difficult to use (inserting and removing the condom)

## **How to use**

The National Directorate for Health (Angola 1998:29) advises that before sexual intercourse it is advisable to add a spermicide. Hold the condom, squeezing the inner sheath with the index finger and the thumb. With the other hand open the minor lips (labia minora) while inserting the condom deep into the vagina and ensuring that the exterior ring remains outside the vagina, covering the minor lips. Use only once.

## ➤ **Diaphragm**

The vaginal diaphragm is a rubber device, arched and flat, with a flexible rim and which covers the cervix (Lowdermilk et al 2002:142).

## **Types of diaphragms**

There are three main types, available in a wide variety of diameters (50 to 95 mm), which differ in the internal circular rim. The four types of rims are: plain spring, coiled spring, arched spring and sealed wide rim. It must feel comfortable and the size must be as large as the woman can use without feeling that it is in.

## **How it works**

The diaphragm is a mechanical barrier which prevents the sperm from meeting the ovule. Before use it is advisable to apply a spermicide such as a gel or contraceptive cream so as to provide better efficiency against a pregnancy. This maintains the sperm in place, against the cervix, during the six (6) hours that are necessary to destroy the sperm.

## **Rate of failure**

The rate of failure, when used alone, is 20% during the first year of use.

## **Effectiveness**

The effectiveness of the diaphragm can be increased when combining it with a spermicide.

## **Advantages**

- Reduces the risk of pelvic inflammatory disease (PID), vaginitis, cystocitis, intraepithelial neoplasia.
- Does not have systemic effects.
- Does not interfere with sexual intercourse, and can be inserted up to 24 hours before (Fraser et al 2006:356).

## **Disadvantages**

Difficulty in using (inserting and removing the diaphragm)

## **Contra-Indications**

Uterine prolapse, cystocele, rectocele, vaginal fistulas.

## **Collateral effects**

Tissue irritability related with the contact with the spermicide, urethritis and recurring cystitis, caused by the diaphragm pressing against the urethra.

## **Nursing points to consider**

Provide guidelines for the female adolescent with regard to the following:

There are various types of diaphragms, so the nurse must use the instructions on the package to explain to the female adolescent the importance of doing one annual check-up with the gynaecologist, when the size of the diaphragm must be checked; perhaps the woman may need it to be readjusted after significant loss or gain of weight (more than 22 to 33 kg), full-term childbirth or abortion during the second quarter. Teach the adolescent how to use and look after the diaphragm.

The diaphragm can be inserted up to 6 hours before sexual intercourse so as to increase the spontaneity, but the spermicide must be applied in the vagina every time there is sexual intercourse. A cold diaphragm and cold gel temporarily reduce sexual stimulation.

## **How to use**

The National Directorate of Health (Angola 1998:30) describes the following:

- Before placing the diaphragm, ensure that it is in an adequate state.
- Wash the hands carefully before and after using the diaphragm.
- The adolescent must hold the diaphragm with one of her hands, narrowing the arch between the index finger and the thumb. With the other hand open the small lips and insert the diaphragm in the vagina.

- The diaphragm is pushed along the back wall of the vagina, so that the front extremity (at the level of the vulva opening) is against the back wall of the symphysis. The diaphragm arch must touch the lateral vaginal walls.
- The diaphragm must cover the cervix and must not feel uncomfortable. One should ask the adolescent to insert the diaphragm before leaving the consultation to ensure that it has been correctly placed.
- It is advisable that a spermicide be used around the arch and inside the diaphragm every time before it is used.
- Remove the diaphragm 6 to 8 hours after sexual intercourse; do not use any vaginal douches during that period. Do not use during menstruation.
- The diaphragm can be kept in position up to 24 hours but not longer than that, due to the possibility of infection. After it is used it must be washed and dried.
- The diaphragm must not be used during the first 6 to 12 weeks after childbirth or abortion during the second quarter (Cronje & Grobler 2003:77).

#### ➤ **Hormonal oral contraceptive (pill)**

According to the Ministry of Health (Angola 1999:80), the pill is a safe contraceptive method when taken daily without forgetting.

#### **Types of combined pill**

The Directorate General of Health (Angola 1998:10) states that there are two types of pill:

- Combined, containing oestrogen and progesterone
- Progestative containing only progesterone

#### **Indications**

The Ministry of Health (Angola 1999:82) explains that the most used pill for the adolescent is the low-dosage combined pill microginon 30 ED (Levonogesterol 0,15 mg Ethinyl estradiol 0,3 mg), which contains reduced hormones, relieves dysmenorrhoea and can be used by most women, including adolescents.

## **Effectiveness**

The Directorate General of Health (Angola 1998:10-11-12) describes the following:

- Combined pill: 0.1 to 1 pregnancies in 100 women/year
- Progestative: 0.5 to 1.5 pregnancies in 100 women/year

## **Advantages**

### **Combined pill**

- High contraceptive effectiveness
- Does not interfere with sexual intercourse.
- Regulates menstrual cycles.
- Improves pre-menstrual stress and dysmenorrhoea.
- Prevents and controls ferropenic anaemia.
- Contributes to the prevention of ID and ectopic pregnancy, ovarian cancer, fibrocystic breast disease.
- Does not alter fertility once it is stopped.

### **Progestative**

- High contraceptive effectiveness. Skipping intake can more easily result in pregnancy than with combined pill.
- Can be used in some instances where oestrogen is not recommended.
- Does not seem to change the quantity or quality of maternal milk, and can be used during breastfeeding.
- Can contribute to preventing fibrocystic breast disease, ovarian cancer and endometrial cancer and PID.
- Does not alter fertility once it is stopped.

## **Disadvantages**

- Requires commitment from the woman, who must ensure she takes the pill daily.



- Does not protect against STIs, namely HIV/AIDS and Hepatitis B.
- Combined pill can affect the quantity and quality of maternal milk.
- Progestative pill is associated with irregularity of the menstrual cycle.
- Progestative pill does not prevent ectopic pregnancy, although it reduces its occurrence (reduces the number of spermatozooids reaching the Fallopian tubes).

## **Contra-indications**

### **Absolute**

- Abnormal genital haemorrhage without conclusive diagnosis
- Cerebral vascular accident (CVA), cerebral or coronary arterial disease, thrombophlebitis and thromboembolic accidents
- Hormonal-dependent neoplasia
- Chronic hepatic disease or in active phase, hepatic tumour
- Cholestatic ictericia during pregnancy and colelitis
- Intoxication due to tobacco when older than 35 years

### **Relative**

- Diabetes mellitus (with danger of vascular, renal, ophthalmologic or other disease – absolute contra-indications)
- Hypertension (higher or equal to 160/100 mmHg - is absolute contra-indication)
- Hyperlipidemia
- Severe depression
- Syndrome of inadequate absorption
- Severe chronic headaches similar to migraines
- Epilepsy and other diseases the treatment of which can interfere with the pill
- Severe varicose veins (due to higher thromboembolic risk)
- Existence of two or more relative contra-indications can transform the situation into absolute contra-indications (Cronje & Grobler 2003:23)

## Collateral effects

- **Nausea and vomiting.** Are common during the first few days but quickly disappear.
- **Changes in the menstrual flow.** Frequent with combined pill: one can notice a reduction in quantity and duration of flow. Eventually can even cause amenorrhea without pathological significance; in these situations, one must exclude the existence of pregnancy.
- **Spotting.** It is not uncommon to have small loss of blood during the first cycles of the combined pill which disappear spontaneously. Should it continue, one can change to another pill with a higher dosage of oestrogen.

With the progestative pill, the irregularity of the cycles is quite common and has no pathological significance.

- **Mastodinia.** Occurs frequently when first used and disappears with continuity. Thinner women are more prone to these complaints. Any nodules or swelling should be correctly checked.
- **Change in weight.** Weight increase can occur, generally associated with increase in appetite. The suggestion of eating correctly and physical exercise is quite useful.
- **Depression.** The majority of users feel more calm and confident, because freed from the fear of pregnancy. However, should there be a link between depression and the pill, another method should be used.

## Nursing care

As already indicated by the National Directorate of Health (Angola 1998:13), it is vital to investigate during consultation the possible absolute and relative contra-indications previously mentioned.

The woman must be clearly informed as to the possibility of changes and the temporary nature of these changes; only then will she be reassured and not stop the method.

## **Physical examination**

With special attention to:

- Blood pressure and weight/height
- Breast examination
- Gynaecological examination (starting the method must not depend on this examination, except in situations justified by the clinic.)

## **Other examinations**

Colpocytology according to guidelines.

In specific situations, and only when necessary, one must request supplementary examinations such as, amongst others, glycaemia, hepatic functions (Cronje & Grobler 2003:97).

## **Counselling**

Counselling must be clear, objective and adequate to the level of understanding of the woman. The non-contraceptive benefits of the pill must be pointed out, and the collateral effects explained, as well as the need to take the pill on a regular basis. In situations where there is a need to immediately start the method, contraceptive must be provided without prior medical consultation. Take into account the risk of STI infection, advise the simultaneous use of condoms and provide them. Contraceptives must be provided for a prolonged period of time, at least 6 months, for long term users.

## **Starting the method**

### **Combined pill**

As already indicated previously by the National Directorate of Health (Angola 1998:14-15).

- The pill must be started on the first day of menstruation (in specific cases, the pill may be started up to the 7th day of the cycle, provided an additional method is used for a week).
- Take daily and at the same time, during 21 days.
- Interrupt for 7 days.
- Restart new package.

### **Progestative pill**

Start during the first month after childbirth. Outside the period of breastfeeding, start on the 1<sup>st</sup> day of the cycle. Take daily at the same time, without interrupting.

When the woman breastfeeds only once or twice a day, one can continue with the combined pill. Finish the Progestative box and start combined pill on the following day.

### **In case of forgetting**

In case of forgetting one should explain the following:

When one misses 1 tablet at the usual time, it is best to take it as soon as possible, provided it is not later than 12 hours, and continue taking it at that same time every day. In this case no supplementary contraception is necessary. Should the period be longer than 12 hours, leave out the tablet you forgot to take, and continue taking the pill using, for the next 7 days, another associated method (condom or spermicide) (Cronje & Grobler 2003:137).

### **Stopping**

- There is no advantage in interrupting the pill periodically.
- When the user wishes to fall pregnant, she must be advised that she must only try it after one spontaneous menstruation (menstruation without being on the pill), due to the effect that the pill has on delaying ovulation and for that reason affecting the calculation of the gestational period. These women should be advised to take folic acid, at least two months before stopping the pill.
- The pill does not cause any foetal deformities or abortion.

- The pill must be interrupted four weeks before any surgery where it is anticipated that the person will be immobilised for longer than one week, or in any other situation requiring immobilisation (Cronje & Grobler 2003:123).

**Do not forget to use an alternative contraceptive method (condom).**

### **Precautions**

Users may be using one of the following medications:

- Fenitone, carbamazepin, barbiturates, primidona, topiramate (but not with sodium valproate), for epilepsy
- Griseofulvin, for fungi
- Espironolactone
- Rifampicine

Instead of the pill should use another contraceptive method such as the condom. Should the user's treatment be long term, it will be preferable to change to this method.

### **Frequency of consultations**

- The first follow-up consultation must be done 3 months after the beginning of contraception.
- Follow-up or subsequent consultations must be done every 6 months or annually, according to the characteristics of the user, the risk factors associated, and whenever there are complications.

### **Physical and gynaecological examination**

- Must be done annually.
- Services must ensure assistance is provided in the reproductive phase productive, whenever the symptoms indicate immediate clarification.

## ➤ **Emergency contraception**

According to the Ministry of Health (Angola 1999:82) the World Health Organization (WHO) defines Emergency Contraception (EC) as the method used to prevent pregnancy after having sexual intercourse.

The most common method of emergency contraception is the combined use of oral oestrogen pills and progestin pills.

### **Available types**

Microginin 30 ED (Levonogestrel 15 mg, Ethinyl estradiol 0,3 mg)

Protinor (Levonogestrel 0,75 mg)

### **Indications**

To prevent pregnancy after unprotected sexual intercourse within a period of 72 hours (3 days).

### **How to use**

- 1      Combined contraceptive YUPZE method (Micriginon)  
Consists in taking 8 microginon tablets twice with a 12 hour break in between:  
First intake: 4 tablets  
Second intake: 4 tablets 12 hours later
  
- 2      Protinor (Levonogestrel 0.75mg)  
Two Prostinor tablets are prescribed to be taken with a 12 hour break in between:  
First intake: 1 tablet  
Second intake: 1 tablet 12 hours later

Lowdermilk et al (2002:150) are of the opinion that emergency contraception can be offered to the woman who had sexual intercourse without protection and requests treatment within the following 72 hours.

No pelvic examination or other tests are necessary unless pregnancy is suspected.

### **Effectiveness**

Effectiveness is approximately 75%.

### **Contra-indications**

The contra-indications of emergency oral contraception are the same as for oral contraceptives.

#### **➤ Intra-Uterine Device (IUD)**

According to Lowdermilk et al (2002:151), the intra-uterine device is small and in the form of a T, inserted in the uterine cavity. IUDs are loaded with copper or with a very effective progestational agent, which damages the spermatozoid going through the uterine tube, thus preventing fertilisation.

It is effective, reversible and of long duration.

The effectiveness and eventual complications depend, largely, on the competency of the health expert.

Cu T-380 device can remain in the uterus for at least 10 years.

It is not advisable for women with an increased risk of being infected through ITS.

According to the Ministry of Health (Angola 1999:82) the Cu T-380 A IUD is the most used, having been approved by FDA and WHO, and has an effectiveness level of at least 10 years.

The use of IUDs can make the menstrual flow heavier and longer.

## **Indications**

The Ministry of Health (Angola 1999:81) describes the IUD as an effective contraceptive method that can be used by adolescents who have had at least one child, as a method of spacing pregnancy for two years after childbirth.

The IUD must not be recommended to the adolescent who has never been pregnant, as well as those who have more than one partner, because it can increase the risk of pelvic inflammatory disease as well as of STIs.

Clinical studies demonstrate that all copper IUDs can remain in the uterus for a period of at least 5 years and many are effective for longer.

## **Effectiveness**

- 0,1 to 2 pregnancies in 100 women/year.
- The effectiveness increases the longer it is used.
- It is more effective in women with children and in those less young.

The National Directorate of Health (Angola 1998:21-24) explains the following:

## **Advantages**

The effect of the IUD does not depend on the woman's remembering to use it; thus its theoretical effectiveness is very close to the practical effectiveness.

- It requires one single well-motivated act which then has a very long-lasting effect.
- Does not have systemic effects (except those with a hormonal content).
- Does not interfere with the sexual function.
- Does not interfere with breastfeeding.
- Can remain in the uterus for many years.
- Enables a rapid return to the previous levels of fertility.
- Contributes to the reduction of the incidence of ectopic pregnancy (reduces the number of sperms that reach the Fallopian tube).



## **Disadvantages**

- Does not protect against STIs.
- Apart from STIs, Pelvic Inflammatory Disease is more frequent in women who use IUD (though this does not seem to be the case with the Mirena IUD).
- Must be placed by a professional.
- The use of the IUD can increase and prolong the menstrual flow.

## **Indications**

- Women who have had children and wish for a more effective contraception method.
- Women who need a very effective method and for whom hormonal contraception is not recommended.
- Women who often forget to take the pill.
- Smokers older than 35 years of age.
- Women whose partners are absent for irregular periods of time.
- Nulliparas who are not able to use any other type of contraceptive method or who do not want to use another (the risks related to a possible STI must be explained) (Angola 1998:20-21).

## **Contra-indications**

As already indicated, the National Directorate of Public Health (Angola 1998:20, 21), after some research, warns:

### **Contra-indications**

#### **Absolute**

- Pregnancy
- Active or recurrent Pelvic Inflammatory Disease
- Any abnormal uterine haemorrhage for which no diagnosis has been established
- Suspected uterine neoplasia

- Anomalies of the uterine cavity
- Patients on immune suppressant medication
- HIV- or AIDS-positive patients
- Allergy to copper (rare) and Wilson's disease (with regard to IUD with copper)

### Relative

- Anterior ectopic pregnancy (consider the use of combined pill or DMPA which prevent GE)
- Menorrhagia; the IUD can increase the amount of blood lost during menstruation
- Chronic anaemia, including Thalassemia and Drepanocytosis
- One single episode of Pelvic Inflammatory Disease (consider the risk of renewed infection)
- Cervico-vaginal infections; treat before inserting IUD. Simple erosion of the colon is not a contra-indication.
- Uterine fibroma are not contra-indications provided they do not deform the cavity and cause no haemorrhage
- Nulliparity; evaluate the risk/benefit
- Valvular heart disease (insertion must be done under antibiotic cover)
- Normal medication with systemic corticosteroids

### Collateral effects

- **Pelvic pain.** Can occur when inserting the IUD and for some days after. Should pain be intense and persistent, the IUD should be removed.
- **Spotting.** Irregular haemorrhage or spotting can occur in the first months after placing the IUD, and will disappear in time.
- **Heavier menstrual flows.** An increase in the quantity or duration of the menstrual flow is common.
- **Vaginal discharge.** There is an increase in the mucoid secretion, which does not have any pathological significance and which must not be confused with cervico-vaginal infections.

## Complications

**Expulsion.** Occurs more frequently in the first 3 months after the IUD is inserted and generally results from the IUD having been inserted too low. The expulsion can be total or partial and causes slight pain and inter-menstrual haemorrhaging. The rate of expulsion of the IUD decreases with age, pregnancy and months of use.

**Pelvic infection.** Occurs in approximately 2% of users. Usually it is due to the lack of asepsis at the time the IUD was inserted or due to the woman having being infected with an STI, the development of which is facilitated by the presence of the IUD (the actual IUD alone does not cause the infection). Symptoms are: pelvic pain, vaginal discharge, abnormal loss of blood, and fever. The common treatment is with wide-spectrum antibiotics. If the situation does not improve after 38 hours of treatment, the IUD must be removed.

**Pregnancy.** Pregnancy is rare amongst users of IUDs.

When the presence of an **intra-uterine pregnancy** is confirmed, and if one intends continuing with the pregnancy, the IUD must be removed as early as possible, which is easy should the strings be visible. If the strings are not visible, one must leave the IUD *in situ* and the pregnancy must be considered as a risk pregnancy and referred to a doctor. The pregnancy can evolve normally with the IUD, but there is an added risk of spontaneous abortion, haemorrhage, amnionitis and pre-term delivery.

There is no evidence of increase in the risk of congenital deformities.

Although IUDs, especially the Tcu 380 A IUD, offer a significant protection against ectopic pregnancy, should an IUD user fall pregnant, 1 in every 30 is an ectopic pregnancy. The ectopic pregnancy is considered as an emergency which must be referred immediately.

## Nursing care

With regard to the contra-indications, collateral effects and complications that might arise, professional technical assistance is required and the correct technical procedure during insertion of the IUD is an important aspect for the successful use of the IUD.

- **Clinical history.** Investigate the possible absolute and relative contra-indications mentioned above.
- **Physical and gynaecological examination.** The gynaecological examination (including visual examination with the speculum) must be done in all follow-up consultations.
- One must determine if the cervix and the vagina do not present any pathologies which are against the insertion of the IUD. Use bimanual examination, with special attention to the size, format and mobility of the uterus and annexes. It is necessary to use a speculum for this examination. For female adolescents the use of a paediatric speculum, 1 to 1.5 cm wide, is advised. Should the adolescent be sexually active, the use of a small adult speculum is advised. Before the examination, one must chat to the female adolescent, while she is still dressed, and models or illustrations can be used to show exactly what will happen. HIV testing is encouraged with informed consent.

**Information for the woman.** Show the IUD; explain its effectiveness and reversibility; inform about the collateral effects and indicate the warning signs for which she must seek assistance:

- pelvic pains
- discharge with pus
- abnormal haemorrhaging
- delay in the menstrual period

### **Supplementary examinations**

- Harvesting for colposcopy, according to technical guidelines

### **Ask questions about**

- date of last menstruation
- menstrual characteristics
- occurrence of irregular haemorrhaging
- existence of pelvic pain or vaginal discharge

## **Motivate follow-up visits**

Confirm the presence of the IUD. Diagnose and treat eventual complications. Inform and motivate frequent follow-up visits: four to six weeks after the placement of the IUD. Afterwards the consultations should continue every six months, or yearly, according to the need and availability of the user (Fraser et al 2006:672-673).

## **Time of placing of IUD**

Once the possibility of pregnancy has been excluded, the IUD can be placed during any phase of the menstrual cycle. Whenever there are doubts with regard to the possibility of a pregnancy, the IUD must not be placed during the week immediately prior to menstruation. It can be placed four to six weeks after childbirth or abortion. A second IUD can be used to immediately replace the other that was removed. The IUD can be used as emergency contraception.

## **Complications during the insertion of the IUD**

- Uterine pains or contractions, more frequent in the nullipara
- Haemorrhaging of the cervix where the hooked forceps attach
- Lipothymia by vagal reaction (rare)

**Perforation.** Occurs in 0,01% of women. Should perforation be suspected at the time of hysteroscopy, the IUD must not be placed. If perforation is suspected after it has been placed, the woman must be referred for localisation of the IUD by means of a pelvic echography or X-ray (front and profile), with contrast in the uterine cavity, for example, with a hysteroscope.

## **2.8 SEXUALLY TRANSMITTED INFECTIONS (STIs)**

### **Concept**

Sexually transmitted infections or STIs are infectious diseases transmitted mainly through sexual contact (Lowdermilk et al 2002:115). According to Praça (2005:64), STIs are infections of the female reproductive system which originate in the external genitals,

vagina and cervix, and which can reach the uterus, tubes and ovaries. Infections of the reproductive system involve lesions or open wounds, ulcerations or localised irritation in the skin and mucous membranes which facilitate the spread of HIV in the tissues and, subsequently into the bloodstream.

According to Lowdermilk et al (2002:116), sexually transmitted diseases are the following: syphilis, gonorrhoea, Chlamydia infections, toxoplasmosis, rubella, cytomegalovirus (CMV) and herpes simplex. Other diseases, such as chickenpox and Group B beta haemolytic streptococci infections can have variable geographic distributions. Besides the STDs indicated above, Lowdermilk et al (2002:115) state that there are other infections such as: human papilloma virus infection (HPV), pelvic inflammation disease (PID), human immune deficiency virus (HIV) and hepatitis B; vaginal infections are bacterial vaginitis, candidiasis, trichomoniasis.

## **Causes**

The most common causes are: multiple sexual partners, unprotected vaginal and anal sexual intercourse, anal oral contact, introducing the hand and the wrist into the vagina without proper hygiene, and sharing of erotic objects, needles and equipment for vaginal douches (Lowdermilk et al 2002:115).

## **Risk factors which contribute to sexually transmitted infections (STIs)**

Socio-economic level, multiparity, progressive urinary infection, falciform disease, obstructive diseases previously unknown, congenital anomalies of the genital-urinary tract, over-use of pharmaceutical products and HIV infection (HIV).

The various infections of the reproductive system can interact with HIV and from this interaction results a mutual strengthening which causes some infections of the reproductive tract to become serious and difficult to treat (Cronje & Grobler 2003:427).

## **Prevention measures**

Prevention of infection is the most effective way to reduce the adverse consequences of STIs and can be done by:

- Avoiding risk behaviour
- Not having sexual contact with multiple partners, and partners who are strangers
- Involvement in a monogamous relationship with a non-infected partner
- Having one single sexual partner
- Avoiding exposure to blood or organic fluids potentially infected
- Consistently using the condom (male and female) as well as a better adapted spermicide
- Avoiding anal intercourse, and should this occur, using the condom and a latex glove in the case of hand penetration
- Avoiding oral-anal contact
- Not sharing erotic objects, needles and equipment for vaginal douches
- Total abstinence of sexual intercourse through which these diseases can be transmitted, through the blood or through organic fluids, or which facilitate skin to skin contact (Lowdermilk et al 2002:116)

## **2.8 CONCLUSION**

This chapter presents an overview of the literature related to the study topic. It presents the manner in which contraception is related to the other key terms: knowledge, adolescent, sexual and reproductive health, and sexually transmitted infections (STIs).

The literature review of the terms provided the researcher with a substantial background in terms of acquisition of knowledge with regard to the study.

## **Chapter 3**

### **Research methodology**

#### **3.1 INTRODUCTION**

The aim of this study was to investigate the knowledge levels of female adolescents regarding contraception.

This chapter describes the research methodology, delimitation of the study, geographical area, research design, target population, sampling method, data collection, data analysis, validity and reliability of the study and ethical considerations. A quantitative, descriptive and exploratory research design was used to investigate the knowledge that female adolescents have of contraception.

Polit, Beck and Hungler (2004:165) state that methodology in research refers to a systematic way of gathering data from a given population in order to understand a phenomenon and to generalise facts obtained from a larger population. Methodology embraces the research design, population, instrument used to collect data, ethical considerations, data analysis and its interpretation. Methodology, therefore, helps the researcher and the reader to understand the process of the research, thus giving it scientific merit.

#### **3.2 AIM AND PURPOSE OF THE STUDY**

The aim of the study was to propose strategies to promote health education programmes on life skills for adolescents, including contraceptive use by the adolescents to reduce unwanted pregnancies. The purpose of the study was to explore the knowledge that female adolescents have about contraception.

##### **3.2.1 Objectives of the study**

The objectives of this study were to

- analyse the knowledge of female adolescents about contraception



- determine the sources of information on the use of contraception methods
- make recommendations for educational programmes on contraception

### **3.3 RESEARCH QUESTION**

The research question to achieve the objectives was as follows:

- What is the knowledge of female adolescents with regard to contraception?

### **3.4 RESEARCH SETTING**

The research setting is the environment in which the research study takes place and can be a natural or controlled environment. Natural settings are real-life study environments without any changes made for the purpose of the study (Burns & Grove 2005:325).

The Asa Branca Health Centre is situated in the Cazenga Municipality in Luanda, Angola, which is one of the municipalities in the province of Luanda. Luanda covers a geographical area of 1 276 700 square metres. According to the 2005 census projection, the population of Luanda is estimated at 5.5 million people and the projected growth rate is 1,93%. Fifty-two percent of the population lives in an urban area while 48% lives in a rural area. The adult population in Angola makes up 53,7% of the total population. 43,5% of the population is between 13 and 19 years of age. In the urban setting there are 5 408 326 males and 5 260 368 females.

The study was done in a natural setting, as there was no manipulation of the environment. Thus no changes were made to the health centre situation or special treatment given to the respondents that could have affected the results.

The data were collected during the normal clinic day. Therefore, the respondents were interviewed while attending the health centre. The clinic has a reception area, consulting room, examination couches with curtains around them to provide privacy, treatment room, dressing room, injection room, duty room and administrator's office, and a conference room which was used for the interviews with the respondents to

provide privacy. The clinics are open from 08:00 am to 16:00 pm Monday to Friday for general health care practices including family planning services.

### **3.5 RESEARCH DESIGN**

Polit et al (2004:164) state that the purpose of the research design is to provide a plan for investigating the research question and is a *blueprint for action*. It is the overall plan that spells out the strategies that the researcher uses to develop accurate and interpretative information.

#### **3.5.1 Quantitative research design**

Quantitative research is “a systematic process of obtaining formal objective data to describe the variables and their relationships. Quantitative research uses structured tools to generate numerical data and uses statistics to interpret, organize and represent the collected data” (Burns & Grove 2005:32). In this study, the research design was quantitative, as the researcher used a structured interview schedule to collect data from the respondents. This method allowed the researcher to ask all the respondents the same questions with predetermined responses, which allowed objective data to be collected throughout the study. The researcher also used frequency tables and graphs to analyse and interpret the findings.

A quantitative, descriptive research design was chosen for this study in order to give a detailed description of the knowledge levels of adolescents regarding contraception. Quantitative research is a formal, objective and systematic process for generating information about the world. The specific questions addressed will generate knowledge which will directly improve the lives of adolescents (Lobiondo-Wood & Haber 2001:256).

According to Polit et al (2004:165), a descriptive survey design may be utilised to study characteristics in a population for the purpose of investigating probable solutions of a research problem.

A survey was chosen for this study for the following reasons:

- It is appropriate for the research objectives of this study, as the aim of the study is not to infer cause and effect but to describe the nature of the research topic (Brink 2006:111).
- There is no active intervention on the part of the investigator that may produce researcher bias (Brink 2006:112).

According to Brink (2006:111-112), a survey design may be utilised to study characteristics in a population to investigate probable solutions of a research problem. In this study, the survey design was used to investigate the knowledge of adolescents regarding contraception in order to find out if the lack thereof might lead to high birth-rates and or any diseases. It is impartial; there is no prejudice in the selection of units participating in the research, the research data can be collected in the natural setting and in a short time, using a structured interview schedule (Brink 2006:112). In this study, the study setting was at the Health Centre of Cazenga in the Cazenga Municipality in Luanda, where adolescents were questioned. Data were collected using a structured interview schedule. The survey, however, has its own limitations. According to Burns and Grove (2005:289), the following are some of the limitations:

- The person who responds to a survey is aware of being studied and this can be responsible for biased data. Sometimes the information collected tends to be relatively superficial because survey questionnaires rarely probe deeply into complexities such as contradictions of human behaviour and feelings. The design also requires the cooperation of the respondents, which might not be forthcoming.
- Surveys can be costly, time consuming and tedious because they are very demanding of personnel.
- Problems with generalisation might occur if the sample is poorly chosen, resulting in the survey not correctly representing the population. This did not apply to this study because findings were only applicable to the area of the Cazenga Municipality in Luanda, Angola.

Despite the limitations, in the researcher's view, the strengths outweighed the weaknesses and the survey was the appropriate design to adopt.

### **3.5.2 Descriptive research design**

A descriptive study “observes and describes the presence, frequency or absence of characteristics of a phenomenon as it naturally occurs, in order to gain additional information. The primary purpose of a descriptive study is to describe the situation, preferences, practices, opinions, concerns or interests of the phenomenon of interest” (Burns & Grove 2005:26; Polit & Beck 2004:189). Descriptive studies provide valuable baseline information. The method is also flexible and can be used to collect information from a large group of respondents. In this study, structured interviews were conducted to elicit information on the knowledge female adolescents have of contraception.

### **3.5.3 Exploratory research design**

Exploratory research aims at investigating the full nature of a phenomenon, the manner of existence, other related factors and the characteristics of the subjects, in order to gain additional information on the situation or practice. Exploratory research is done to increase the researcher’s knowledge of the field of study and provides valuable baseline information for further investigation. The method uses interviews and observational methods to collect data (Brink 2006:151). The research design was exploratory as it examined the existing knowledge of female adolescents attending the health centre and other factors related to the phenomenon, such as factors that influence choice of contraceptive methods and sources of information.

## **3.6 TARGET POPULATION**

The target population is the entire aggregation of respondents that meet the designated set of criteria (Burns & Grove 2005:43-44). The target population in this study consists of female adolescents between the ages of 13 and 19 in the Cazenga Municipal area, Luanda, Angola. The criteria for inclusion and exclusion are clearly stated.

### **3.6.1 Inclusion criteria**

According to Polit et al (2004:224), inclusion criteria are the characteristics the respondents must have in order to be included in the study. The respondents selected were all female adolescents between 13 and 19 years old in the Cazenga Municipality area and spoke Portuguese, the language the researcher is well conversant with. The respondents had to be willing to be interviewed by the researcher.

### **3.6.2 Exclusion criteria**

Brink (2006:124) defines exclusion criteria as characteristics which a participant may possess that could adversely affect the accuracy of the results. In this study, male adolescents and female adolescents who have not had any children were excluded from the study.

## **3.7 SAMPLING DESIGN AND PROCEDURES**

Sampling involves a process of selecting a sub-section of a population that represents the entire population in order to obtain information regarding the phenomenon or instrument. A sample is a sub-section of the population that is selected to participate in a study. There are two methods of sampling: one yields probability samples, in which the probability of selection of each respondent is assured; the other yields non-probability samples, in which the probability of selection is unknown (Polit et al 2004:225).

In this study non-probability sampling was used.

### **Non-probability sampling**

Non-probability sampling is a process of selecting respondents into the study with less chance of obtaining a representative sample (Burns & Grove 2005:40). Non-probability sampling was used to select the respondents for the study, by using the convenience sampling technique.

### **3.7.1 Sampling site**

Luanda was conveniently chosen by the researcher due to proximity and being the capital city with the highest population in the country. The clinic was chosen for the study because it was the only health centre which responded timeously to the researcher when permission was sought to undertake the research. This clinic represents the health services set up in Luanda, Angola.

### **3.7.2 Sampling of respondents**

#### ***3.7.2.1 Convenience sampling***

Convenience sampling was used to select the respondents in the study. One hundred respondents were interviewed in the clinic between 7 June 2006 and 7 July 2006. The researcher interviewed respondents each day from among the adolescents waiting to be seen at the clinic. The researcher explained the purpose of the study, their rights and that participation was voluntary. The respondents then signed a written consent form. According to Polit and Beck (2004:262), as well as Burns and Grove (2005:243), convenience sampling uses readily available respondents in a study; for example, patients waiting to be seen in a clinic. This sampling method should be used with caution, as the respondents may be atypical and introduce bias into the study. To prevent bias, only respondents who met the inclusion criteria were selected.

### **3.7.3 Sample size**

Burns and Grove (2005:354) state that there are no hard or fast rules about the sample size but a sample should have at least 30 respondents. According to Polit and Beck (2004:267-268), quantitative research designs require large samples to increase representativeness and reduce sampling error. Because of the limited scope of this study a sample of 100 respondents was used. The adolescents attending the clinic in the clinic were a heterogeneous group as they came from different ethnic and socio-economic backgrounds and cultural norms and beliefs.

### **3.8 DATA COLLECTION**

Data collection is a systematic way of gathering information which is relevant to the research purpose or questions (Burns & Grove 2005:421). Data were collected between 7 June and 7 July 2006 using a structured interview schedule (annexure D). The prospective respondents at the Cazenga Health Centre were approached and requested to participate in the study. Detailed information about the study was given to the adolescents, using their mother tongue, before consent to participate was obtained (annexure C). Both verbal and written consent was obtained before the respondents were interviewed by the researcher. An interview provides quality data about what people are doing or thinking about a phenomenon (Burns & Grove 2005:422).

#### **3.8.1 Data-collection instrument**

A structured interview schedule was designed after the literature review and with the help of the two supervisors and a statistician. In the interview schedule, the researcher asked open-ended and closed questions to find out what people knew and thought about the phenomenon under study (annexure D).

The interview schedule allows objective data collection from the respondents and eliminates diversion from the topic. It prevents bias or subjective judgments from the researcher. In addition, all the respondents are asked the same questions, which allows objective comparison of results (Brink 2006:153, 158).

The researcher designed an interview schedule that was free from bias and used the same structured questions for all the respondents to ensure consistency of responses. Questions were asked to elicit the knowledge of respondents on contraception and sources of information. The interview schedule was divided into five sections.

*Section A* comprised the demographic data, and sought to obtain respondents' details such as age, gender, and educational status.

*Section B* was aimed at evaluating the knowledge of female adolescents' physical and emotional changes, the age when puberty starts and the relationship with the mother.

*Section C* dealt with knowledge, attitudes and practices of female adolescents with regard to contraception.

*Section D* sought to find out the knowledge that adolescents have about contraception.

*Section E* aimed at determining the knowledge of adolescents on STIs, sexual violence and taboos on contraception.

### **3.8.2 Conducting the interviews**

A structured interview is “a method in which information is collected through personal interaction with the respondents to give their views” (Brink 2006:151-152). In this study, the researcher visited the selected research site, interviewed the selected sample, using the structured interview schedule, and documented the respondents’ responses in the same order and manner. This method allowed the respondents to clarify questions, where necessary. When deciding on an interview schedule the researcher took into account the following advantages and disadvantages of the interview.

#### **3.8.2.1 Advantages of structured interviews**

Interviews have the following advantages:

- Interviews are more feasible for most people; the uneducated or illiterate can all answer questions from an interviewer. Thus, responses can also be obtained from individuals who cannot read or write.
- The response rate for interviews is usually high, as respondents are less likely to refuse to be interviewed if someone is available.
- An interview is a flexible method, which allows the researcher to explore the deeper meanings of phenomena.
- Face-to-face interviews also produce information through personal observations of the respondents’ verbal and non-verbal communication.
- The researcher can clarify ambiguous or confusing questions.
- The respondents are less likely to leave a question unanswered.
- The researcher controls the structured interview (Burns & Grove 2005:396-397).



### **3.8.2.2 *Disadvantages of structured interviews***

Interviews have the following disadvantages:

- Interviews are time consuming and costly, as the researcher has to travel to the respondents' venue and conduct the interview.
- The structured interview schedule with predetermined responses could make respondents give the information that the researcher wants, thus the respondents give responses as specified by the researcher not their own ideas (Burns & Grove 2005:396-397). This constraint could be overcome by allowing the respondents to give any other response apart from the responses provided in the interview schedule.

### **3.8.3 Pre-testing of instrument**

A pre-test or pilot study is a small-scale trial of the data-collection instrument to determine clarity of questions and whether the instrument elicits the desired information (Polit & Beck 2004:296). In order to ensure reliability and validity the interview schedule was pre-tested on five female adolescents attending a health centre clinic (with similar attributes) in Luanda to check the clarity of questions and identify vague or non-acceptable questions. Adjustments were made based on the outcome of the pre-test results. The data collected during the pre-test were not part of the study.

## **3.9 VALIDITY AND RELIABILITY**

Reliability is the degree of consistency with which the data-collection instrument produces the same results every time it is implemented in the same situation or used by different investigators. The data-collection instrument should be accurate and stable to reflect true scores of the attributes under investigation and minimise error (Brink 2006:214; 1996:171; Burns & Grove 2005:396, 399). To ensure reliability, the researcher pre-tested the interview schedule on female adolescents attending a similar health centre in Cazenga Municipal area in Luanda with the same attributes as the health centre for this study, who were not part of the sample. This was done to identify vague, unacceptable questions and check consistency of results.

### **3.9.1 Validity**

Validity is the extent of accuracy with which an instrument measures the construct it is supposed to measure in the context of the concepts/variables being studied (Brink 2006:214-219). A structured interview schedule was developed after a review of relevant literature to incorporate and measure important variables in the study. The researcher and supervisors closely examined the questions in the interview schedule to ensure that they measured the desired variables. The face, content, and construct validity were also examined.

#### ***Face validity***

Face validity refers to subjective judgment on whether the research instrument appears to measure what it is supposed to measure (Burns & Grove 2005:377-378). Face validity was maintained by constructing questions relevant to the study and the interview schedule was evaluated by two health care practitioners, two midwives, two supervisors and a statistician to check the appearance, consistency and whether the tool measured what it was supposed to measure. Changes were made according to the feedback from the statistician, the supervisors, nurse educators, research unit officer and health care practitioners who reviewed the interview schedule.

#### ***Construct validity***

Construct validity ensures that abstract concepts are measured adequately and logically, and relationships between variables are identified, with an instrument based on theory and clear operational definitions. Construct validity includes the definition of variables in line with existing literature or theory and differentiates between respondents who possess the trait and those without the trait (Burns & Grove 2005:162). In this study the interview schedule was based on the literature reviewed and its relevance to the variables in the study. The variables were operationally defined to create a common understanding between the researcher and readers.

## ***Content validity***

Content validity is the evaluation of the tool to ensure that all the components of the variables to be measured in a study are included in the interview schedule without neglect of important components (Brink 2006:160). To meet this criterion, the researcher reviewed relevant literature before developing the instrument and ensured that all the parts/necessary variables were included. The instrument was also given to two fellow nurse educators, the two supervisors, statistician and two health care practitioners for comment. The interview schedule was then altered according to their evaluation.

### **3.9.2 Threats to internal and external validity**

#### ***3.9.2.1 Internal validity***

Internal validity is the extent to which the results of the study reflect reality rather than extraneous variables. Threats to internal validity are factors that may give false positives or false negatives in the measurement of variables. Lack of internal validity may be observed when other variables rather than the independent variables under study are responsible for part of or the entire observed outcome on the dependent variable. Therefore, the researcher has to be observant of other variables rather than the dependent variables that may affect the outcome of the results (Burns & Grove 2005:218). The researcher was observant of the following factors, which could give false or negative measurement of the variables in the study.

## ***Setting***

The study was conducted in a natural environment, i.e. clinic, as the researcher wanted to explore the knowledge of female adolescents on the phenomenon of interest and could not alter the results of the study.

## ***History***

History is the events or factors occurring at the same time that the study is being done (Burns & Grove 2005:219-220). The researcher paid particular attention to life-skills and

family-planning programmes that could affect the results of the study; for example, clients who had attended life-skills programmes before might have more information than those who had not attended such programmes. The life-skills and family-planning programmes might influence the knowledge that female adolescents attending the clinic have on the phenomenon of interest, as adolescents enrolled in these programmes are given relevant information to make informed decisions on joining the programme. Participation in these programmes was noted on the interview schedule and taken into account in data analysis.

### **3.9.2.2 External validity**

External validity deals with the ability to generalise the findings of the study to members of the population other than those in the sample (Burns & Grove 2005:234). The study has limited generalisability due to the sampling approach of respondents and a small sample size.

### **3.9.3 Reliability**

Reliability relates to the precision and accuracy of the instrument. If used on a similar group of respondents in a similar context, the instrument should yield similar results (Lobiondo-Wood & Haber 2001:192). Accurate and careful phrasing of each question to avoid ambiguity or leading respondents to a particular answer ensured reliability of the tool. Respondents were informed of the purpose of the interview and of the need to respond truthfully.

#### **3.9.3.1 Pre-test**

A pre-test is a trial run of the data collection instrument. Its purpose is to check the time taken to complete the questionnaire, whether it is too long or too short, too easy or too difficult and to check the clarity of the questionnaire items, and to eliminate ambiguities or difficulties in the wording (Polit et al 2004:254).

A pre-test was conducted to test the questionnaire for reliability. Five (5) respondents with similar characteristics to the research sample were interviewed using the structured questionnaire. Following the pre-test, no questions were rephrased as these proved to

be clear and relevant. Time allocated for the completion of the interview was approximately 30 minutes.

### **3.10 ETHICAL CONSIDERATIONS**

Pera and Van Tonder (2005:4) define ethics as “code of behaviour considered correct”. It is crucial that all researchers are aware of research ethics. Ethics relates to two groups of people: those conducting research, who should be aware of their obligations and responsibilities, and the “researched upon”, who have basic rights that should be protected. The study therefore had to be conducted with fairness and justice by eliminating all potential risks. The respondents must be aware of their rights. Ethical issues observed in a study may include “informed consent, right to anonymity and confidentiality, right to privacy, justice, beneficence and respect for persons” (Lobiondo-Wood & Haber 2001:84-86, 90).

To ensure the ethical conduct of the study, the researcher observed the following principles:

#### **3.10.1 Permission to conduct the study**

Permission to conduct the study was obtained from the Director of the Municipal Health Centre of Cazenga (see annexure A for a copy of the letter requesting permission and annexure B for the permission granted).

The request for permission to carry out the study was submitted by the researcher to the Ministry of Health. Authorisation was also obtained from the school at the time the study was done. Permission was also obtained from the Director of the Health Centre of the Cazenga Municipality in Luanda, Angola, at the time the study took place. Written permission (informed consent) was also obtained from the participants (LoBiondo Wood & Haber 2001:161) (see annexures A, B and C).

In this study no names were indicated in view of the information obtained, and a numerical code was used by the researcher, so she is the only person who is aware of the source of those data.

### **3.10.2 Respect for persons as autonomous individuals**

Respect for persons is a basic human right. Respondents are autonomous individuals who have the right to choose to either participate in the research or not. *Collins English Dictionary* (1991:286) defines choice as “the act or an instance of choosing or selecting; the opportunity or power of choosing”. The decision has to be made without coercion. Respondents were allowed to act independently by giving their informed consent to participate in the study. Prior to the respondents’ giving consent, the purpose of the study was fully explained to them in the language they were conversant with. Risks and benefits were highlighted. The respondents were informed that participation was voluntary and they were free to withdraw should they so wish. The respondents were assured that neither participation, withdrawal nor refusal to participate would affect their entitlement to health services. Prior to signing the consent, there was a period of question time to ensure that the participants fully understood the explanations. At the end of the explanations, the respondents were asked to sign a written consent (see annexure C for an example of the consent form).

### **3.10.3 Confidentiality and anonymity**

LoBiondo-Wood and Haber (2001:162) state that confidentiality means that no information provided by participants shall be made available to anyone. The anonymity of an individual or an institution is protected by making it impossible to link or relate any aspect related to data to a specific individual, person or institution. Confidentiality and anonymity are guaranteed by ensuring that data obtained will not be used in any way except by the researcher who is aware of the source of those data.

In this study no names were indicated on the completed questionnaires and a numerical code was used to ensure that only the researcher was aware of the source of data.

### **3.10.4 Privacy and dignity**

Privacy refers to the freedom that any individual has to determine the extent, scope and general circumstances according to which he or she will share or not share any private information with others (LoBiondo-Wood & Haber 2001:163). For this study, privacy was

maintained by interviewing the respondents in a separate room away from the other clients.

### **3.10.5 Avoiding harm**

Avoiding harm is another basic human right to be considered when conducting research on human beings. According to Burns and Grove (2005:165), risks that may be encountered in research include physical, psychological, emotional, social and financial ones. In this study, maintaining privacy, confidentiality and anonymity during the completion of the questionnaire prevented any psychological harm.

### **3.10.6 Justice**

Justice relates to the “fair treatment of those involved in the study” (Burns & Grove 2005:180). In this study, the participants were treated fairly by giving them information prior to participation and by giving them the option to withdraw from the study if they wanted to without any negative consequences regarding entitlement to health services. Selection of the sample following the guidelines of the inclusion criteria also ensured that all those who met the criteria had a fair chance to participate in the study.

### **3.10.7 Informed consent**

Informed consent is a “legal requirement before one can participate in a study” (Brink 2006:35-39). After a full explanation of the nature of the study, participants were asked to give either verbal consent, for those who could not read or write, or written consent to willingly participate in the study.

### **3.10.8 Right to withdraw from the study**

Participants were informed that they could withdraw from the study at any time. This right was explained to them before their involvement in the study, before the interview was conducted. This right is part of informed consent (LoBiondo-Wood & Haber 2001:163).

### **3.10.9 Disclosure of results**

The results are disseminated in the format of a research report. This report tried to stimulate the readers to want to study it, read it and determine the viability of its implementation.

This report must not disclose to the reader any secrets or weaknesses of the institution but must present recommendations to improve the knowledge acquired by the participants.

The participants were informed that a copy of the results would be made available to the Health Centre where the study was done. The information could be published in relevant periodicals if required or desirable, so that the participants could be informed with regard to the results of the study.

### **3.11 DATA ANALYSIS**

Data analysis is the “systematic organisation and synthesis of the research data and the testing of research hypotheses, using those data” (Polit et al 2004:311). It also entails “categorising, ordering, manipulating and summarising the data and describing them in meaningful terms” (Brink 2006:170). The completed interview schedules were given to a statistician who used the SPSS Version 13.0 computer program to analyse the data. Most of the questions included in the structured interview schedule were closed questions. These were coded for easy analysis by computer. The open-ended questions were categorised by hand by the researcher. Descriptive statistics, such as frequency tables and percentages, were used in the data analysis and summaries. The findings are discussed and the data presented in the form of frequency tables and bar graphs in chapter 4.

### **3.12 CONCLUSION**

This chapter discussed the research design and methodology used in the study. A quantitative, descriptive, exploratory design was used to investigate the research objectives and questions. A structured interview schedule was used to elicit data from



female adolescents on the phenomenon of interest. Chapter 4 describes the data analysis and interpretation.

## **Chapter 4**

### **Data analysis and interpretation**

#### **4.1 INTRODUCTION**

This chapter discusses the data analysis and findings of 100 structured interview schedules completed by female adolescents who attended the Asa Branca Health Care Centre in the Cazenga Municipal area, Luanda, Angola, during 2006. The purpose of the study was to ascertain the knowledge of female adolescents with regard to contraception.

The objectives of the study were to

- analyse the knowledge of adolescents about contraception
- determine the sources of information on the use of contraception methods
- make recommendations for educational programmes on contraception

The researcher collected data from respondents using a structured interview schedule. After signing the consent forms indicating their willingness to participate in the study, these female adolescents were interviewed. The consent form was folded and put into a separate box from the anonymously completed interview schedules to ensure anonymity. In this way no signed consent form could be linked to any specific completed questionnaire.

A total of one hundred female adolescents were interviewed at the Asa Branca Health Centre in the Cazenga Municipal area, Luanda, Angola, between June and July 2006.

The structured interview schedules consisted of five sections:

- Section A: Demographic data
- Section B: Adolescence
- Section C: Sexuality
- Section D: Contraception

- Section E: Sexually Transmitted Diseases

The data from the questionnaires were statistically analysed by a statistician from the University of South Africa (Unisa). The SPSS Version 13 computer program was used for the data analysis. The questions in the structured interview schedule consisted of categorical responses which led to categorical variables which were analysed in a particular way.

#### **4.1.1 Data presentation**

The following explanation of the data analysis process was provided by the statistician. Summary statistics used for the responses to each individual question are frequencies, i.e. counts of how many respondents selected a particular response. These frequencies are illustrated by means of pie charts or bar charts. Bar charts are particularly useful in the case of a question that offered a number of alternatives and where the respondents were allowed to mark more than one choice (the 'Yes/No' options), where the bar chart compares the frequencies of the different choices. The pie chart is used in cases where the respondents are allowed to choose only one alternative, and the pie chart then illustrates the share of the total respondents opting for each choice.

In items where not all the respondents responded, the frequencies and percentages were calculated according to the number of responses. Missing responses were thus not included.

In some instances the percentage adds up to a decimal larger than 100,0%. This calculation was rounded to 100,0%.

The information is presented in tables, pie charts and bar charts. As the frequency of the 100 respondents equals the percentage of 100 percent, only the frequency is indicated in the tables, while only the percentage is utilised in the different types of graphs.

## 4.2 SECTION A: DEMOGRAPHIC DATA

The demographic data included the age of respondents, the level of schooling, ethnic group, religion, language, family structure and family relations, discussion about sex with family and friends and knowledge about menstruation. Though not central to the study, the data helped to contextualise the findings and the formulation of appropriate recommendations on lifestyle changes which would enable more adolescents to utilise contraceptives to prevent unplanned pregnancies.

### 4.2.1 Age of respondents (item 1)

Of the respondents 49,0% (n=49) were older than 17 years; 30,0% (n=30) were 17 years old; 13,0% (n=13) were 16 years old; 5,0% were 15 years old and 3,0% were 14 years old.

The frequency table 4.1 is as follows:

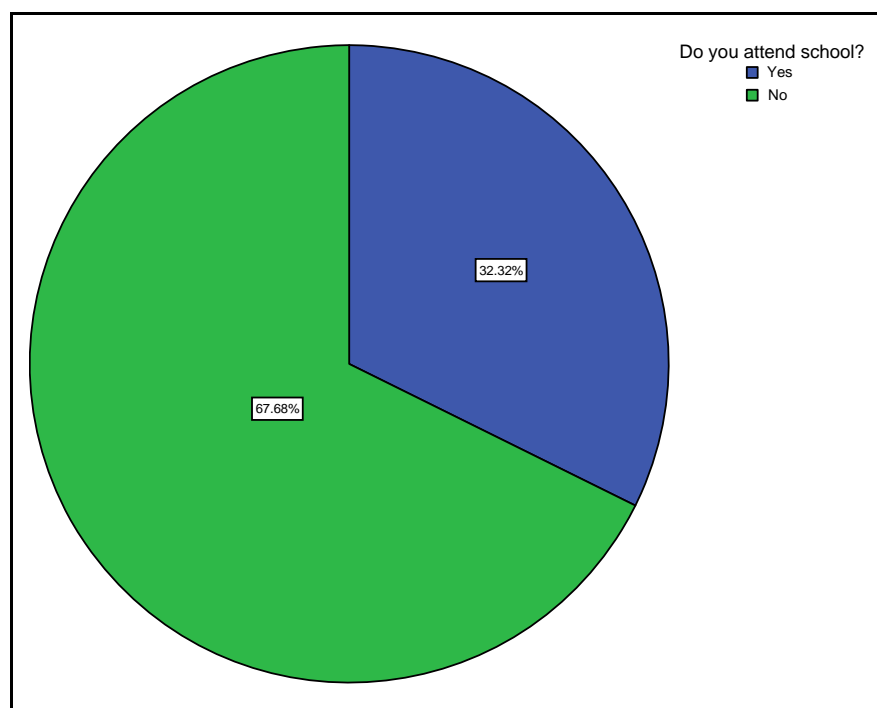
**Table 4.1 Age of respondents (N=100)**

Age	Frequency	Percentage
14 years	3	3,0
15 years	5	5,0
16 years	13	13,0
17 years	30	30,0
Older than 17 years	49	49,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

According to Garcia (2005:1-5), one can consider this group of female adolescents as belonging to the middle stage of sexuality, which goes from 14 to 17 years of age.

#### 4.2.2 School attendance of respondents (item 2)

The respondents were asked whether they attended school or not. Of the respondents 67,68% (n=67) stated that they did not attend school and 32,32% (n=32) indicated that they did. The pie chart illustrates that only one third of respondents attended school (Figure 4.1).



**Figure 4.1**  
**School attendance of respondents (N=99)**

According to Fernandes (2005:5), the state of education in Angola is far from being satisfactory. A study carried out with a total of 4,3 million illiterates indicates that 3,6 million were women older than 15 years.

According to MICS (2003:128), one third of the Angolan population cannot read or write, and only 54,0% of women can read and write. In the capital (Luanda), 79,0% of the population have only attended school at primary level.

In the municipality of Cazenga in Luanda there are 66 schools, 22 of which are at level two and teach grades 5 and 6, with a total of 30 079 adolescents (Municipal Education Delegation of the Municipality of Cazenga 2006).

#### **4.2.3 Highest grade passed (item 3)**

The respondents were requested to indicate their highest school level. This item was only answered by 87 respondents, thus N=87.

Of the respondents 19,5% (n=17) indicated having attended grade 5; 17,2% (n=15) attended grade 6; 19,5% (n=17) attended grade 7; 9,2% (n=8) attended grade 8; 3,4% (n=3) attended grade 9; 4,6% (n=4) attended grade 10 and 1,1% (n=1) attended grade 11; 25,3% (n=22) attended other grades. The “If you answered Yes” prescription was obviously ignored. Most respondents had not progressed beyond grade 8.

#### **4.2.4 Activity of respondents not attending school (item 4)**

The respondents were requested to indicate what they were doing if not attending school. Of the 67 respondents who were not going to school, only 20 responded to this question. Of these respondents 20,0% (n=4) indicated that they worked at the market; 15,0% (n=3) indicated that they worked at home; 15,0% (n=3) indicated that they assisted their parents; 30,0% (n=6) indicated that they looked after the children; 5,0% (n=1) stated that they did nothing; while 15,0% (n=3) indicated other activities (refer to Table 4.2).

**Table 4.2 Activities if not attending school (N=20)**

<b>Activity</b>	<b>Frequency</b>	<b>Percentage</b>
4.1 Work at a market	4	20,0
4.2 Work at home	3	15,0
4.3 Assist parents	3	15,0
4.4 Look after children	6	30,0
4.5 Nothing	1	5,0
4.6 Other	3	15,0
Total	20	100,0

#### **4.2.5 Reasons for not attending school (item 5)**

This question hoped to determine the reasons why the respondents did not attend school. The reasons are stated as follows in Table 4.3:

Of the respondents 29,0% (n=29) indicated that they had no money to continue their schooling; 16,0% (n=16) indicated that their parents had not encouraged them to continue with schooling; 39,0% (n=39) stated that they did not continue studying due to pregnancy; 2,0% (n=2) stated that they had no motivation; 1,0% (n=1) respondent indicated having had a bad experience at school; 5,0% (n=5) indicated other reasons.

Pregnancy and lack of funds seem to be the main reasons that led the respondents not to attend school.

**Table 4.3 Reasons that led respondents to not continue attending school (N=100)**

Reasons	Frequencies	Percentage
5.1 I have no money	29	29,0
5.2 My parents do not encourage me	16	16,0
5.3 I am pregnant	39	39,9
5.4 I am not motivated	2	2,0
5.5 I had a bad experience at school	1	1,0
5.6 Bullying or abuse by teachers	0	0,0
5.7 Others	5	5,0
5.8 No answer	8	8,0
<b>Total</b>	<b>100</b>	100,0

According to Cavasin and Arruda (2005:7), pregnancy in adolescence occurs more frequently amongst girls of 15 to 19 years of age and at this age it has many educational and social implications for the young mother, such as having to leave school and other potential projects.

#### **4.2.6 Ethnic group (item 6)**

The respondents were asked to indicate the ethnic group they belonged to.

The majority of the respondents 79,0% (n=79) belonged to the ethnic group Kimbundo; 12,0% (n=12) belonged to other ethnic groups; and 9,0% (n=9) indicated that they belonged to the Umbundo ethnic group.

Refer to frequency Table 4.4 as follows:

**Table 4.4 Ethnic group (N=100)**

<b>Ethnic Group</b>	<b>Frequency</b>	<b>Percentage</b>
6.1 Kimbundo	79	79,0
6.2 Umbundu	9	9,0
6.3 Ganguela	0	0,0
6.4 Kuanhama	0	0,0
6.5 Other	12	12,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

**4.2.7 Religious affiliation (item 7)**

The respondents were asked to indicate their religious affiliation.

Of the respondents 40,4% (n=40) were Catholic; 4,0% (n=4) belonged to the Evangelical Church; 2,0% (n=2) belonged to Simão Toco church; 6,1% (n=6) were from the Universal Kingdom of God; 7,1% (n=7) were Jehovah's Witnesses; 19,2% (n=19) did not follow any religion and 21,2% (n=21) belonged to other religions. Most respondents are Catholic, with a substantial number belonging to no religion or other religions (refer to Table 4.5).

The frequency table is as follows:

**Table 4.5 Religious affiliation (N=99)**

<b>Church</b>	<b>Frequency</b>	<b>Percentage</b>
7.1 Catholic	40	40,4
7.2 Evangelical	4	4,0
7.3 Mana	0	0,0
7.4 Simão Toco	2	2,0
7.5 Messianic	0	0,0
7.6 Universal Kingdom of God	6	6,1
7.7 Jehovah's Witnesses	7	7,1
7.8 None	19	19,2
7.9 Other	21	21,2
<b>Total</b>	<b>99</b>	<b>100,0</b>



#### 4.2.8 Language spoken (item 8)

From Table 4.6 it is evident that the languages spoken by the respondents are as follows:

Of the respondents 22,0% (n=22) spoke Kimbundu; and 2,0% (n=2) spoke Kikongo; 76,0% (n=76) spoke only Portuguese.

The frequency table is as follows:

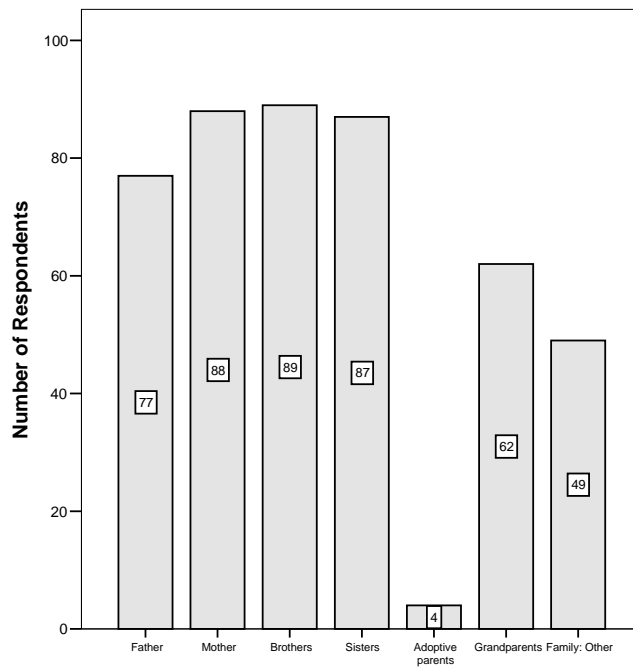
**Table 4.6 Language spoken (N=100)**

Language spoken		Frequency	Percentage
8.1	Kimbundu	22	22,0
8.2	Kikongo	2	2,0
8.3	Fiote	0	0,0
8.4	Tchiokwe	0	0,0
8.5	Portuguese	76	76,0
<b>Total</b>		<b>100</b>	<b>100,0</b>

#### 4.2.9 Family structure (item 9)

The respondents were asked to indicate their family structure. The majority of respondents indicated that their family consisted of a mother (88), father (77), brothers (89) sisters (87) and grandparents (62); only 4 respondents mentioned that their family consisted of adoptive parents and 49 respondents indicated that the family structure comprised others. The bar chart illustration is presented in Figure 4.2).

According to Lowdermilk et al (2002:27), the extended family involves the main family and other related kin. These include grandparents, uncles, aunts and cousins. Through this kinship network, the extended family provides patterns and support for all its members.

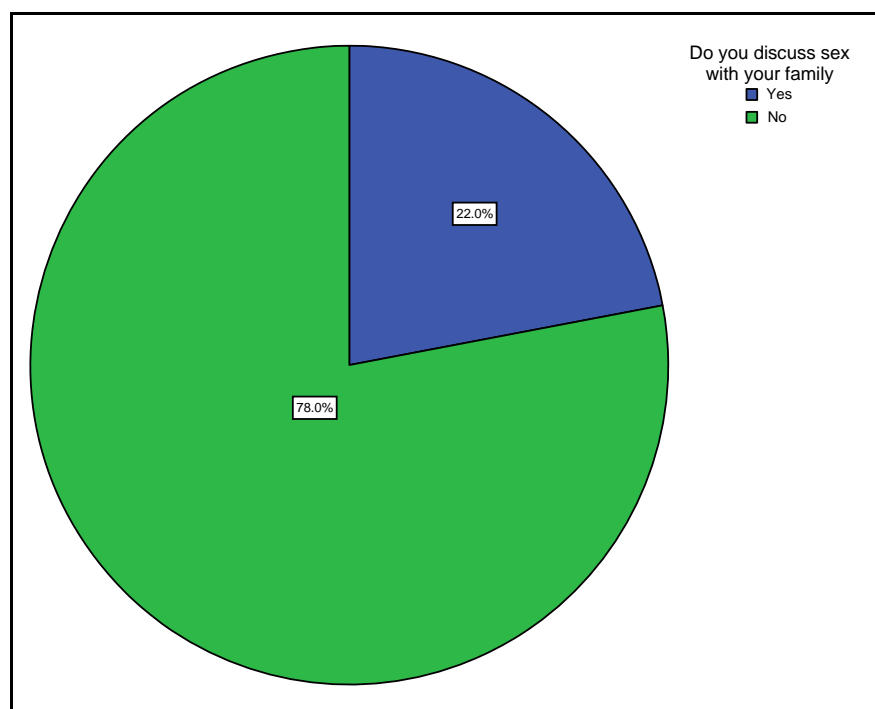


**Figure 4.2**  
**Family structure (N=100)**

#### **4.2.10 Sex discussion with the family (item 10)**

The respondents were requested to indicate whether they discussed sex with their families. Fewer than a quarter of the respondents indicated that they discussed sex with their families (refer to Figure 4.3).

Of the respondents 22,0% (n=22) talk to their family about sex; 78,0% (n=78) do not talk to their family about sex.



**Figure 4.3**  
***Sex discussion with the family (N=100)***

Silva, Martins, Neves and Lopes (1999:27) state that the father and mother are the first intervening parties in the process of sexual learning, both with regard to establishing the sexual roles and in the development of values about the body and erotic behaviour, and they continue to fulfil a vital role, on a different level, until adolescence. Often the main reason for lack of communication has to do with the parents not being at ease and feeling ashamed of discussing this topic. The study seems to confirm that the mother represents an important source of information for the young girls.

#### **4.2.11 Information on discussion about sex with the family (item 11)**

In this question, the respondents who acknowledged that they did discuss sex issues with their families (item 10) were asked in an open question to give the information that they discussed with their family relating to sex. It appears that this was a sensitive question and no responses were received from the respondents.

#### 4.2.12 Reasons for not discussing sex with the family (item 12)

The respondents were requested to state the reasons why they did not discuss sex with the family. Shyness and a fear of rejection were the main reasons why respondents did not discuss sex with their families (refer to Table 4.7).

Of the respondents 1,0% (n=1) indicated that the parents are old-fashioned; 58,6% (n=54) indicated that they feel shy; 2,0% (n=2) indicated that they do not want the family to know that they are interested; 3,0% (n=3) indicated that the family may think they are promiscuous; 24,0% (n=24) indicated that the family does not understand them and they will be rejected; 1,0% (n=1) indicated that they have conflicts with the family; 7,0% (n=7) indicated that they do not discuss sex with the family for other reasons.

**Table 4.7 Reasons why respondents do not discuss sex with their families (N=100)**

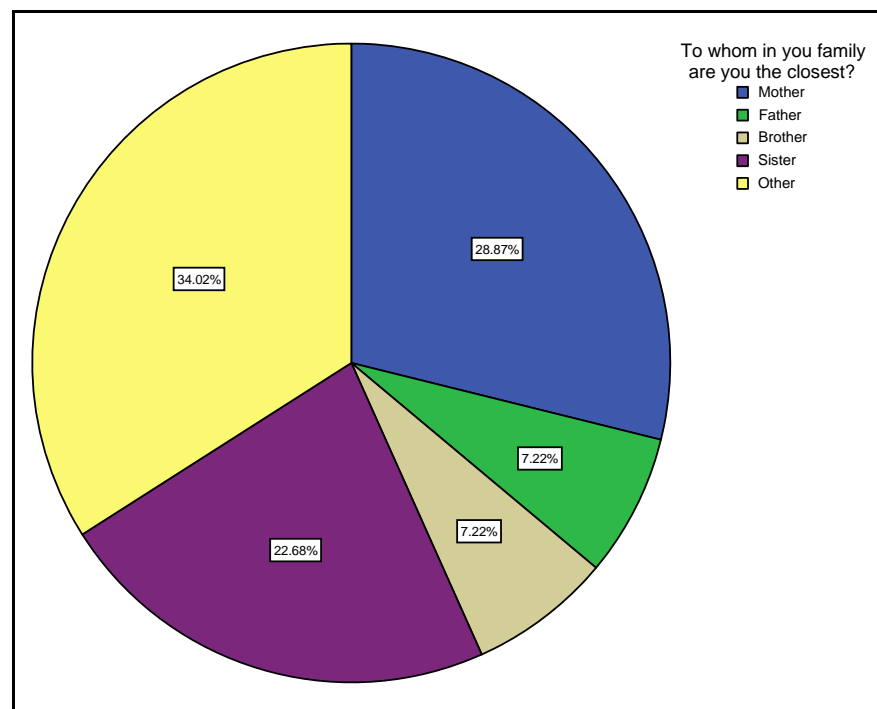
Reasons	Frequencies	Percentage
12.1 My parents are old fashioned	1	1,0
12.2 I am shy	54	54,0
12.3 I do not want my family to know I am interested	2	2,0
12.4 My family might think I am promiscuous	3	3,0
12.5 My family does not understand me, I will be rejected	24	24,0
12.6 I have conflicts with my family	1	1,0
12.7 Others	7	7,0
12.8 No answer	8	8,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

According to Tiba (1994:134), reluctance by children to ask questions about sex or other difficulties can be a result of a strict education. Anyone who is curious normally asks the person he or she trusts and with whom he or she feels at ease.

#### 4.2.13 Relationship with a family member (item 13)

The respondents were asked to state to which family member they were the closest (refer to Figure 4.4).

Of the respondents 28,87% (n=28) are closest to their mother; 7,22% (n=7) are closest to their father; 7,22% (n=7) are closest to their brothers; 22,68% (n=22) are closest to their sisters; while 34,02% (n=33) have close relationships with other people.



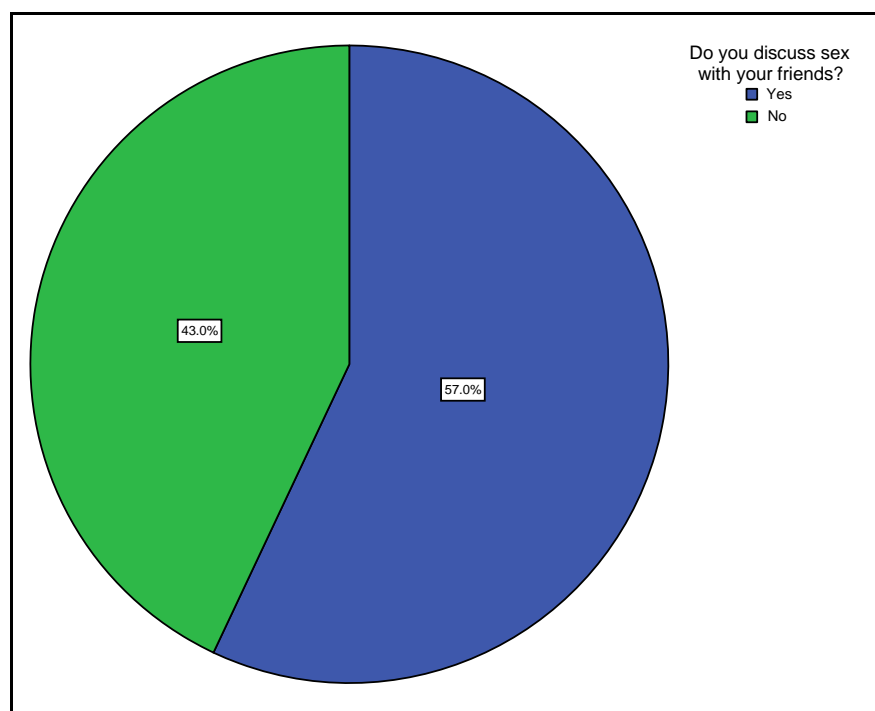
**Figure 4.4**  
***Relationship between the respondents and family members (N=97)***

#### **4.2.14 Discussing sex with friends (item 14)**

In this item the respondents were asked whether they discuss sex with their friends.

Of the respondents 57,02% (n=57) spoke to their friends about sex; 43% (n=43) did not talk to friends about sex.

The respondents are more willing to talk about sex with friends than with family members. The pie chart in Figure 4.5 illustrates the answers to this specific question.

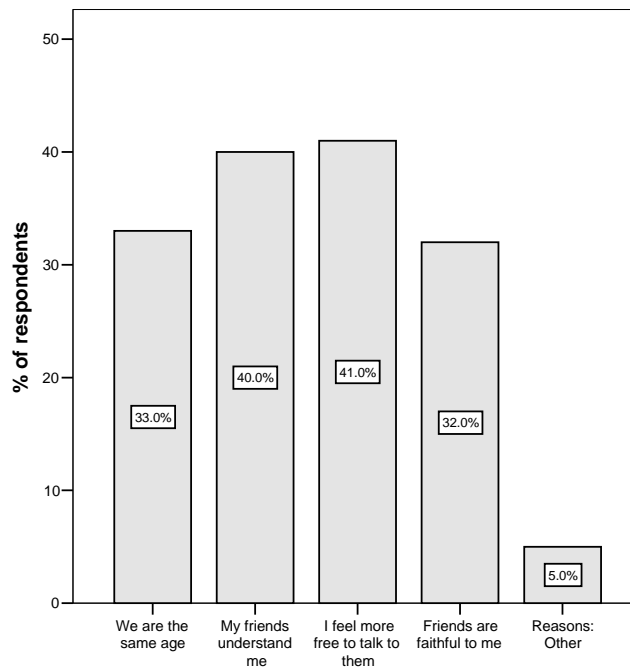


**Figure 4.5**  
***Discussing sex with friends (N=100)***

#### **4.2.15 Reasons for discussing sex with friends (item 15)**

Respondents were requested to indicate the reasons why they discussed sex with their friends. According to the responses there seem to be a variety of reasons why the respondents are able to discuss sex with their friends:

Of the respondents 33,0% (n=33) justified the fact that they discuss sex with their friends by saying that they are the same age; 40,0% (n=40) said that they discuss sex with their friends because they understand them; 41,0% (n=41) indicated that they feel more at ease with their friends; 32,0% (n=32) indicated that friends are loyal to them; 5,0% (n=5) of the respondents gave other reasons for chatting to their girlfriends about sex. The findings are illustrated in Figure 4.6.



**Figure 4.6**

***Reasons why respondents can discuss sex with their friends (N=100)***

According to Bradley and Dubinsky (1995:47-48), it is important that adolescents can make friends and have relationships outside the family circle. Their development and sense of identity will depend, to a certain extent, on their ability to establish new relationships outside the family environment. Filled with emotions, doubts, anxieties and contradictory feelings, adolescents have a great need to communicate and to share their pain, their sadness, their worries and pressures with a special girl friend. Often, this intimacy with a girl friend seems to replace the previous intimacy with the father or the mother.

**4.2.16 Reasons for not discussing sex with friends (item 16)**

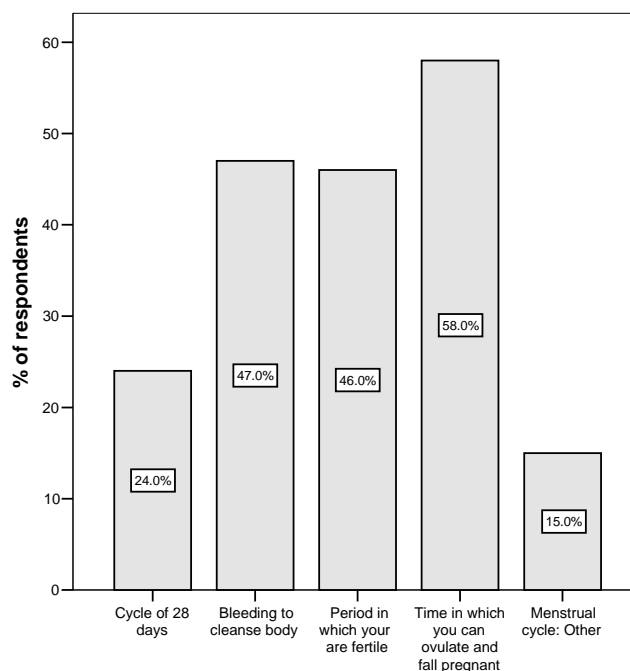
In an open question, the respondents were asked to indicate why they did not discuss sex with their friends. There were no responses from the respondents.

**4.2.17 Menstrual cycle (item 17)**

In item 17 the respondents were asked to explain what the menstrual cycle was.

Most of the respondents regard the menstrual cycle as a time in which they can ovulate and fall pregnant, or believe that it is a period of fertility or a time of bleeding to cleanse the body (view Figure 4.7 for their responses).

Of the respondents 24,0% (n=24) regarded the menstrual cycle as being a 28-day cycle; 47,0% (n=47) indicated that the menstrual cycle is bleeding to cleanse the body; 46,0% (n=46) indicated that it is the period in which girls/women are fertile; 58,0% (n=58) were of the opinion that this is the period when ovulation occurs and one can fall pregnant.



**Figure 4.7**  
***Understanding of the menstrual cycle (N=100)***

Knowledge about the menstrual cycle is important for adolescents owing to the fact that it is cyclic bleeding, which starts approximately 14 days after ovulation. During the period of ovulation the adolescent could possibly fall pregnant should she have sexual intercourse during this phase.

Lowdermilk et al. (2002:85) explain that between 8 and 11 years of age, young girls continuously secrete small quantities of oestrogen which gradually increase, the oestrogen and gonadotrophine variations becoming a cyclic pattern at least before the first menstruation. Around 13 years of age, the first menstruation starts. Initially, the periods are irregular, unpredictable, painless and anovulatory. After about a year or



more, a hypothalamic-hypophyseal rhythm is established and the ovary produces oestrogen cyclically which forms a mature ovule. The ovulation periods become regular and are monitored by progesterone.

Neto (2005:3) points out that during puberty and adolescence, the parents are responsible for educating their children and should be concerned with transmitting values, rules and information about the changes in the body and how to deal with the issue.

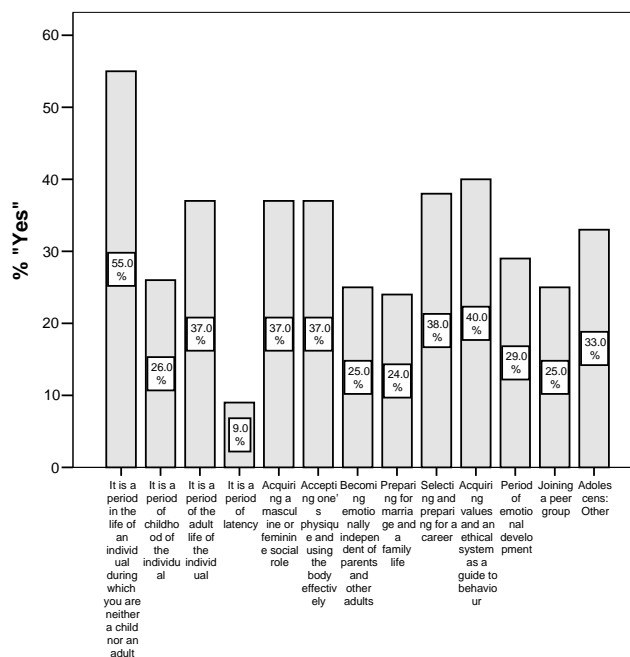
### **4.3 SECTION B: ADOLESCENCE**

The data on adolescence included the definition of the term 'adolescence', age at which adolescence begins, the physical and emotional changes during adolescence and a discussion of sex during adolescence

#### **4.3.1 Understanding of the term “adolescence” (item 18)**

In item 18 respondents were asked to indicate from the options the correct meaning of the term “adolescence” in their view. Of the respondents 55,0% (n=55) regarded adolescence as the period in the life of an individual during which one is considered neither as a child nor an adult; 26,0% (n=26) regarded adolescence as a period in the childhood of an individual; 37,0% (n=37) regarded it as a period in the adult life of the individual; 9,0% (n=9) regarded it as a period of latency; 37,0% (n=37) regarded it as the time of acquiring a masculine or feminine social role; 37,0% (n=37) regarded it as accepting one's physique and using the body effectively; 25,0% (n=25) regarded it as becoming emotionally independent of parents and other adults; 24,0% (n=24) regarded adolescence as the period of preparation for marriage and a family life; 38,0% (n=38) regarded it as the period of selecting and preparing for a career; 40,0% (n=40) regarded it as the time of acquisition of values and an ethical system as a guide to behaviour; 29,0% (n=29) regarded it as the period of emotional development; 25,0% (n=25) regarded it as the period in which to join a peer group; 33,0% (n=33) indicated other reasons.

There seems to be fair amount of ignorance about the meaning of adolescence. The bar chart in Figure 4.8 illustrates this.



**Figure 4.8**  
**Understanding of the term "adolescence" (N=100)**

Azevedo (2001:10) refers to adolescence as a period of fundamental and irreversible changes, and of major internal turmoil. During this phase the adolescent tries to establish her identity. She leaves childhood, goes through the discovery of changes in her body and soul and chooses the path for her adult life but at the same time does not feel welcome in the adult world, or very comfortable with that role. It is not a matter of the adult world being hostile. Parents continue loving their children and protecting them even if their protection seems excessive, girl friends are always loyal and provide support. But adolescents feel like adults and want to be treated as such.

#### 4.3.2 Age at which adolescence begins (item 19)

Of the respondents 6,0% (n=6) indicated that adolescence starts around 8-10 years of age or less; 8,0% (n=8) indicated that adolescence starts around 10-12 years of age; 13,0% (n=13) indicated that adolescence starts around 12-14 years of age; 47,0% (n=47) indicated that adolescence starts around 14-16 years of age or more; 26,0% (n=26) did not answer (refer to Table 4.8).

The respondents are not at all certain about the onset of adolescence.

The frequency table is as follows:

**Table 4.8     Age at which adolescence begins (N=100)**

<b>Beginning of adolescence</b>	<b>Frequency</b>	<b>Percentage</b>
8-10 years of age or less	6	6,0
10-12 years of age	8	8,0
12-14 years of age	13	13,0
14-16 years of age or more	47	47,0
No answer	26	26,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

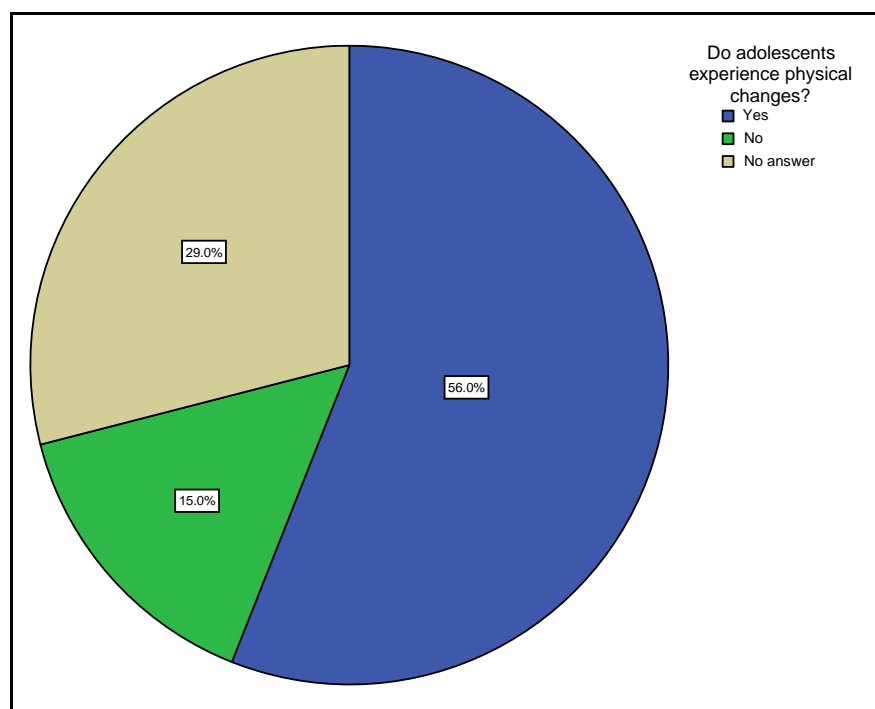
According to the WHO (2001:21), adolescence starts at approximately 10 years of age.

#### **4.3.3 Physical changes in adolescence (item 20)**

Respondents were asked to indicate if adolescents experienced physical changes during adolescence.

Of the respondents 56,0% (n=56) indicated that adolescents experience physical changes; 15,0% (n=15) indicated that adolescents do not experience physical changes; 29,0% (n=29) did not answer.

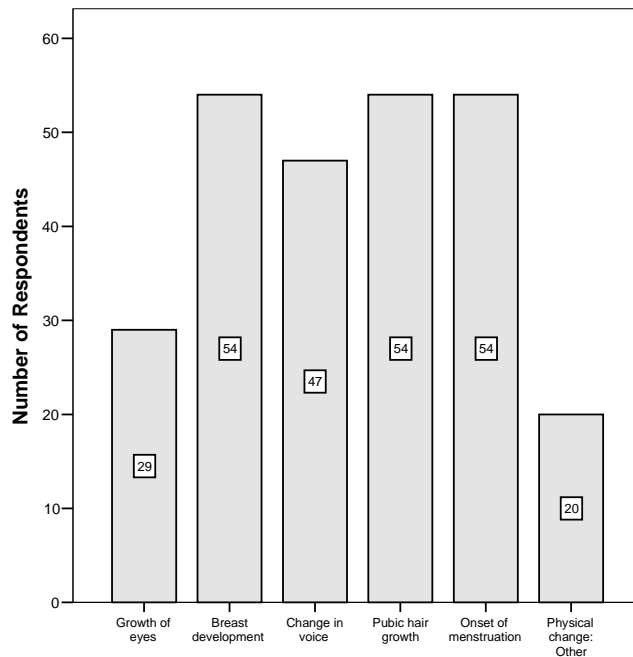
Just more than 50,0% of the respondents were aware of the physical changes taking place during adolescent. The pie chart in Figure 4.9 illustrates this.



**Figure 4.9**  
***Physical changes in adolescence (N=100)***

#### **4.3.4 Physical changes experienced by adolescents (item 21)**

In item 21, the respondents had to indicate what physical changes adolescents experience. Of the respondents 29,0% (n=29) indicated growth of the eyes; 54,0% (n=54) indicated breast development; 47,0% (n=57) indicated change in voice; 54,0% (n=54) indicated growth of pubic hair; 54,0% (n=54) indicated onset of menstruation; 20,0% (n=20) indicated “Other”. In spite of the formulation of the question (“if your answer was YES ... “), only 28 respondents who had not said “YES” replied to this question as well. There seems to be uncertainty among the respondents about the physical changes that occur during adolescence. The bar chart in Figure 4.10 illustrates the answers.

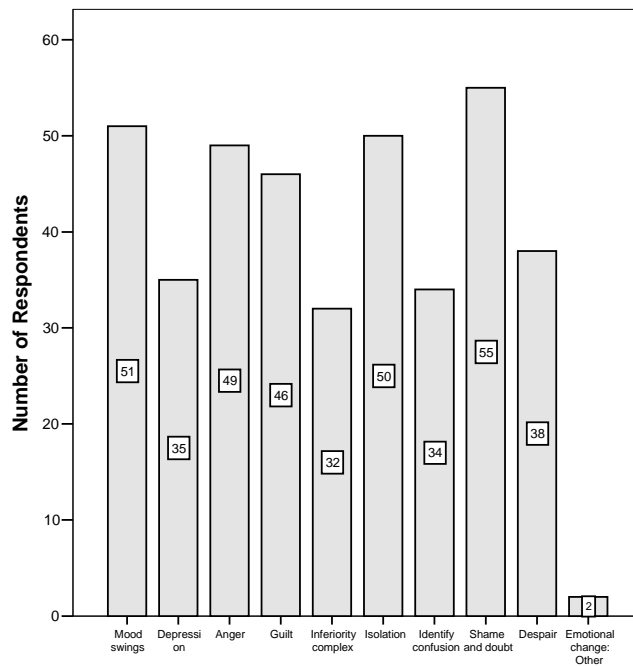


**Figure 4.10**  
***Physical changes experienced by adolescents (N=100)***

Azevedo (2001:12) points out that to adolescent girls the body no longer seems to be what it was before: there is an increase in height, in the growth of auxiliary and pubic hair, increase of the ovaries, breast development and pigmentation of the areola, growth of external genitals and development of the vagina, appearance of a white vaginal secretion and later the onset of menstruation, pimples or acne, and increase in the size of the hips.

#### **4.3.5 Emotional changes expected during adolescence (item 22)**

Slightly more than 50,0% of the respondents expressed their opinions. The bar chart in Figure 4.11 illustrates the opinions of those who did express them. Fifty-five of the respondents identified shame and doubt as an emotional change during adolescence. Of the respondents 51 indicated that mood swings could be expected during this phase. Isolation was also experienced by 50 of the respondents. Forty-nine respondents experienced anger, while 46 experienced guilt as one of the emotional changes that may occur. Thirty-eight respondents mentioned despair, while 35 respondents mentioned that depression could be experienced.



**Figure 4.11**  
***Emotional changes expected during adolescence (N=55)***

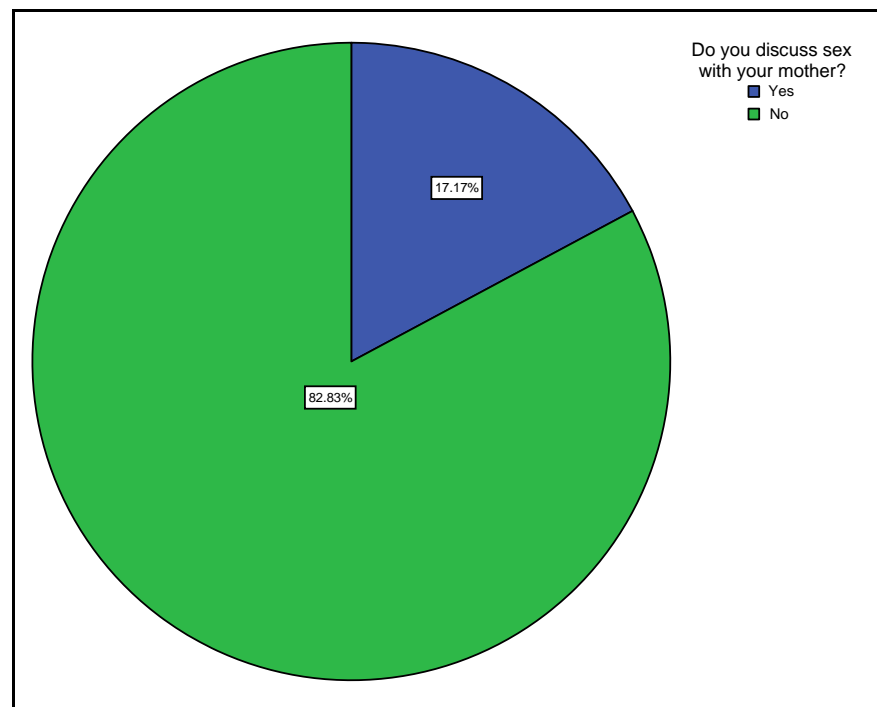
Azevedo (2001:10-12) points out that hormonal changes during the adolescent period bring about mood swings. Intense mood changes can be observed, from sullen temper to violent rage, which can be disturbing for the family. They are the result of the adolescent's attempt to define her identity, to make use of her will and to feel the effect.

As adolescence is a period of learning how to deal with new mechanisms, new facts, new emotions and new forms of relationship. It is in this process of transition from one phase (child) to that of adolescence that the young girl must receive understanding from the people around her and those with whom she lives and socialises, to enable her to experience a smooth transition. If she lacks knowledge about what is happening during this phase, there will be difficulties which will make this transition more stressful and antagonistic and, according to the circumstances, can leave lasting traces of bitterness and family conflict. Understanding is knowledge: one has to be informed to understand.

#### **4.3.6 Discussing sex with the mother (item 23)**

The adolescents were requested to indicate whether they discussed sex with their mothers or not.

Of the respondents 17,17% (n=17) indicated that they discuss sex with their mothers; 82,83% (n=82) indicated that they do not discuss sex with their mothers. Only one in every six respondents discusses sex with their mothers. This is illustrated in the following pie chart (Figure 4.12):



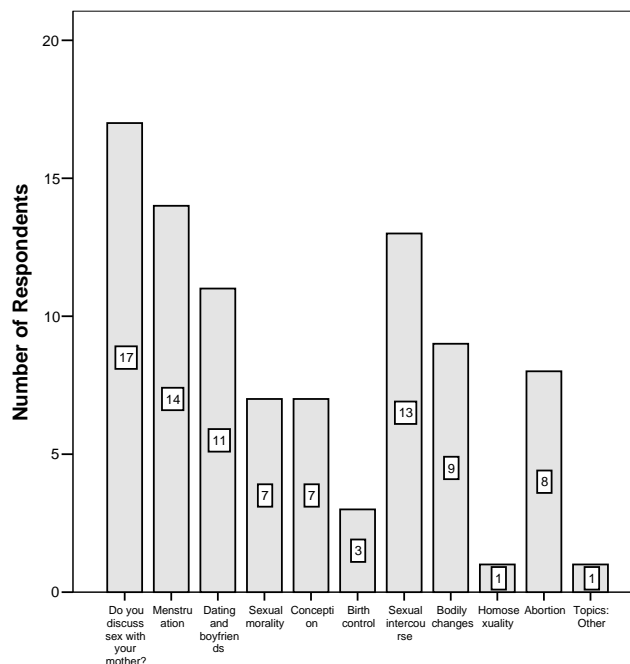
**Figure 4.12**  
***Discussing sex with the mother (N=99)***

Vilar (1994:17) has pointed out that in a study of the adolescents interviewed about discussions between parents and children on sex, 16,0% stated that they had discussed sexuality with their mothers. Their first discussion took place when they were between 8 and 12 years of age and they talked about menstruation, reproduction and sexual intercourse.

The author concludes that it is not an easy task to promote and deal with dialogue between parents and children on sexuality. However, he advises mothers to discuss sexuality with their daughters and not to push them away and that they must be mothers "who can be approached and questioned".

#### 4.3.7 Topics discussed with mothers about sex (item 24)

The respondents were requested to indicate the topics which were discussed with their mothers. Menstruation, dating and boyfriends and sexual intercourse seem to be the main topics discussed with their mothers. The majority of the respondents, namely 14, indicated that menstruation was discussed; 13 respondents said that sexual intercourse was discussed. Dating with boyfriends was also mentioned by 11 respondents as a point of discussion. Only 9 respondents discussed the bodily changes which may take place; while 8 respondents discussed abortions. Sexual morality and conception were discussed by only 7 of the respondents. This is illustrated in the bar chart in Figure 4.13 below:



**Figure 4.13**

***Topics discussed with mothers about sex (N=17)***

According to Furlani (2000:4-8), sexual education should start during childhood. Even before puberty, it is already possible to discuss menstruation, pregnancy, sexual involvement, body hygiene, gender relations, social life, dating, and expressing of affection. Sexual education must be done continuously and permanently.

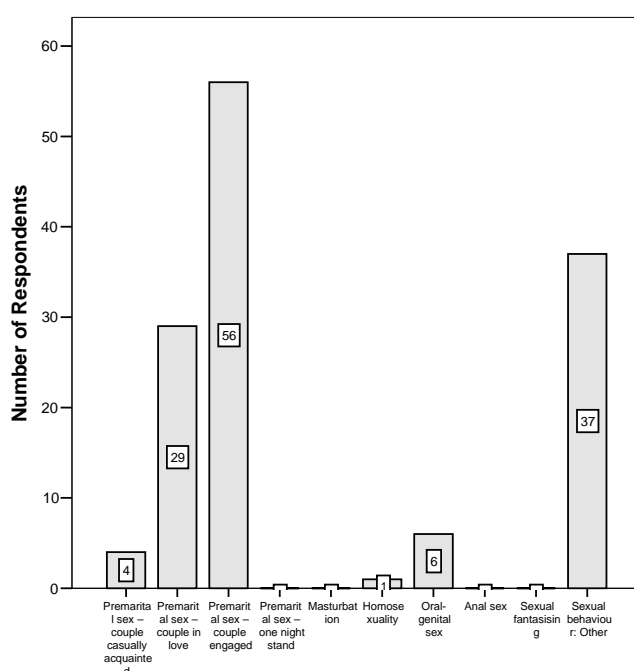


## 4.4 SECTION C: SEXUALITY

The aspects covering sexuality in section C include: sexual behaviour, sexual intercourse, consequences of unprotected sex, contraception, and abortion.

### 4.4.1 Sexual behaviours which are part of your orientation (item 25)

Premarital sex (of a couple in love or engaged) and “other” topics seemed to be the main focus. The majority of the respondents (56) indicated that premarital sex is acceptable behaviour if the couple are engaged, while 29 respondents indicated that premarital sex when the couple is in love is acceptable behaviour. Furthermore, 11 respondents indicated that premarital sex if the couple were casually acquainted (6), oral-genital sex (6), and homosexuality (1) were acceptable behaviour. The bar chart in Figure 4.14 illustrates this.



**Figure 4.14**  
**Sexual behaviours which are part of your orientation (N=100)**

Moura (2005:3) explains that women in Angola form an attachment at a very young age, often after puberty. Women get married at between 17,5 and 19,2 years of age, which is considered a relatively early age for marriage. The first marriage is also the beginning of the reproductive period. This is a phenomenon which seems to happen in most African countries.

#### 4.4.2 Sexual intercourse (item 26)

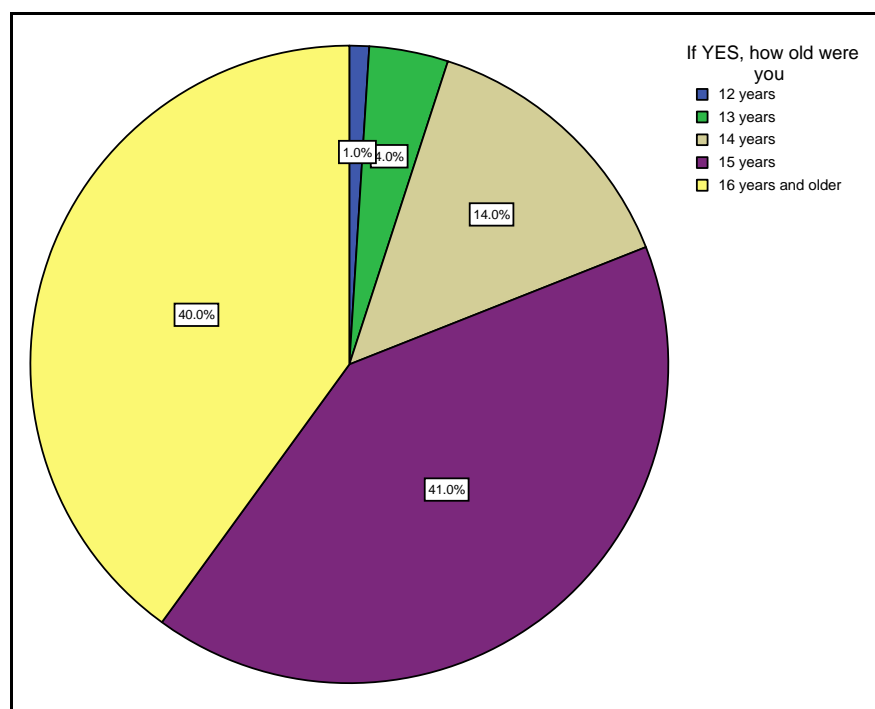
Of the respondents, 99,0% (n=99) stated they have had sexual intercourse; 1,0% (n=1) stated that she had not had sexual intercourse. Having sexual intercourse seems to be the general norm.

**Table 4.9 Sexual intercourse (N=100)**

Answer	YES	%	NO	%	TOTAL
Sexual Intercourse	99	99,0	1	1,0	100,0

#### 4.4.3 Age when first started having sexual intercourse (item 27)

Of the respondents, the majority 41,0% (n=41) first had intercourse at the age of 15, while 40,0% indicated that sexual intercourse first took place at the age of 16 years. 1,0% (n=1.0) started having sexual intercourse at 12 years of age; 4,0% (n=4) started at 13 years of age; 14,0% (n=14) started having sexual intercourse at 14 years of age (refer to Figure 4.15).

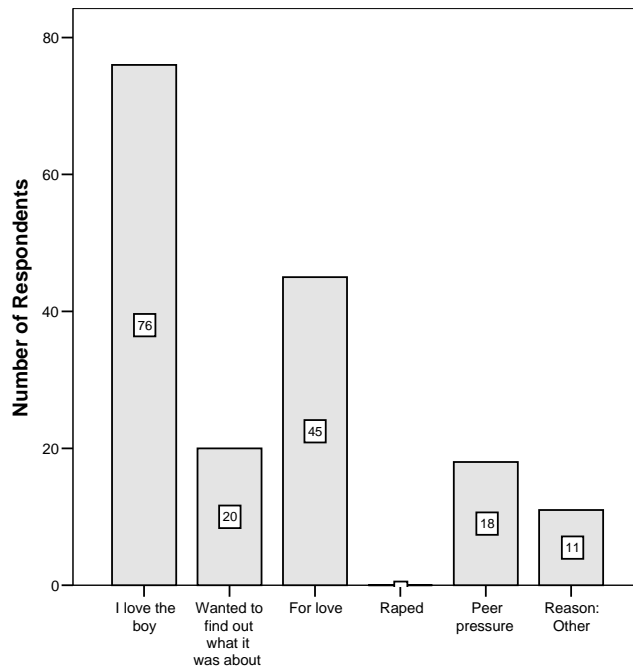


**Figure 4.15**  
**Age when started having sexual intercourse (N=100)**

According to Vitalle and Amácio (2005:1-11), sexual involvement during adolescence has started taking place at an earlier and earlier age, with immediate undesirable consequences within this age group, such as the increase in sexually transmitted infections (STI), and pregnancies that are undesired and for this reason end up in abortion. When sexual involvement ends in pregnancy, it results in untimely and long-term consequences for both the adolescent and the newborn. The female adolescent can experience problems in growth and development, emotional and behavioural problems and educational and learning problems, besides the complications related to pregnancy and childbirth.

#### **4.4.4 Reasons for having sexual intercourse (item 28)**

The respondents in this item had to state the reasons for sexual intercourse. Love for the partner was stated by 76 of the respondents as being the main reason for intercourse. Many of the respondents (45) furthermore indicated that they had intercourse for love, while 20 respondents wanted to find out what it was all about. Peer pressure played a role in 18 respondents' reason for having intercourse (see Figure 4.16).

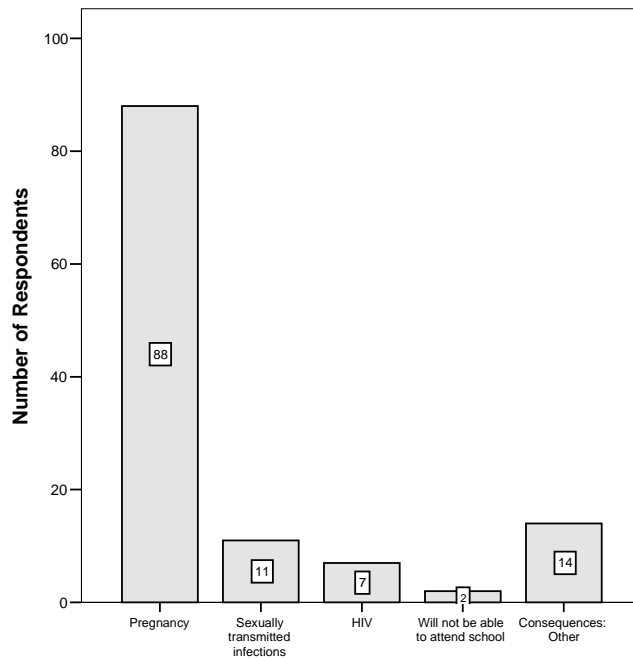


**Figure 4.16**  
***Reasons for having sexual intercourse (N=100)***

Bradley and Dubinsky (1995:73) state that during this period of adolescence there is an intense need to recover an idealised object. During childhood it is often directed at the mother, with whom the child feels or wants to feel in perfect unity. When the adolescent girl falls in love, she brings all her fantasies and anxieties into this new relationship. It is common for adolescents to be so moved by the intensity of their feelings that they cannot sleep, eat or concentrate on anything else.

#### **4.4.5 Consequences of having unprotected sex (item 29)**

The bar chart in Figure 4.17 illustrates that 88,0% of respondents are aware of the possibility of falling pregnant as a result of having unprotected sex, but very few of them realise that it may result in HIV (7,0%) and other STIs (11,0%).



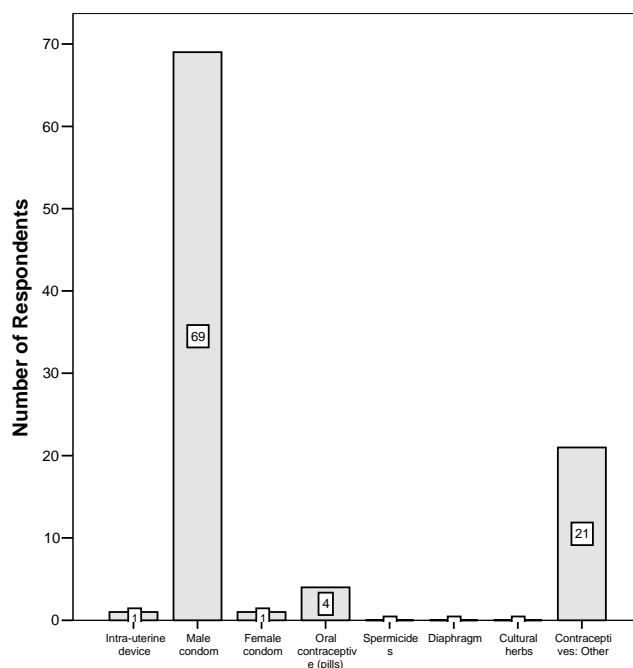
**Figure 4.17**  
***Consequences of having unprotected sex (N=100)***

Adolescent women, in comparison with adult women, are genitally more susceptible to infection, thus increasing the risk of contamination through contact with an infected individual (Morgado, Pereira & Canavarro 2005:6-12).

Unprotected sex has negative repercussions such as: undesired pregnancy, induced abortions and increase in STIs (Anticoncepcionais na adolescência 2005:2-5).

#### **4.4.6 Contraceptive methods used (item 30)**

For this item the respondents had to indicate what contraceptive methods they used if they had had intercourse before. Male condoms seem to be the predominant method (69,0%) Oral contraceptives were only used by 4,0% of the respondents; one respondent indicated that she used an intra-uterine device while one respondent indicated the use of cultural herbs. The bar chart in Figure 4.18 illustrates this.



**Figure 4.18**  
**Contraceptive methods used (N=100)**

#### 4.4.7 Abortion (item 31)

The respondents were requested to indicate whether they had had an abortion or not.

Of the respondents 8,0% (n=8) indicated that they had already had an abortion; 92,0% (n=92) indicated they had never had an abortion (refer to Table 4.10).

**Table 4.10 Have you ever had an abortion (N=100)**

Answer	YES	%	NO	%	Total
Abortion	8	8,0	92	92,0	100,0

Leal (2001:9) states that in a study done on the voluntary interruption of pregnancy, the minority of women for whom the interruption of pregnancy leaves important consequences are youngsters with a tendency to emotional trauma, who show symptoms such as: persistent extreme anxiety; being somatic; experiencing insomnia, depressive thoughts, regret and guilt; being uninterested in sex; having diminished self-esteem, moving away from regular relationships, manifesting anorexia or bulimia. Three in every four women in that situation experiment with suicidal ideas.

#### **4.4.8 Where was the abortion done? (item 32)**

The frequencies are as follows:

Five respondents had abortions at home and three had them at the hospital.

#### **4.4.9 Age at the time of the abortion (item 33)**

Of the respondents who indicated that they had had an abortion, four respondents were 15 years old at the time and four were 16 years old.

### **4.5 SECTION D: CONTRACEPTION**

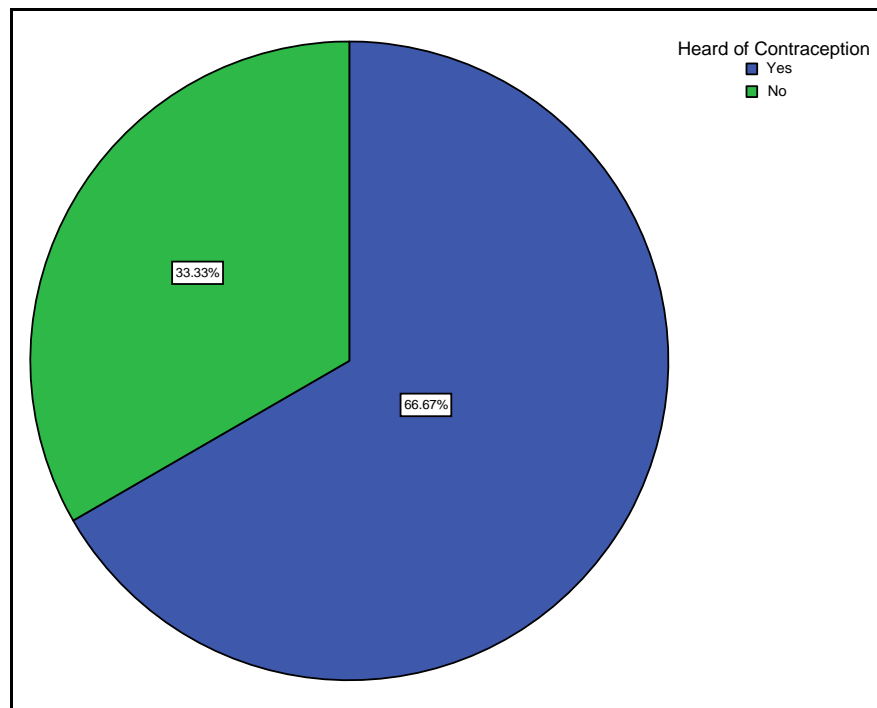
The study explored the knowledge adolescence have with regard to contraception.

#### **4.5.1 Knowledge of contraception (item 34)**

The respondents were required to indicate whether they had ever heard about contraception.

Of the respondents 66,0% (n=66) had heard of contraception; 33,0% (n=33) had never heard of contraception.

About two-thirds of the respondents had heard about it. The pie chart in Figure 4.19 illustrates this:

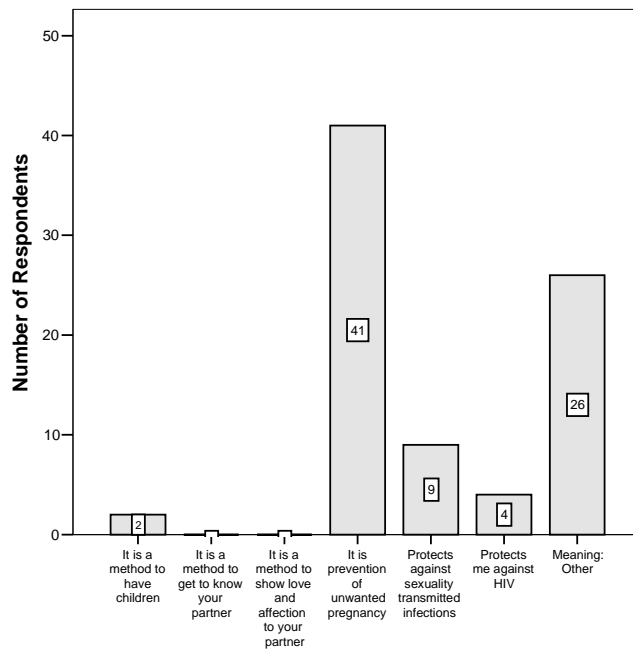


**Figure 4.19**  
**Knowledge of contraception (N=99)**

#### **4.5.2 Meaning of contraception (item 35)**

In this item the respondents had to explain what was meant by contraception. The response rate was very low. The prevention of unwanted pregnancy was the main objective selected, by 41 of the respondents. Protection against sexually transmitted infections was identified by 9 respondents, while 4 respondents said that contraception would protect them from HIV. Two respondents indicated that contraception was a method to have children, while 26 indicated “other” but did not specify what it meant for them. The bar chart in Figure 4.20 illustrates this:



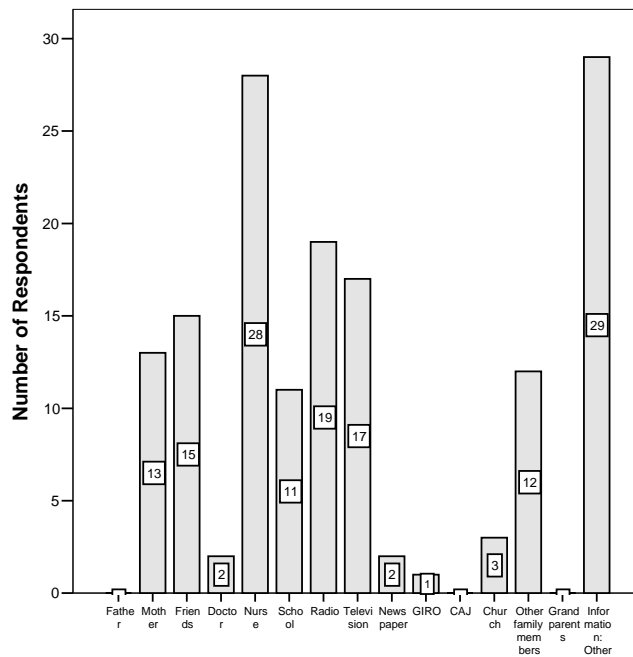


**Figure 4.20**  
**Meaning of contraception (N=100)**

A lack of knowledge on contraception has negative repercussions on the life of the adolescent, especially the fact that she may become a mother at an early age and as a consequence interrupt her own life. She loses her freedom, will not be able to fulfil her study projects, has limited prospects for the working market, and loses opportunities for personal development and options in life to which she has a right. Lack of knowledge also exposes her to other risks such as abortion and sexually transmitted infections (STIs), amongst which is AIDS (Fraser et al 2006:22).

#### **4.5.3 Source of information (item 36)**

Nurses and “Other” seem to be the most frequent sources of information, but no single source of information seems to be generally available. The bar chart in Figure 4.21 illustrates this:



**Figure 4.21**  
**Source of information on contraception (N=100)**

#### 4.5.4 Belief in the use of condoms (item 37)

Of the respondents 36,4% (n=28) believe in the use of condoms as a contraceptive method and 63,6% (n=49) do not believe in the use of condoms as a contraceptive.

The frequency table is as follows:

**Table 4.11 Belief in the use of condoms as a contraceptive (N=77)**

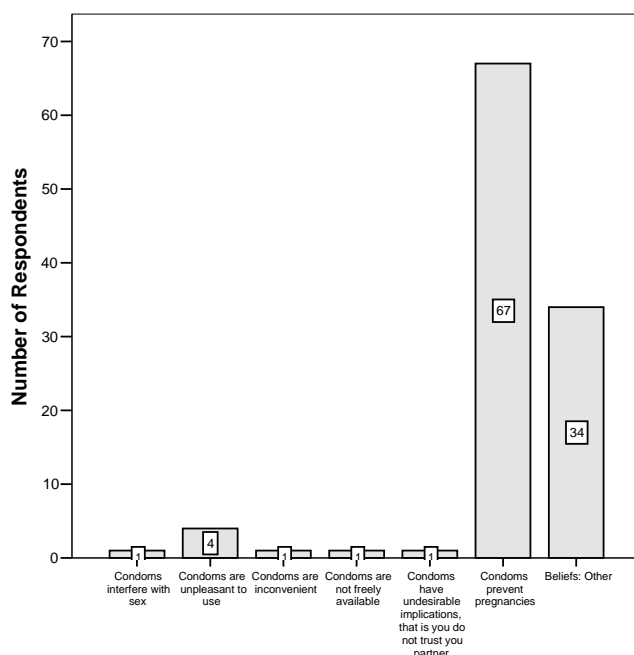
Answer	YES	%	NO	%	Total
I believe in the use of condoms	28	36,4	49	63,6	77

Vicente and Lopes (1999:13) explain that in a study that was carried out it was found that young couples who are not fully motivated to use condoms limit their use to the periods that they think of as being fertile periods, resulting in high rates of failure (15/100 women per year or more, according to the type of use). Many of those who do use condoms, do so in an irregular manner, limiting its use to some periods of the cycle,

and are unaware of the care that must be taken when opening the packet; they use oily lubricants or ignore a tear in the condom.

#### 4.5.5 Beliefs with regard to condom use (item 38)

According to 67 respondents, the main value of condoms is that they prevent pregnancies. The bar chart in figure 4.22 illustrates this:



**Figure 4.22**

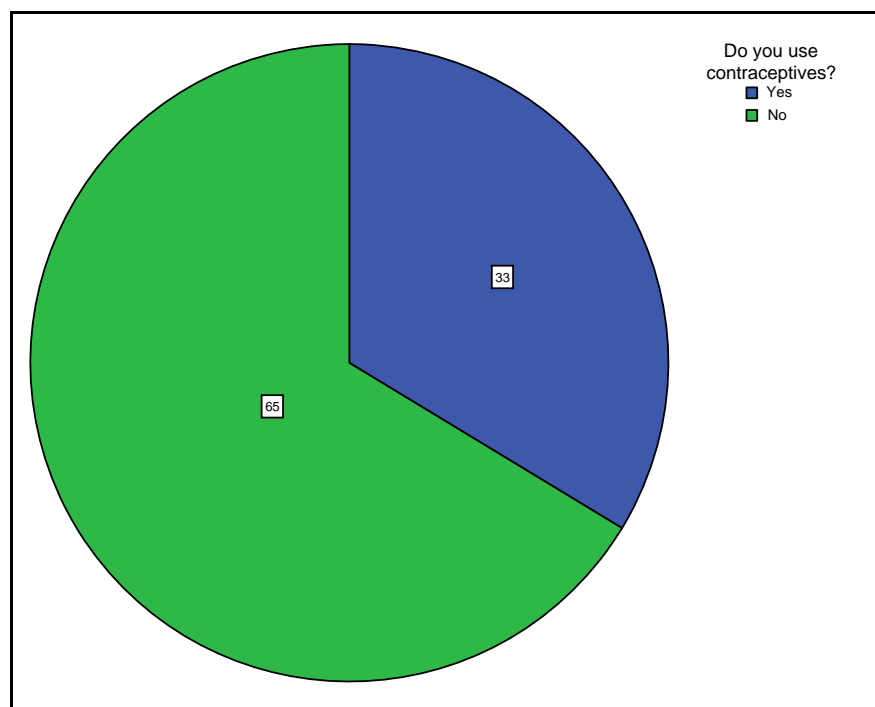
***Beliefs with regard to condom use (N=100)***

Vicente and Lopes (1999:39) point out that the condom is an important means of preventing pregnancy, and in addition the condom is the method scientifically recognised as being able to protect one from sexually transmitted infections (STIs), including AIDS. The female condom has the same protective effect, although studies in this regard are more limited.

#### 4.5.6 Use of condoms as a contraceptive (item 39)

Of the respondents, 33,7% (n=33) use a condom; 66,3% (n=65) do not use a condom; 2,0% (n=2) did not answer. Although 99 of the respondents have had sexual

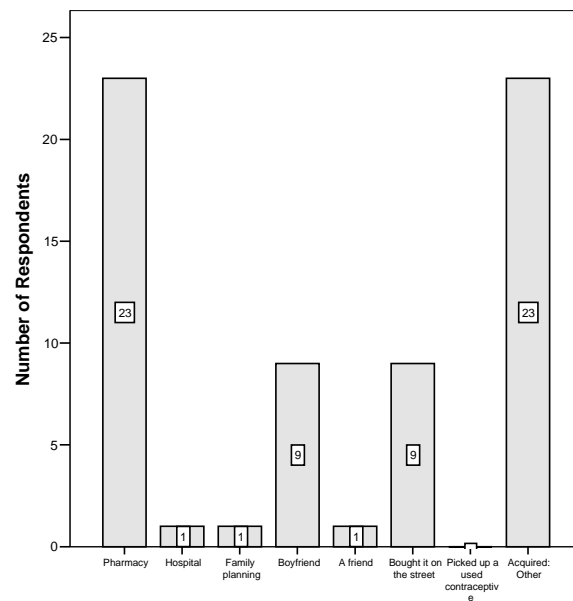
intercourse, only one third use the condom as a contraceptive. The pie chart in Figure 4.23 illustrates the frequency of the statistics.



**Figure 4.23**  
**Use of contraceptives (N=98)**

#### **4.5.7 Acquisition of contraceptives (item 40)**

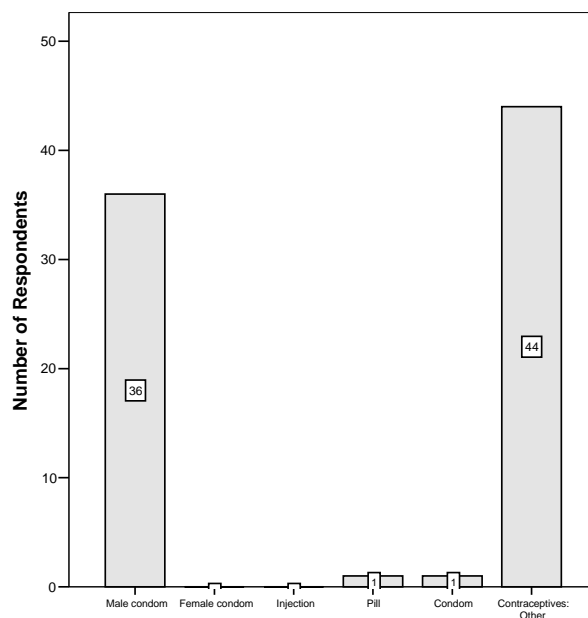
The main sources for the acquisition of contraceptives are pharmacies (23), while 9 respondents indicated that they got the contraceptives from their boy friend, and a further 9 respondents indicated that they bought contraceptives on the street. The hospital, family planning clinic and a friend were each selected by one respondent respectively as places to acquire contraceptives, almost a quarter (23) of the respondents indicated “other” as a source. The bar chart in Figure 4.24 illustrates this:



**Figure 4.24**  
**Acquisition of contraceptives (N=100)**

#### 4.5.8 Type of contraceptive used (item 41)

Most of the respondents (44,0%) used “other” contraceptives, while 36,0% used the male condom. One respondent used the pill and one respondent used a female condom (refer to Figure 4.25).



**Figure 4.25**  
**Type of contraceptive used (N=100)**

#### 4.5.9 Information received about vaginal contraceptives (item 42)

This item was very poorly answered; possibly this method is not generally used.

Of the respondents 1,0% (n=1) stated that vaginal contraceptives help to prevent some Sexually Transmitted Diseases (STDs) and conditions caused by STDs; 2,0% (n=2) indicated that they prevent pregnancy; 1,0% (n=1) stated that they are easy to use with a little practice; 1,0% (n=1) that these do not have the side-effects of hormones; 95,0% (n=95) did not answer. Very little information was received, possibly because this method is unfamiliar to them (refer to Table 4.12).

The frequency table is as follows:

**Table 4.12 Information received about vaginal contraceptives (N=100)**

Information received	Frequency	Percentage
42.1 Benefits and risks of the methods	0	0,0
42.2 Help prevent some STDs and conditions caused by STDs	1	1,0
42.3 Prevent pregnancy	2	2,0
42.4 Can be stopped at any time	0	0,0
42.5 Easy to use with a little practice	1	1,0
42.6 No side-effects from hormones	1	1,0
42.7 No guidance received	0	0,0
42.8 Did not answer	95	95,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.10 Partner's agreement with guidance received about vaginal contraception (item 43)

Of the 82 respondents who indicated using contraceptive methods, only 3,0 % (n=3) of respondents indicated that their partners agreed with the guidance provided; 79,0% (n=79) did not answer; 18,0% (n=18) do not use contraceptive methods.

The frequency Table 4.13 is as follows:

**Table 4.13 Partner's agreement with guidance received about vaginal contraception (N=100)**

Answer	YES	%	No answer	%	Do not use	%	Total
Agree with guidance	3	3,0	79	79,0	18	18,0	100,0

#### **4.5.11 Method used to prevent unwanted pregnancy (item 44)**

Of the respondents 35,0% (n=35) indicated that they normally use the female condom to prevent pregnancy; 3,0% (n=3) indicated that they abstain from having sex so as to prevent pregnancy; 62,0% (n=62) did not answer this item. So the male condom and, in some cases, abstaining from having sex, seem to be the methods used. The statistics of this item is in contrast with 4.5.8, where it was noted that only one respondent used the female condom. This incongruent could be due to the respondents inconsistent answering of the questions.

The frequency Table 4.14 is as follows:

**Table 4.14 Method used to prevent undesired pregnancy (N=100)**

Method	Frequency	Percentage
44.1 Pill	0	0,0
44.2 Male condom	0	0,0
44.3 Female condom	35	35,0
44.4 I do not have sexual intercourse	0	0,0
44.5 Depo provera (injection)	3	3,0
44.6 Apply the IUD	0	0,0
44.7 Spermicides	0	0,0
44.8 No answer	62	62,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

Vicente and Lopes (1999:39) are of the opinion that the double method, associated with the condom, is a very safe contraceptive method for preventing pregnancy and preventing sexually transmitted infections (STI), including AIDS. The author adds that various studies have indicated that the safer the contraceptive method used the more efficacious is the simultaneous use of the condom. Hence many authors advocate the promotion of the condom with the double objective of protection.

#### 4.5.12 How do spermicides work? (item 45)

For this item the respondents were requested to indicate how they thought spermicidal contraceptives worked. Ignorance with regard to spermicides was reported by 72,0% of the respondents.

Of the respondents 2,0% (n=2) indicated that spermicides make the sperm unable to come into contact with the ovule; 1,0% (n=1) indicated "Other"; 25,0% (n=25) did not answer this item. The frequency Table 4.15 is as follows:

**Table 4.15 How spermicides work (N=100)**

How spermicides work	Frequency	Percentage
45.1 Spermicides kill sperm	0	0,0
45.2 Spermicides make sperm unable to move toward the egg	2	2,0
45.3 I don't know	72	72,0
45.4 Other	1	1,0
45.5 No answer	25	25,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.13 How do diaphragms and cervical caps work? (item 46)

The majority of the respondents (69,0%) indicated that they did not know how diaphragms and cervical caps work. Of the respondents 3,0% (n=3) specified that diaphragms and cervical caps block sperm from entering the uterus and tubes where sperm could meet an egg. Ignorance about the working of diaphragms and cervical caps seems to be prevalent.

The frequency Table 4.16 is as follows:

**Table 4.16 How diaphragms and cervical caps work (N=100)**

How diaphragms and cervical caps work	Frequency	Percentage
46.1 They block sperm from entering the uterus and tubes where sperm could meet an egg	3	3,0
46.2 I don't know	69	69,0
46.3 Other	0	0,0
46.4 No answer	28	28,0
<b>Total</b>	<b>100</b>	<b>100,0</b>



#### 4.5.14 Information received about oral contraceptives (item 47)

It is of great concern that the findings illustrated that the respondents did not have any knowledge about how oral contraceptives work. Of the respondents 1,0% (n=1) indicated that oral contraceptives are very effective when used correctly; 1,0% (n=1) stated that oral contraceptives can be used provided that the woman wants to prevent pregnancy; 1,0% (n=1) mentioned that the person can stop taking the pill at any time; 1,0% (n=1) mentioned that fertility returns soon after stopping; 1,0% (n=1) stated that oral contraceptives can be used as emergency contraceptives after having unprotected sexual intercourse.

Most of the respondents seem to know almost nothing about oral contraceptives.

The frequency Table 4.17 is as follows:

**Table 4.17 Information received about oral contraceptives (N=100)**

Information received	Frequency	Percentage
47.1 Very effective when used correctly	1	1,0
47.2 No need to do anything at time of sexual intercourse	0	0,0
47.3 Monthly periods regular, lighter monthly bleeding	0	0,0
47.4 Can be used as long as woman wants to prevent pregnancy	1	1,0
47.5 Can be used at any age from adolescence to menopause	0	0,0
47.6 User can stop taking pills at any time	1	1,0
47.7 Fertility returns soon after stopping	1	1,0
47.8 Can be used as an emergency contraceptive after unprotected sex	1	1,0
47.9 Should be taken every day to be most effective	0	0,0
47.10 No information received	0	0,0
47.11 On side-effects	0	0,0
47.12 Other	0	0,0
47.13 No answer	95	95,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.15 How do oral contraceptives work? (item 48)

Of the respondents 1,0% (n=1) specified that oral contraceptives thicken cervical mucus, making it difficult for sperm to pass through; 72,0% (n=72) indicated that they

did not know; 27,0% (n=27) did not provide any answer. Virtually no knowledge seems to exist about the topic.

The frequency Table 4.18 is as follows:

**Table 4.18 How oral contraceptives work (N=100)**

<b>How oral contraceptives work</b>	<b>Frequency</b>	<b>Percentage</b>
48.1 Stop ovulation (release of eggs from ovaries)	0	0,0
48.2 Thicken cervical mucus, making it difficult for sperm to pass through	1	1,0
48.3 I don't know	72	72,0
48.4 Other	0	0,0
48.5 No answer	27	0,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### **4.5.16 Information about injectable contraceptives (item 49)**

From answers to this item it is evident that the respondents have virtually no knowledge of injectable contraceptives. Of the respondents 1,0% (n=1) stated that injectable contraceptives prevent pregnancy in the long term; 1,0% (n=1) stated that they do not interfere with sex; 1,0% (n=1) said that it is not necessary to take pills every day; 97,0% (n=97) did not answer.

The frequency Table 4.19 is as follows:

**Table 4.19 Information on injectable contraceptives (N=100)**

<b>Information on injectable contraceptives</b>	<b>Frequency</b>	<b>Percentage</b>
49.1 Very effective	0	0,0
49.2 Private – no one else can tell that a woman is using it	0	0,0
49.3 Long-term pregnancy prevention, but reversible	1	1,0
49.4 Does not interfere with sex	1	1,0
49.5 No daily pill taking	1	1,0
49.6 Can be used at any age	0	0,0
49.7 Long period before the next injection	0	0,0
49.8 No information received	0	0,0
49.9 Other	0	0,0
49.10 No answer	97	97,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.17 How does injectable contraception work? (item 50)

In this item the respondents were required to indicate how injectable contraceptives work. It is also evident from these findings that the respondents are unaware of this contraceptive method.

Of the respondents 1,0% (n=1) specified that injectable contraceptives mainly stop ovulation (release of eggs from ovaries); 2,0% (n=2) stated that they thicken cervical mucus, making it difficult for sperm to pass through; 57,0% (n=57) did not know; 40,0% did not answer. The frequency Table 4.20 is as follows:

**Table 4.20 How injectable contraception works (N=100)**

How injectable contraception works	Frequency	Percentage
50.1 Mainly stops ovulation (release of eggs from ovaries)	1	1,0
50.2 Thickens cervical mucus, making it difficult for sperm to pass through	2	2,0
50.3 I don't know	57	57,0
50.4 Other	0	0,0
50.5 No answer	60	60,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.18 Have you ever heard of emergency contraception? (item 51)

Of the respondents 98,0% (n=98) indicated that they had never heard of emergency contraception; 2,0% (n=2) had heard of emergency contraception. This is evidently a method hardly known among the respondents.

The frequency Table 4.21 is as follows:

**Table 4.21 Have you ever heard of emergency contraception? (N=100)**

Answer	YES	%	NO	%	Total
Have you ever heard of emergency contraception	2	2,0	98	98,0	100,0

Fraser et al (2006:672) indicate that emergency contraception is when contraception was not used, used incorrectly or failed (as in condom mishap). There are two methods, namely, the copper intra-uterine device or a progestogen-only method, comprising two pills, prescribed according to the medical practitioner.

According to Leal and Saito (2003:40), learning about emergency contraception (EC) can be a bridge to gaining information about other types of contraception, such as the use of condoms. Faced with the risk of pregnancy during adolescence, one must take into account the age in order to prescribe a contraceptive. In those situations where the condom is the only anti-contraception method used, emergency contraception (EC) reinforces the safety of the user in terms of the barrier method, as the EC constitutes an efficient option in cases of a tear or displacement of the condom.

#### 4.5.19 Meaning of emergency contraception (item 52)

Of the respondents 1,0% (n=1) indicated that emergency contraception is the use of an oral pill taken up to 72 hours after sexual intercourse; 1,0% (n=1) stated that it is the use of an oral pill taken up to 72 hours *before* sexual intercourse; 98,0% (n=98) provided no answer. The subject is almost completely unknown among the respondents.

The frequency Table 4.21 is as follows:

**Table 4.21 Meaning of emergency contraception (N=100)**

<b>Meaning of emergency contraception</b>	<b>Frequency</b>	<b>Percentage</b>
52.1 It is an intramuscular injection	0	0,0
52.2 It is the use of an oral pill taken up to 72 hours before sexual intercourse	1	1,0
52.3 It is the barrier method	0	0,0
52.4 It is the use of an oral pill taken 72 hours after sexual intercourse	1	1,0
52.5 After unprotected sex can prevent pregnancy	0	0,0
52.6 I don't know	0	0,0
52.7 Other	0	0,0
52.8 No answer	98	98,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.20 Reason for using emergency contraception (item 53)

The knowledge that the respondents demonstrated in this item was poor.

Of the respondents 1,0% (n=1) indicated that she would use emergency contraception after having been raped; 3,0% (n=3) indicated they did not know; 97,0% (n=97) did not provide an answer.

The frequency Table 4.23 is as follows:

**Table 4.23 Reason for using emergency contraception (N=100)**

<b>Reason for using emergency contraception</b>	<b>Frequency</b>	<b>Percentage</b>
53.1 After being raped	1	1,0
53.2 After casual sex/unprotected sex	0	0,0
53.3 After a party and getting drunk	0	0,0
53.4 After sexual violence	0	0,0
53.5 After forced sex	0	0,0
53.6 A condom has broken	0	0,0
53.7 An IUD has come out of place	0	0,0
53.8 Woman has run out of oral contraceptives or is late with injectable contraceptive	0	0,0
53.9 I don't know	3	3,0
53.10 Other	0	0,0
53.11 No answer	96	96,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### 4.5.21 Source of emergency contraception (item 54)

The majority 99,0% of the respondents were unaware of the source of emergency contraception as they did not provide an answer to this question. Of the respondents 1,0% (n=1) stated that emergency contraception is available at a hospital.

The frequency Table 4.24 is as follows:

**Table 4.24 Source of emergency contraception (N=100)**

Availability of emergency contraception	Frequency	Percentage
54.1 Clinic	0	0,0
54.2 Hospital	1	1,0
54.3 Doctor	0	0,0
54.4 Other	0	0,0
54.5 No answer	99	99,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

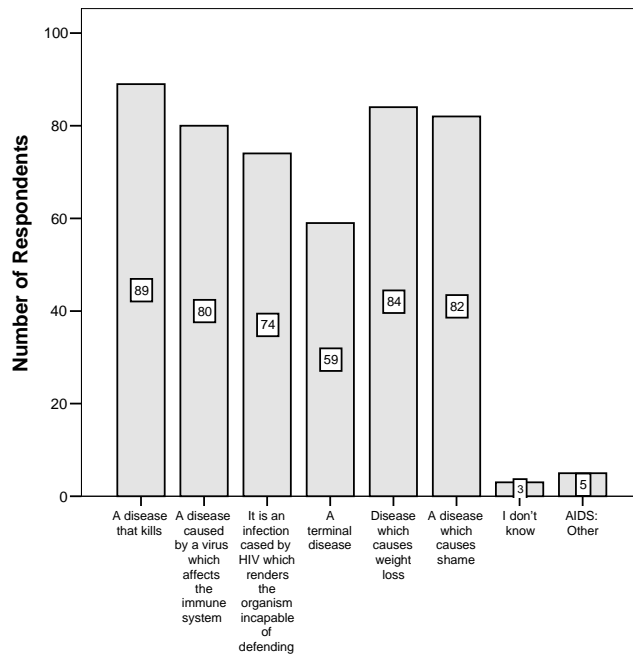
## **4.6 SECTION E: SEXUALLY TRANSMITTED INFECTIONS (STIs)**

The study explored general knowledge that the participants had with regard to sexually transmitted infections.

### **4.6.1 Definition of AIDS (item 55)**

A reasonably high percentage of the respondents knew at least the basic facts about AIDS. Of the respondents 89,0% (n=89) indicated that AIDS is a disease that kills; 80,0% (n=80) indicated that it is a disease caused by a virus which affects the immune system; 74,0% (n=74) stated that it is an infection caused by HIV which renders the organism incapable of defending itself against infections; 59,0% (n=59) said that it is a terminal disease; 84,0% (n=84) said that it is a disease which causes weight loss; 82,0% (n=82) indicated that it is a disease which causes shame; 3,0% (n=3) said they did not know; 5,0% (n=5) indicated "Other".

The bar chart in Figure 4.26 illustrates this:

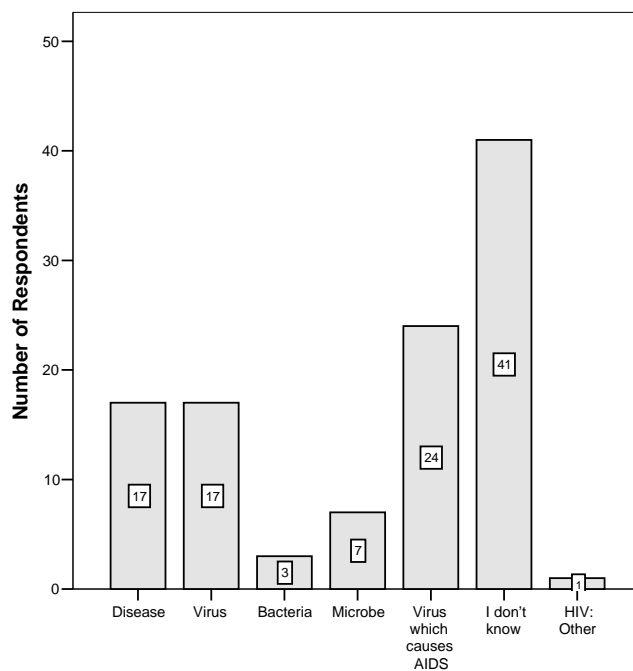


**Figure 4.26**  
**Definition of AIDS (N=100)**

#### 4.6.2 Definition of HIV (item 56)

In this item the respondents were requested to explain what HIV was. Of the respondents 17,0% (n=17) indicated that HIV is a disease; 17,0% (n=17) indicated that it is a virus; 3,0% (n=3) said it is a bacteria; 7,0% (n=7) said it is a microbe; 24,0% (n=24) said that it is a virus which causes AIDS; 24,0% (n=24) answered that they did not know; 1,0% (n=1) indicated “Other”.

The respondents seem less well aware of the facts concerning HIV. The bar chart in Figure 4.27 illustrates the information in the table:



**Figure 4.27**  
**Definition of HIV (N=100)**

Notwithstanding the fact that adolescents have a basic knowledge about AIDS, more than half are ignorant about HIV. It is believed that lack of knowledge about HIV can significantly influence other attitudes with regard to the disease.

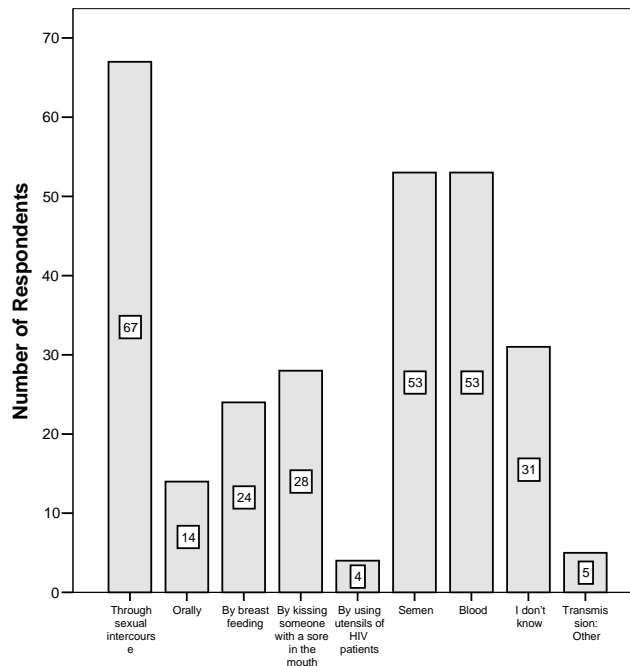
According to Morgado et al (2005:6), the younger the woman, the more evident the lack of information on sexual and reproductive aspects and on HIV infection. To be an adolescent, to be pregnant and to be HIV infected represent three crisis situations which require very different adaptations. The authors stress the need for the development of general prevention programmes which will enable adolescents and others to reduce their risk behaviours, change their dysfunctional life styles and live a more integrated sexuality.

#### **4.6.3 HIV transmission (item 57)**

More than 50% of the respondents had some knowledge on how HIV was transmitted. Of the respondents 67,0% (n=67) mentioned that HIV is transmitted through sexual intercourse; 14,0% (n=14) stated that HIV is transmitted orally; 24,0% (n=24) said HIV is transmitted through breastfeeding; 28,0% (n=28) said that HIV is transmitted by kissing someone with a sore in the mouth; 4,0% (n=4) said that HIV is transmitted using the



utensils of HIV patients; 53,0% (n=53) said HIV is transmitted through semen; 53,0% (n=53) said HIV is transmitted through blood; 31,0% (n=31) said they did not know; 5,0% (n=5) indicated “Other”. Some of the respondents seem well informed, but many lack sufficient knowledge in this regard. This fact is illustrated by means of the bar chart in Figure 4.28:



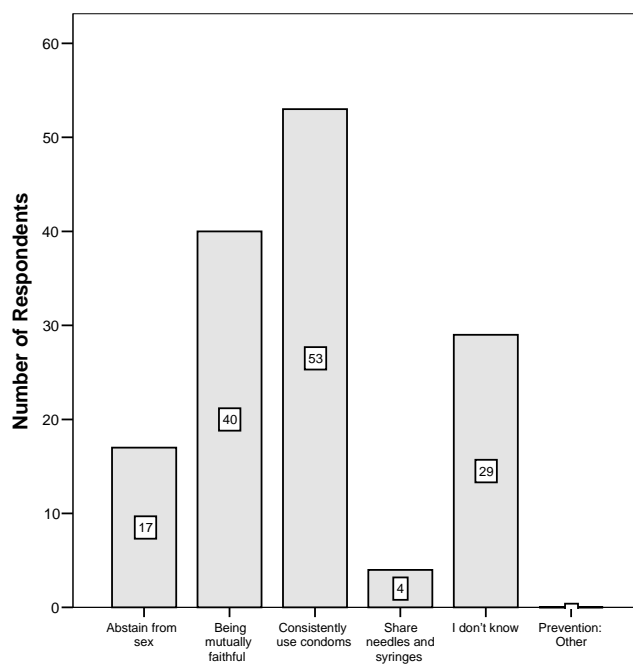
**Figure 4.28**  
**HIV transmission (N=100)**

#### 4.6.4 HIV prevention (item 58)

Most of the respondents are not well informed about measures to prevent the spread of HIV.

Of the respondents 17,0% (n=17) stated that HIV is prevented by abstaining from sex; 40,0% (n=40) said that HIV is prevented by being faithful to one's partner; 53,0% (n=53) said that HIV is prevented through the consistent use of condoms; 4,0% (n=4) said that HIV is prevented by sharing needles and syringes; 29,0% (n=29) said they did not know.

The information is illustrated by means of the bar chart in Figure 4.29:

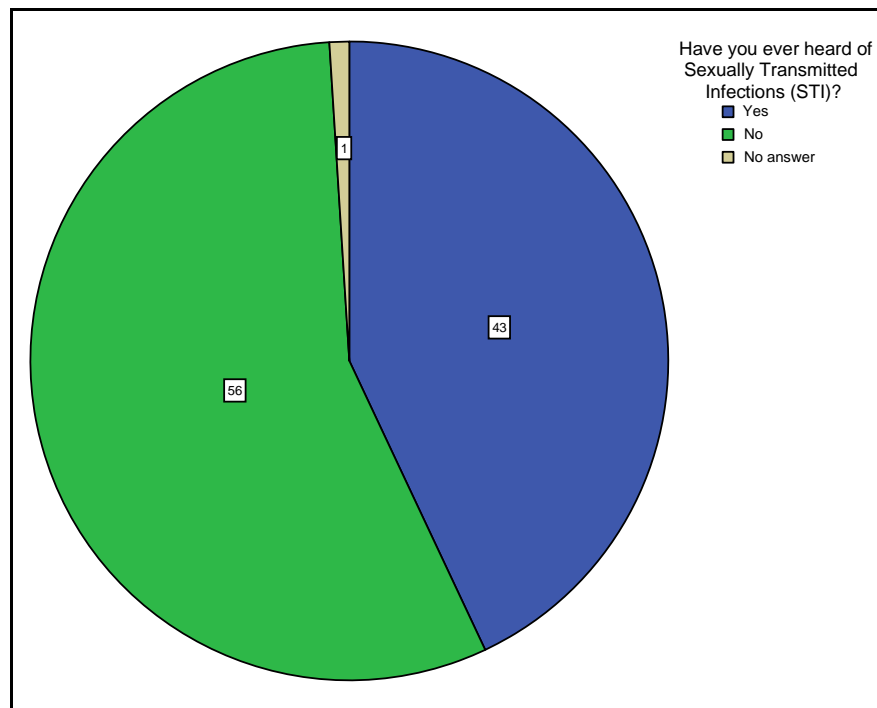


**Figure 4.29**  
**Prevention of HIV (N=100)**

#### 4.6.5 Have you ever heard of Sexually Transmitted Infections (STIs)? (item 59)

Of the respondents 56,0% (n=56) had never heard of STIs; 43,0% (n=43) had heard of STIs; 1,0% (n=1) did not answer the item.

The pie chart in Figure 4.30 illustration is as follows:



**Figure 4.30**

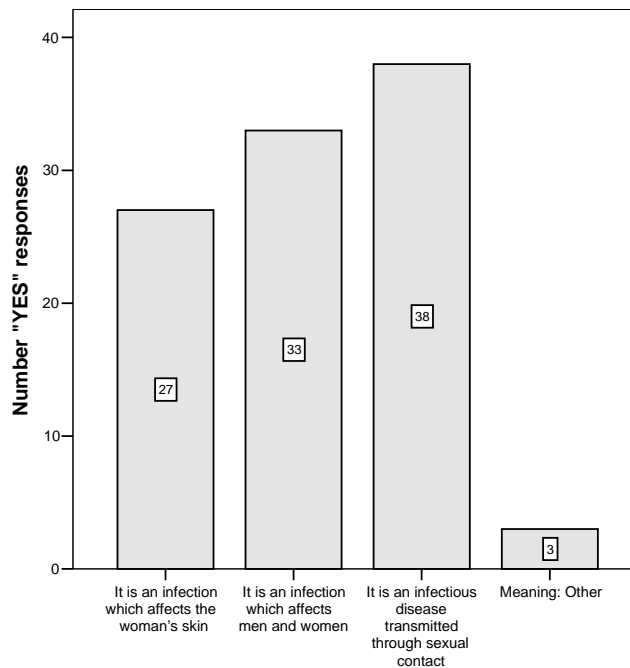
***Have you ever heard of Sexually Transmitted Infections (STIs)? (N=100)***

#### **4.6.6 Meaning of STIs (item 60)**

Of the respondents 27,0% (n=27) indicated that a STI is an infection which affects the woman's skin; 33,0% (n=33) indicated that it is an infection which affects men and women; 38,0% (n=38) indicated that it is an infectious disease transmitted through sexual contact; 3,0% (n=3) indicated "Other".

Most of the respondents who had heard about STIs seem to be reasonably well informed.

The bar chart in Figure 4.31 illustrates the number of "YES" replies.



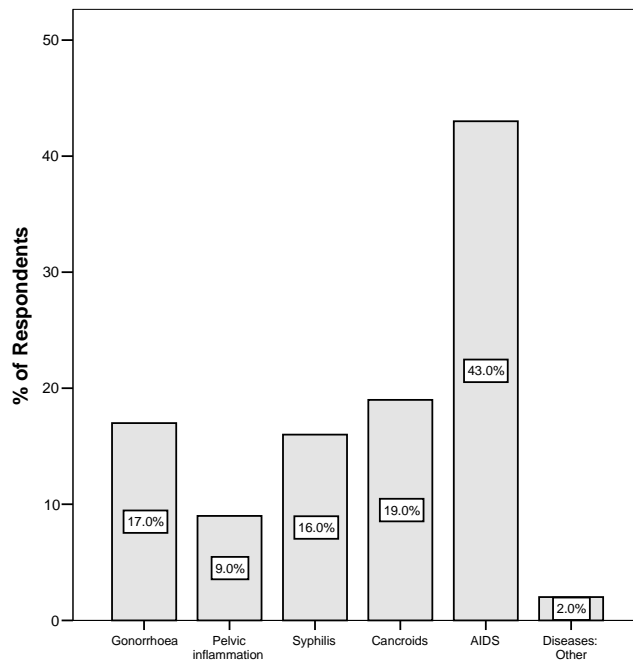
**Figure 4.31**  
**Meaning of STIs (N=100)**

The prevention of the infection (primary prevention) is the most efficient manner of reducing the adverse consequences of STIs for women. The immediate diagnosis and the treatment of present infections (secondary prevention) can also prevent personal complications and transmission to others (Lowdermilk et al 2002:115).

#### **4.6.7 STI diseases (item 61)**

Of the respondents 17,0% (n=17) knew that gonorrhoea was a sexually transmitted infection; 9,0% (n=9) indicated that pelvic inflammation was a sexually transmitted infection; 16,0% (n=16) knew that syphilis was a sexually transmitted infection; 19,0% (n=19) indicated that cancrroids were sexually transmitted diseases; 43,0% (n=43) indicated they knew about AIDS as a sexually transmitted infection; 2,0% (n=2) indicated they knew about other sexually transmitted infections.

Awareness of AIDS seems to be the most common. About half the respondents who had heard about STIs did not know that syphilis and gonorrhoea are STIs, at least not under those names. The corresponding bar chart in Figure 4.32 follows:

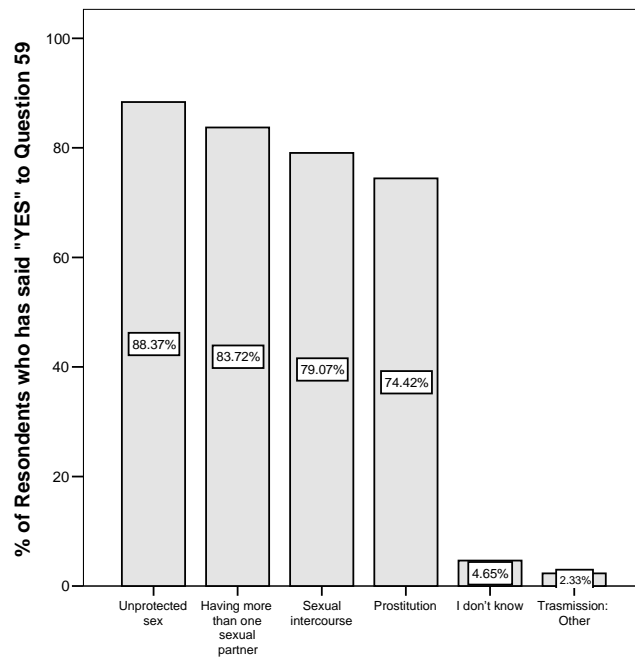


**Figure 4.32**  
**STI diseases (N=100)**

#### 4.6.8 STI transmission (item 62)

Of the respondents 88,37 (n=88) said that STIs are transmitted by having unprotected sex; 83,72% (n=83) said that STIs are transmitted by having more than one sexual partner; 79,07% (n=79) stated that STIs are transmitted by having sexual intercourse; 74,42% (n=74) indicated that STIs are transmitted through prostitution; 4,65% (n=4) stated that they did not know how STIs are transmitted; 2,33% (n=2) indicated “Other”.

There is a fair amount of agreement among the respondents who said they had heard about STIs. The following bar chart in Figure 4.33 illustrates their views.



**Figure 4.33**  
**Transmission of STIs (N=100)**

#### 4.6.9 Have you ever been raped? (item 63)

None of the respondents reported or admitted that they had been raped. Therefore the next two questions (64 and 65) became redundant.

The frequency table is as follows:

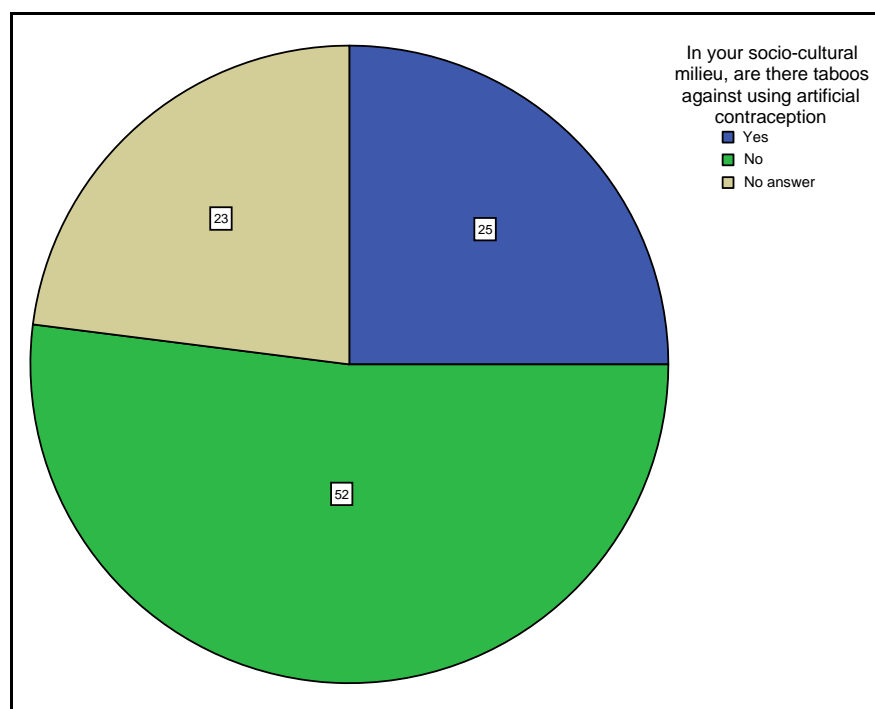
**Table 4.25** Relates to the issue of rape (N=100)

Answer	YES	%	NO	%	Total
Raped	0	0,0	100	100,0	100

#### 4.6.10 Socio-cultural taboos about the use of artificial contraception (item 66)

Of the respondents 25,0% (n=25) stated that there are taboos against the use of artificial contraception; 52,0% (n=52) said that there are no taboos against the use of artificial contraception; 23,0% (n=23) did not answer the item.

The information is illustrated in the pie chart of Figure 4.34.



**Figure 4.34**

***Socio-cultural taboos about the use of artificial contraception (N=100)***

In Angola marriages involving adolescents are still very common in some cultures. These female adolescents generally are under a lot of pressure from the family and society to have children soon after getting married. Through an adequate sexual education, adolescents can develop knowledge and self-confidence which will enable them to take decisions with regard to their sexual behaviour, including the decision to have sex or to get married only when they feel they are ready.

However, discussions on the topic of contraception are still very limited; contraception is often considered as a method imposed to reduce fertility instead of being a health intervention (Moura 2005:6).

**4.6.11 Decisions about contraception (item 68)**

Of the respondents 43,0% (n=43) stated that they themselves decide on contraception; 26,0% (n=26) said that their partners decide on contraception; 21,0% (n=21) said the family decides on contraception; 5,0% (n=5) stated that their community or religious

leaders decide on contraception; 2,0% (n=2) specified “Other”; 3,0% (n=3) did not answer.

The most predominant answer is that they themselves make the decision.

The frequency Table 4.26 is as follows:

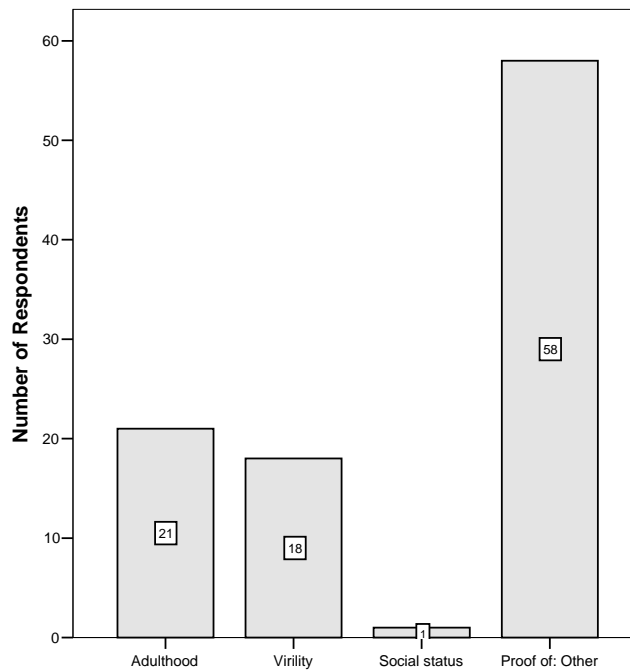
**Table 4.26 Decisions about contraception (N=100)**

<b>Decisions about contraception</b>	<b>Frequency</b>	<b>Percentage</b>
68.1 Yourself	43	43,0
68.2 Your partner	26	26,0
68.3 The family	21	21,0
68.4 Community or religious leaders	5	5,0
68.5 Other	2	2,0
68.6 No answer	3	3,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### **4.6.12 Children seen as proof of... (item 69)**

Of the respondents 21,0% (n=21) consider children as proof of adulthood; 18,0% (n=18) consider children as proof of virility; 1,0% (n=1) consider children as proof of social status; 58,0% (n=58) indicated “Other”. It appears that children are mostly seen as proof of something other than adulthood, virility and social status. The fact is illustrated in the bar chart in Figure 4.35.



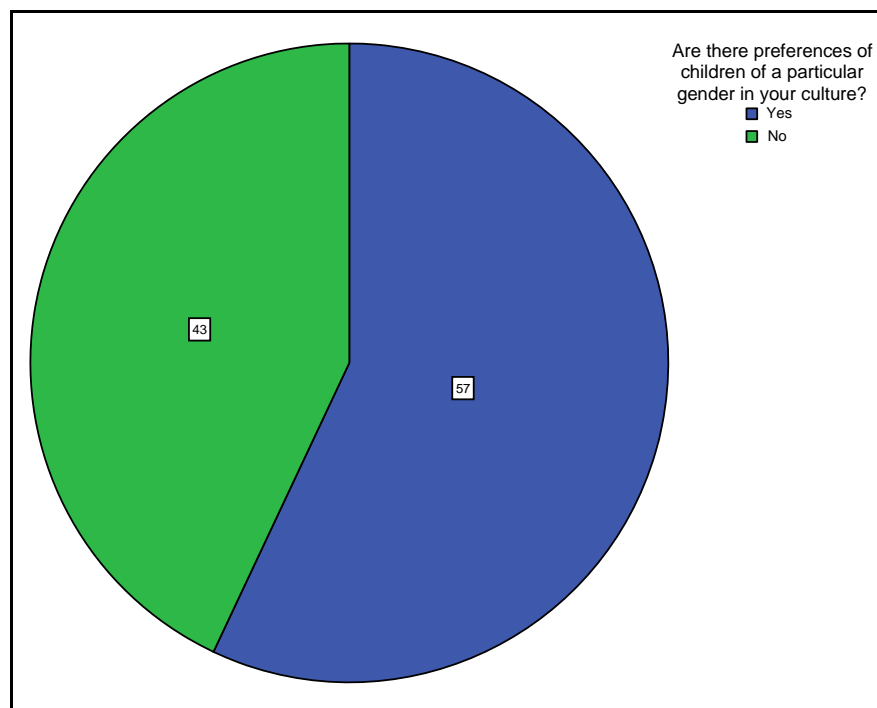


**Figure 4.35**  
***Children as proof of ... (N=100)***

An unplanned pregnancy in an adolescent can be accidental, but often is due to a subconscious desire to have a baby. This yearning to have a baby can be the result of wanting to give and to receive affection, and can be particularly strong in adolescents who feel they are not really loved, or feel rejected and inadequate. They expect the baby not only to bring them love, but also to give meaning to their lives (Bradley & Dubinsky 1995:79).

#### **4.6.13 Cultural preferences with regard to a particular gender (item 70)**

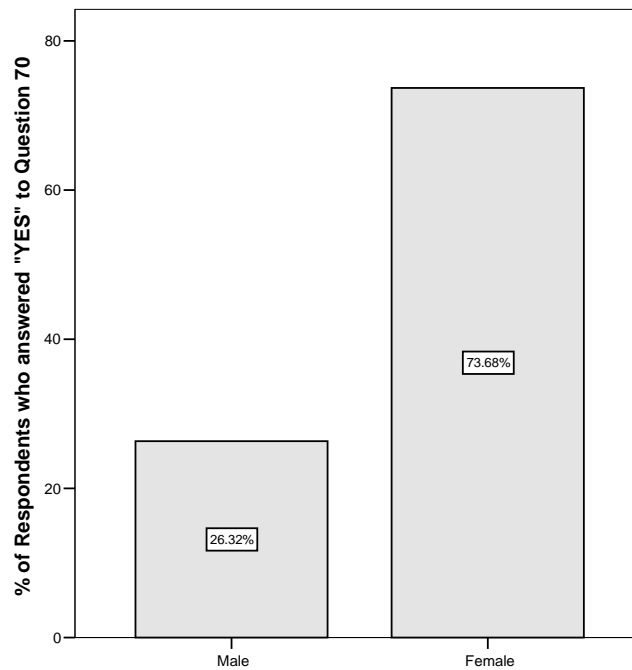
Of the respondents 57,0% (n=57) have preferences with regard to the gender of their children; 43,0% (n=43) do not have preferences. The majority of respondents (57,0%) answered in the affirmative. The pie chart in Figure 4.36 illustrates this:



**Figure 4.36**  
***Cultural preferences with regard to gender (N=100)***

#### **4.6.14 Preferred gender (item 71)**

Of the respondents, 26,32% (n=32) prefer males; 73,68% (n=73) prefer females. Of those respondents who said that there are such preferences, 42 out of 57 (i.e. almost 75%) said that the preference is for baby girls. This is illustrated in the bar chart contained in Figure 4.37.



**Figure 4.37**  
**Preferred gender (N=57)**

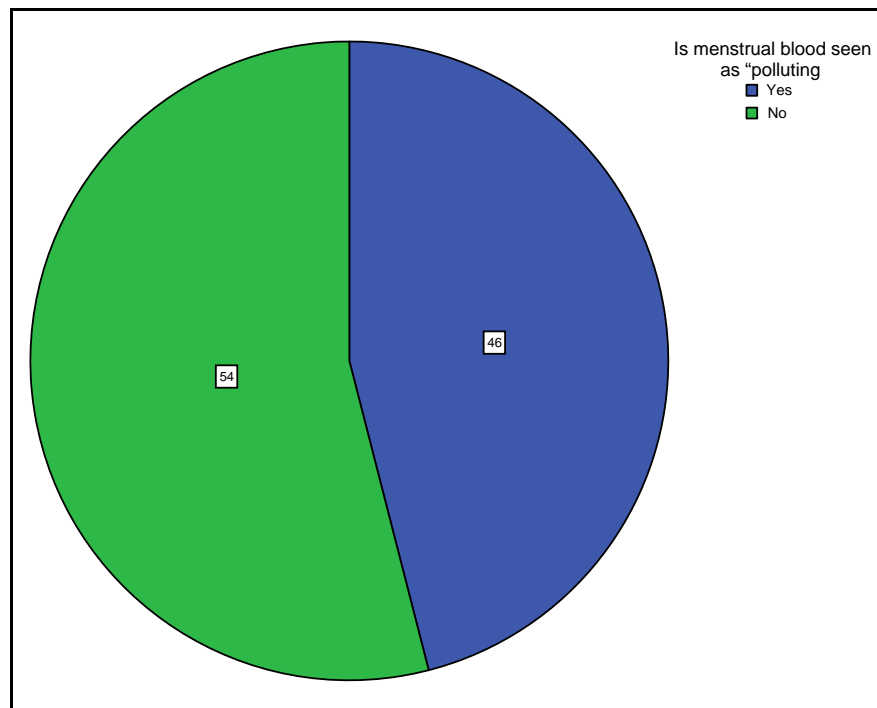
When looking after the baby the adolescent associates the baby with a doll, and could also be looking after the child within herself. If adolescents were more informed about the needs of a real baby, probably they would have a more caring and responsible attitude with regard to pregnancy (Bradley & Dubinsky 1995:80).

Item 72 was omitted.

#### **4.6.15 Menstrual blood considered as “polluting” (item 73)**

Of the respondents 46,0% (n=46) consider menstrual blood as “polluting”; 54,0% (n=54) do not consider menstrual blood as “polluting”. Therefore a slight majority (54,0%) do not see menstrual blood as “polluting”.

The pie chart in Figure 4.38 illustrates this.



**Figure 4.38**  
***Menstrual blood considered as “polluting” (N=100)***

#### **4.6.16 Acceptance of contraceptives (item 74)**

Of the respondents 2,0% (n=2) consider menstrual blood as “polluting” and believe that it affects their acceptance of oral contraception; 2,0% (n=2) consider menstrual blood as “polluting” and believe that it affects their acceptance of intra-uterine devices; 43,0% (n=43) consider “Other”; 53,0% (n=53) did not give an answer.

Very few respondents see menstrual blood as affecting the acceptance of oral contraception or IUDs, but it does affect their acceptance of “other” things.

The frequency Table 4.27 is as follows:

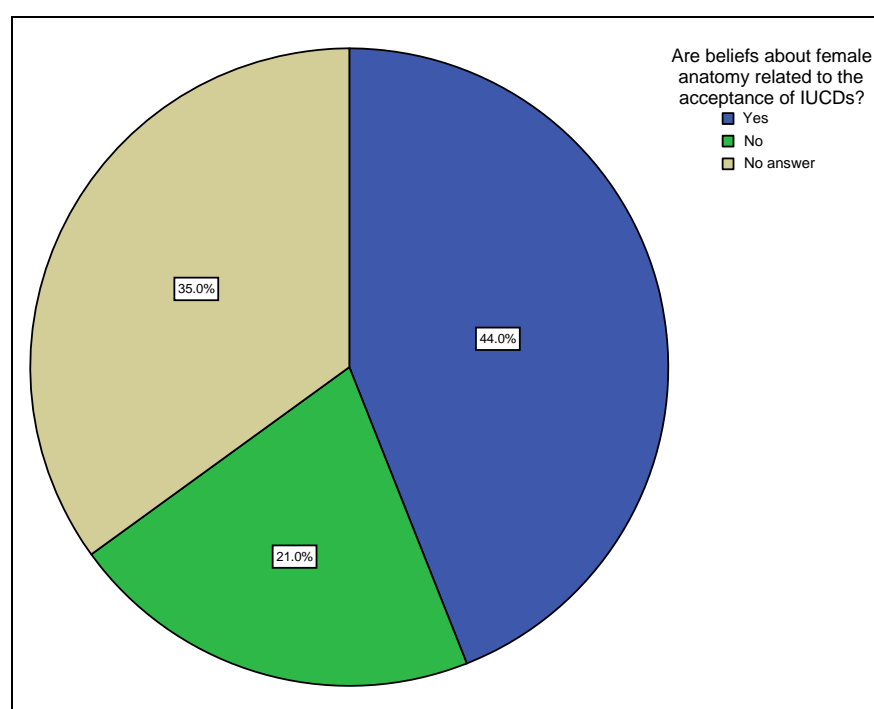
**Table 4.27 Acceptance of contraceptives (N=100)**

Acceptance of contraceptives	YES	Percentage
74.1 Oral contraception	2	2,0
74.2 Intra-uterine contraception devices (IUCDs)	2	2,0
74.3 Other	43	43,0
74.4 No answer	53	53,0
<b>Total</b>	<b>100</b>	<b>100,0</b>

#### **4.6.17 Beliefs about female anatomy related to the acceptance of IUCDs (item 75)**

Of the respondents 44,0% (n=44) are of the opinion that beliefs about female anatomy are related to the acceptance of IUDs; 21,0% (n=21) do not think that the beliefs about female anatomy are related to the acceptance of IUDs; 35,0% (n=35) did not answer. About two-thirds of those respondents who answered the question answered in the affirmative.

The pie chart in Figure 4.39 illustrates this.



**Figure 4.39**

***Beliefs about female anatomy related to the acceptance of IUCDs (N=100)***

According to the IPPF Declaration/International Medical Advisory panel (IMAP) (1995:21), the intra-uterine device (IUD) is not a good choice for women at high risk of developing STIs; for example, women with more than one sexual partner. In general, it is thought that single adolescents who are sexually active run a higher risk of becoming infected with STIs. For some adolescents the use of an IUD can increase the risk of developing DIP and of subsequent infertility. A copper IUD can be used as post-sex contraception if used within five days after unprotected sexual intercourse. This has the advantage of ensuring a future contraceptive protection when the adolescent is considering the use of IUD as a contraceptive method.

#### **4.6.18 Description of beliefs (item 76)**

In an open question, the respondents were required to answer item 76 if they believed that the female anatomy was related to the acceptance of IUCDs. Although 44 respondents agreed that the female anatomy was related to the acceptance of IUCDs, none of the respondents described any specific beliefs in this item.

### **4.7 CONCLUSION**

This chapter discussed the data analysis and interpretation. The main components of the questionnaire dealt with the demographic data, and the topics of adolescence, sexuality, contraception and sexually transmitted infections. Chapter 5 presents the findings, conclusions and recommendations.

## **Chapter 5**

### **Results, conclusions and recommendations**

#### **5.1 INTRODUCTION**

The purpose of this study was to explore the knowledge female adolescents have about contraception. A quantitative, exploratory and descriptive research design was applied in this study, using a structured interview schedule. This chapter discusses the conclusions, with reference to the objectives and findings, points out the limitations of the study and makes recommendations for practice and further research.

#### **5.2 OBJECTIVES**

The objectives of this study were to

- analyse the knowledge of adolescents about contraception
- determine the sources of their information on the use of contraception methods
- make recommendations for educational programmes on contraception

#### **5.3 RESULTS**

For this study a structured interview schedule was developed and comprised the following five sections; the results will be discussed in line with these sections:

**Section A:** Demographic data

**Section B:** Adolescence

**Section C:** Sexuality

**Section D:** Contraception

**Section E:** Sexually transmitted infections

### **5.3.1 Section A: Demographic data**

The sample consisted of 100 participants, female adolescents who used the Health Centre of the Municipality of Cazenga, Luanda, Angola.

The age of the respondents varied between 14 and 19 years of age, the average age being 17 years or more (79,0%). The youngest age of respondents was 14 years (3,0%). At the time of the interview, 32,32% of the respondents were attending school and 67,68% did not attend school, and had not attended above grade 8. Of the respondents who had left school, 29,0% had interrupted their schooling because of lack of financial means, but the main reason given for leaving school was having fallen pregnant (39,0%). The majority of respondents (79,0%) belong to the ethnic group Kimbundo. As regards the religious affiliation of the participants, 40,4% were Catholic and 21,21% did not belong to any religion.

The families were reported as consisting of the mother (88,0%); father (77,0%); brothers (89,0%) and sisters (87,0%). With regard to communication with the family, fewer than one quarter of respondents talk or discuss sex with the family (22,0%), and 78,0% do not talk to the family. Respondents indicated that shyness (54,0%) and rejection (24,0%) were the main reasons why they did not discuss sex with the family.

With regard to a close relationship with family members, mothers (28,87%) and sisters (22,68%) were the most prevalent answers. Many respondents (57,0%) are more at ease talking about sex with their friends than with family members. It seems that there are a variety of reasons why respondents can discuss sex with their friends; friends understand them (40,0%); they feel at ease discussing sex with them (41,0%).

The majority of respondents, 58,0%, consider the menstrual cycle as a period during which ovulation occurs and one can fall pregnant, or believe that it is a period of fertility (46,0%) and bleeding to cleanse the body.

### **5.3.2 Section B: Adolescence**

There seems to exist a level of ignorance with regard to the meaning of adolescence. Of the respondents, 55,0% believe it is a period in the life of an individual when one is



neither considered as a child nor as an adult; 26,0% consider it as a period of immaturity of an individual; 37,0% consider it as a period of the adult life of an individual; for 37,0% it is the acquisition of a male or female social role; for 37,0% it is the acceptance of one's body and using it in an efficient manner; 25,0% indicate it as becoming emotionally independent from the parents; 38,0% stated it is a choice of and preparedness for a professional career; for 40,0% it is the acquisition of values within an ethical system as an orientation to behaviour.

With regard to knowledge about the age of onset of adolescence, it was ascertained that respondents are basically not sure when adolescence begins; 6,0% indicated that it starts, more or less, between 8 and 10 years of age; 8,0% between 10 and 12 years of age; 13,0% between 12 and 14 years of age; 47,0% between 14 and 16 years of age; while 26,0% did not answer this question, as they may have been unsure of the meaning of the onset of adolescence.

With regard to the physical changes which the adolescent may experience during adolescence, the majority of respondents do not have much knowledge on this topic and fewer than 50,0% of respondents answered that question. With regard to the type of physical change during that phase, 29,0% indicated physical changes during adolescence such as growth of the eyes; 54,0% indicated the development of breasts; 47,0% a change in voice; 54,0% growth of pubic hair; 54,0% first menstruation.

As far as emotional changes that may be experienced by the adolescent, just over 50,0% of respondents gave an opinion about emotional changes experienced; 51,0% indicated mood swings; 50,0% indicated that isolation was experienced; fewer than 50,0% reported the following experiences with regard to emotional changes: 35,0% depression; 49,0% anger; 46,0% a feeling of guilt; 32,0% an inferiority complex; 34,0% confusion in terms of identity; 55,0% shame and doubt; 38,0% despair.

With regard to discussing sex with their mothers, only one in every six respondents discusses sex with their mother (17,0%); of these, 14 discuss menstruation; 11 discuss dating and boyfriends; 13 discuss sexual intercourse. These seem to be the most important topics discussed with their mothers.

### **5.3.3 Section C: Sexuality**

As regards sexual behaviour being part of the adolescents' orientation, pre-marital sex - being in love (29,0%); or being engaged (56,0%); and "Other" (37,0%) seem to be the main focus of the respondents' sexual behaviour. In the great majority of the cases (99,0%), sexual intercourse is prevalent; furthermore, the respondents had had sexual intercourse from the age of 16 years and older (40,0%); 15 years old (41,0%); 14 years old (14,0%), while one respondent had experienced sexual intercourse at the age of 12 years (1,0%). This was the youngest age indicated as the age of first sexual intercourse.

Love or being in love with the boy (76,0%) seems, as indicated, to have been the main reason to have sexual intercourse; 20,0% of the respondents indicated that they wanted to find out what sexual intercourse was about. The consequences of unprotected sex were explained as follows: 88,0% of respondents are aware of the possibility of falling pregnant as a result of having unprotected sex, but very few are aware that it can end in transmitting and acquiring HIV and other STDs.

Male condoms seem to be the predominant contraceptive method, used by 69 of those adolescents who were sexually active. One respondent reported using cultural herbs as a contraceptive method and 4 respondents indicated that they used oral contraceptives (see Figure 4.18).

Of the respondents that were interviewed only 8 reported that they had had abortions, 5 of which had been performed at home and 3 at a hospital. Of the respondents who stated that they had had an abortion, 4 were fifteen years old at the time and 4 were sixteen years old.

### **5.3.4 Section D: Contraception**

With regard to the respondents' knowledge of contraception, 66,67% or approximately two-thirds of respondents had heard about contraception; 33,33% had never heard of contraception.

The level of understanding of the meaning of contraception by the respondents was poor, and the response rate was very low; only 41 of the respondents stated that it prevented unwanted pregnancy, while 9 respondents saw contraception as protection against sexually transmitted infections.

As far as the source of information on contraception went, 28 of the respondents named nurses; 19 respondents the radio; 17 respondents television, 15 respondents friends, 13 respondents mothers and 12 respondents reported other family members as the source of information with regard to contraception.

With regard to the respondents' belief about the use of contraceptives, the most prevalent opinion is that condoms prevent pregnancy; this was reported by 67 respondents.

Although the respondents reported that they had had sexual intercourse, only one third used contraceptives (33,0%). The main sources for obtaining contraceptives were pharmacies (23%) and "other" sources (23,0%).

As regards the kind of contraceptive used, 69,0% of the respondents mentioned the use of the male condom and 44,0% allegedly use "other" contraceptive methods.

Very little information was received from the respondents with regard to the use of vaginal contraceptives; only two respondents stated that prevention of pregnancy was the information they received as to the purpose of vaginal contraceptives; furthermore, only one respondent indicated that they help to prevent Sexually Transmitted Diseases (STDs) and conditions caused by STDs.

Of the 82,0% respondents that indicated using contraceptive methods, only 3 respondents indicated that the partners agreed with the guidance provided.

Male condoms (35 respondents) and, in a few cases (3 respondents), avoiding having sexual intercourse seem to be the only contraceptive methods used to prevent unwanted pregnancies. Approximately 35 respondents normally use the male condom to avoid pregnancy; 3 respondents indicated using the abstinence method; 62,0% did not answer the question.

As far as how spermicides work, ignorance seems to prevail. Only 2 respondents said that spermicides prevent the sperm from coming into contact with the ovule; 72 do not know how spermicides work and 25 respondents did not answer the question.

The respondents' knowledge with regard to the working of diaphragms and cervical caps was poor. Only 3 respondents specified that spermicides block the sperm, preventing it from entering the uterus and the tubes where it can come into contact with the egg; 68 respondents did not know how spermicides work; 28 respondents did not answer the question.

Respondents seem to have no basic knowledge about information received regarding oral contraceptives. 1,0% mentioned they are very effective when used correctly; only one respondent reported that the information received was that oral contraceptives can be used if a woman wants to prevent falling pregnant; one respondent said that the person can stop taking the pill at any time; one respondent reported that contraceptives can be used with emergency contraceptives; 95,0% did not answer the question. As regards how oral contraceptives work, 1,0% said oral contraceptives thicken the cervical mucus; 72,0% do not know how oral contraceptives work; 27,0% did not answer.

Respondents seem not to have knowledge about injectable contraceptives. 1,0% specified it is long-term prevention; 1,0% said they do not interfere with sex; 1,0% said it is not necessary to take pills every day; 97,0% did not answer. As regards how injectable contraceptives work, 1,0% stated that contraception with injections essentially stops ovulation (release of the eggs from the ovaries); 2,0% said it thickens the cervical mucous, making it difficult for the sperm to go through; 57,0% did not know; 40,0% did not answer.

Of the 100 respondents, 2,0% have heard about emergency contraception; 98,0% have never heard about it. The subject of emergency contraception is almost completely unknown to the respondents, 1,0% indicated that it is the use of an oral pill taken up to 72 hours after sexual intercourse; 1,0% indicated that it is the use of an oral pill taken 72 hours *before* sexual intercourse; 98,0% did not answer. With regard to the reason for the use of emergency contraception, 1,0% stated that it is used after having been raped; 3,0% do not know; 97,0% did not answer. As far as its availability goes, 1,0% indicated it is available at the hospital; 99,0% did not answer.

### **5.3.5 Section E: Sexually transmitted infections (STIs)**

A reasonably high percentage of respondents have basic knowledge about AIDS. 89,0% of respondents indicated that AIDS is a disease; 80,0% said AIDS is a disease caused by a virus that affects the immunologic system; 74,0% said AIDS is an infection caused by HIV which renders the organism incapable of defending itself against infections; 59,0% said it is terminal disease; 84,0% said it is a disease that causes weight loss; 82% that it is disease that causes shame; 3,0% do not know; 5,0% indicated "Other".

As regards respondents' knowledge of HIV, they seem to be less aware of the facts related to HIV. Seventeen percent mentioned that it is a disease; 17,0% said it is a virus; 3,0% that HIV is a bacteria; 7,0% that HIV is a microbe; 24,0% said HIV is a virus that causes AIDS; 41,0% do not know; 1,0% indicated "Other". The respondents seem to be well informed about the transmission of HIV but some respondents have no knowledge in this regard, 67,0% said HIV is transmitted through sexual intercourse; 14,0% said HIV is transmitted orally; 24,0% through breastfeeding; 28,0% by kissing someone who has a mouth sore; 4,0% by using cutlery of HIV patients; 53,0% through semen; 43,0% through blood; 31,0% do not know; 5,0% "Other". As regards prevention of HIV, the majority of respondents are not well informed on how to prevent it; 17,0% stated that HIV can be prevented through abstaining from sexual intercourse; 40,0% by being faithful to one's partner; 53,0% through the consistent use of the condom; 4,0% by sharing needles and syringes; 29,0% of the respondents did not know.

With regard to knowledge of STIs, fewer than 50,0% of respondents had heard about STIs (i.e., had perhaps heard the term), and these seemed to be reasonably well informed about its meaning, 27,0% stated that it is an infection that affects a woman's skin; 33,0% said it is an infection that affects men and women; 38,0% said it is an infectious disease transmitted through sexual contact; 3,0% indicated "Other". Approximately half of the respondents that had heard of STIs did not know that syphilis and gonorrhoea were STIs, at least not known by these names; awareness that AIDS is an STI seems to be possessed by more respondents; 17,0% mentioned that they know about gonorrhoea; 9,0% know about pelvic inflammation; 16,0% know about syphilis; 19,0% know about cancrroids; 43,0% know about AIDS, and 2,0% know about other STIs.

As far as transmission of STIs is concerned, there is a certain level of consensus amongst respondents who indicated having heard of STIs; 88,37% said that STIs are transmitted through unprotected sex; 83,72% by having more than one sex partner; 79,07% during sexual intercourse; 74,42% through prostitution; 4,65% of the respondents did not know ; 2,33% indicated "Other".

When asked whether they had been raped no respondent admitted having been raped.

With regard to the socio-cultural taboos, 25,0% of the original number of 100 respondents indicated that there were taboos against the use of artificial contraception, and 43,0% of the respondents stated they themselves made decisions about contraception; 26,0% said their partners took the decisions; 21,0% indicated the family took the decisions; 5,0% indicated the community or religious leaders; 2,0% others; 3,0% did not answer.

With regard to whether children were considered as proof of adulthood, virility, social status and "Other", the majority of the respondents seem to consider children as proof of something else; 21,0% consider children as proof of adulthood; 18,0% as proof of virility; 1,0% as proof of social status; 58,0% considers children as proof of "Other".

Furthermore, with regard to preferences about the gender of children, 26,32% indicate a preference for male children and 73,68% for female children.

Approximately 46,0% of respondents consider menstrual blood as being polluting; 54,0% do not consider menstrual blood as being polluting. Of the respondents that consider menstrual blood as polluting very few consider it as affecting the acceptance of oral contraceptives or of IUDs, but it affects other things, and 2,0% believe it affects the acceptance of intra-uterine devices; 43,0% considered "Other" and 53,0% did not answer.

When respondents were questioned about the anatomy of a woman and its relationship to the acceptance of IUDs, 44,0% consider that there could be a relation between the anatomy and IUCDs.

## **5.4 CONCLUSIONS**

The conclusions are drawn from the findings. It must, however, be noted that in most questions there were substantial missing values owing to respondents' not answering or filling in the questions, which in itself could imply that they did not know how to respond or did not have the knowledge to do so.

### **5.4.1 Section A: Demographic data**

The results of this study indicated that female adolescents who use the Health Centre of the Municipality of Cazenga were, on average, 17 years old, with only one third attending school, and the majority had not attended higher than 8<sup>th</sup> grade. Pregnancy and financial resources were the reasons that led them to not continue their schooling.

The majority of respondents are Catholic and belong to the ethnic linguistic group Kimbundo, while Portuguese is their language of communication. The majority have an extended family and only a quarter discuss sex with the family, while fear and shame are the main reasons why female adolescents do not talk about sex with the family and are more prone to discussing sex with their girl friends.

### **5.4.2 Section B: Adolescence**

With regard to adolescence, there is a high level of ignorance, female adolescents basically do not know the meaning of the term 'adolescence', they are not sure when the adolescent phase starts; the respondents indicated uncertainty about the physical changes that occur during this phase and basically fewer than 50,0% answered the questions.

It was evident that the respondents lack knowledge about the menstrual cycle.

It was ascertained that just over 50,0% of adolescents expressed their opinion with regard to emotional changes during adolescence. This can be explained, as in some way life for them seems to be lived at a more intense level than before. As regards their talking to their mothers about sex, only one in every six adolescents talks to their

mothers about this topic. Menstruation, dating, boyfriends and sexual intercourse are the topics most discussed with their mothers.

### **5.4.3 Section C: Sexuality**

With regard to sexuality it was observed that the majority started having sexual intercourse at an early age; 56,0% of adolescents stated that pre-marital sex was an acceptable act (if the couple were in love or engaged), as well as other topics, and in the majority of cases they were 15 years old or older when they engaged in sexual intercourse, with 12 years of age being the youngest age during which an adolescent started having sexual intercourse.

These results confirmed that, in general, female adolescents indicate having sexual intercourse for love or for being in love, as the main reasons.

Taking into account that the majority started having sexual intercourse at age 15 years, 88,0% of the respondents are aware of the possibility of falling pregnant as a result of having had sexual intercourse without protection, but very few are aware of the fact that this could result in HIV transmission or transmission of other STIs.

It must be pointed out that as far as contraceptive methods are concerned, male condoms are the predominant contraceptive method, although 8,0% had already had abortions, five of these having been done at home and three in the hospital.

### **5.4.4 Section D: Contraception**

Approximately two-thirds of adolescents have heard about contraception but do not know the meaning of contraception. They had, as a source of information most frequently available, nurses and “others”. The lower educational level of the adolescents could have been a determinant of the low level of knowledge on contraception.

As regards the belief in the use of condoms, only 72,0% believe in their use; of these, the most prevalent opinion is that condoms prevent pregnancy.



The present results confirm that, in general, female adolescents seem to have some knowledge on some of the methods of contraception. The method indicated as the best-known is the male condom. The respondents seem to be less aware of the use of the condom. To the question asked “do you use the condom?” only one-third of the respondents indicated using condoms, and the main source for obtaining these is indicated as being the pharmacies. With regard to the question “what contraceptive do you use?”, 37,0% stated they use the male condom and 44,0% indicated “Other”.

The respondents could not identify other oral and emergency contraceptive methods, spermicides, diaphragms, cervical caps, and injectables; these are topics practically unknown to the female respondents. The awareness campaigns on the risks of sexual transmission of the AIDS virus, which promote the use of the male condom when having sexual intercourse, have probably given the male condom a predominant position amongst the younger generation.

#### **5.4.5 Section E: Sexually transmitted infections (STIs)**

A reasonably high percentage of respondents have knowledge of at least, the basic facts of AIDS. That is not the case with HIV; female adolescents seem to be less aware of the facts related to HIV. Some seem to be well informed about HIV but others do not have knowledge in this regard. The majority of female adolescents are also not well informed on how to prevent HIV transmission.

Less than 50,0% of the respondents had heard about STIs (or, perhaps heard about the topic) and seemed to be reasonably well informed about the meaning, as well as the type of transmission. Of the STIs that they know, AIDS seems to be the best known because approximately half had heard of AIDS as an STI, but they did not know that syphilis and gonorrhoea were STIs, or at least did not know them under this terminology.

Of the 100 original respondents, 25% indicated that there were taboos against the use of artificial contraception.

Of the respondents 43,0% indicated that they themselves take the decision about the type of contraceptive to be used.

As far as children are concerned, the majority of respondents consider children as a sign of virility, status or social position and the majority, 75,0% of the respondents, indicated that the gender preference amongst them was for female children.

Menstrual blood was not considered as 'polluting' by 54,0% of the respondents. Approximately two-thirds of the respondents believe that the woman's anatomy is related to the acceptance of oral contraceptives or IUDs.

## **5.5 RECOMMENDATIONS**

Based on the findings, the recommendations will be provided specifically for enhancing the knowledge levels of adolescents with regard to contraception.

As adolescence is a period of major changes at various levels, such as family, social, emotional and personal levels, it is the responsibility of the parents and education and health professionals to alert young female adolescents to the consequences of unprotected sex, and help them to explore values and to feel at ease with sexuality, by means of an adequate education. In this way they may develop enough knowledge and self-confidence to enable them to take wise decisions with regard to their sexual behaviour. Thus it is vital that efforts be multiplied in terms of implementing projects that help to improve the quality of life of female adolescents.

### **5.5.1 Improved knowledge of contraception through the family**

Sexual education must start at birth and be integrated within a global education. The father and the mother are the first intervening parties in the process of sexual learning, both through providing sexual role models and determining values about the body and sexual behaviour. During adolescence, the parents will continue to play a vital role at a different level.

Therefore it is of the utmost importance to develop sexual education programmes not only for female adolescents but also for fathers and mothers, taking into consideration their educational levels and distinct needs as families, with the aim of developing skills on how to talk, without any difficulty, about sexual topics, how to confront conflict, and

how to know how to listen to the questions and the needs of female adolescents. It is thus recommended that:

- Educational programmes should be launched in all clinics and communities on sex education and contraception to improve communication between parents/families and the adolescents.
- As most adolescents received some sex education from their mothers, but lacked information about contraception, a concerted drive should be launched in the Cazenga District, in Luanda, Angola to teach adult women about pregnancy and contraception. Moreover, these adult women should be assisted through appropriate teaching strategies such as role-play and case studies to facilitate their task of providing sex education to their daughters. Joint sex education sessions for mothers and adolescent daughters should also be offered by knowledgeable health care staff members.

### **5.5.2 Improving knowledge with regard to contraception for female adolescents**

Based on the conclusions, the following recommendations might begin to address some of the knowledge that adolescents should have about contraceptives:

- Adolescents should receive sex education before they reach the age of 12.
- Such sex education topics should include menstruation, sexual intercourse, pregnancy and contraception. Sex education should be repeatedly offered and by the time the adolescent girls reach the age of 14, they should be knowledgeable about different contraceptives and about the accessibility thereof.
- Education on contraception should also include discussion of emergency contraception and termination of pregnancy.
- Contraception information sessions should also address which side-effects might occur from using specific contraceptives, so that women can make informed choices. Full details must be given on how the contraceptives work, the side-effects and medication to be taken for the side-effects, as well as full details of how the contraceptives should be taken or applied/inserted. Discontinuation of one method and commencement of another method should only be done under the guidance of knowledgeable clinic staff if unplanned pregnancies are to be avoided. All adolescents should be advised to use condoms should they be

forced to discontinue the use of any contraceptive method, in order to prevent both unwanted pregnancies and STIs, including HIV and AIDS.

- Contraceptives, emergency contraceptives and TOP services should be freely accessible to all adolescents – including school children.
- Clinics providing reproductive health services for adolescents only should be available over weekends and during the evenings.
- Specific policies should guide clinic nurses about issues such as the types of contraceptive to be issued to adolescents; maintaining a non-judgemental attitude towards sexually active adolescents; and facilitating adolescents' success with contraceptives, emergency contraceptives and TOP services – not obstructing these efforts – if the issue of adolescent pregnancies is to be addressed successfully in the Cazenga area particularly, but also elsewhere.
- The majority of the adolescents did not have knowledge of emergency contraceptives. It is thus recommended that emergency contraceptives be advertised in clinics, at schools and also during radio and television broadcasts. Better utilisation of emergency contraceptives could assist adolescents to postpone having children until they are emotionally, socially and financially capable of caring for their children. However, adolescents who need emergency contraception need to be counselled in this regard.
- Educators should provide moments to reflect, to think about the responsibilities involved in sexual practices, to discuss gender relations in terms of relationships, because this aspect is directly linked to pregnancy in adolescence.
- During sexual education, the adolescent must not be limited to purely informative aspects. The adolescent must take an active and participative role in sexual education, from planning the activities, debating ideas on personal and social values and gathering information to conducting debates and moments of reflection, as well as evaluating these services.
- Adolescents should be given the chance to exchange opinions with their peer group about what has been taught with regard to sexual education.

### **5.5.3 The Ministry of Education**

- With the aim of encouraging the National Education Institute (*Instituto Nacional de Educação (INIDE)*), education agents should be trained to cooperate with the Ministry of Health.
- Educational approaches to themes related to human sexuality must be created as part of curricula and of extracurricular activities, according to the needs of female adolescents.
- Support should be given to families in terms of sexual education for female adolescents, because of the family's involvement in teaching/learning.
- Mechanisms should be established for individualised support specifically geared towards female adolescents who need it, through the creation of partnerships between the school and the community and with the health services.

According to the advice provided by Bradley and Dubinsky (1995:80), school curricula and extra curriculum activities must also address child development, as well as the principle of maternity, in accordance with the needs of female adolescents.

### **5.5.4 The Health Centres**

In order to provide counselling it is necessary to have an environment of support and encouragement and the counselling expert must be able to create a relationship with the user and to speak in a language that the user can understand.

### **5.5.5 The Ministry of Health**

- Space should be created for family planning consultation in which the female adolescent can, through a process of reflection, perceive herself as an individual responsible for her body and for her will, able to identify risk situations to which she is exposed. Privacy is a right of the female adolescent; irrespective of her age, she must be attended to alone, within a private space for consultation.
- Information must be provided which makes it possible for her to know her body, as well as to learn about the anatomy and physiology of the female and male reproductive system.

- Existing contraceptive methods should be presented by discussing the advantages and disadvantages, trying to empower the female adolescent, preferably together with the partner, to choose the method most adequate to her life context.
- The concept of double protection should be discussed, as any proposal aimed at the reproductive health of adolescents must, inevitably, bring with it the objective not only of protecting against pregnancy but also against STIs.
- There must be patience, opportunity and willingness to inform adolescents, from both genders, through sexual education (Leal & Saito 2003:36-37).

Bradley and Dubinsky (1995:80) are of the opinion that if female adolescents were more informed about the needs of a real baby, they probably would have a more careful and responsible attitude with regard to pregnancy.

#### **5.5.6 The media**

The media should:

- Try to invest in the development of personal discipline in adolescents and try to better utilise the means of social communication, with a view to enabling better and more correct sex education to adolescents.
- Actively partake in the dissemination of programmes on contraception and, if possible, create and open a specific channel for adolescents.

### **5.6 RECOMMENDATIONS FOR ADDITIONAL RESEARCH**

While conducting the research and compiling the report, it became apparent that further research is required:

- According to the results obtained in the study, it would be of vital importance in the future to study not only the knowledge of adolescents but also their attitudes and their practices with regard to contraception.

- Questionnaires should be administered to adolescents at schools or homes in order to identify factors that might contribute to their non-utilisation of contraceptives.
- A survey could be conducted on adolescents' attitudes towards contraceptives, including those of male adolescents.
- Research could be conducted to evaluate what mothers teach and fail to teach their adolescent daughters about menstruation, sexual intercourse, pregnancy and contraception.

The use of the condom prevents the transmission of sexually transmitted infections (STIs) as well as preventing pregnancy. According to Moura (2005:3), in Angola the first marriage or first union usually marks the start of the reproductive period. As Angola is a country with a high level of HIV/AIDS, It would be advisable to study, in the future, another relevant topic: How should women with AIDS fall pregnant?

## **5.7 LIMITATIONS OF THE STUDY**

The following limitations which could limit the generalisability of the research results were identified:

- Tuition and supervision of the dissertation was through the medium of distance tuition and in addition to the language difficulty, distance education proved a personal limitation during the study, mainly because when it came to discussing problems, direct communication with the lecturers was not possible. All the communication was done through interpreters.
- The lack of up-to-date data and reference sources in Angola related to the topic proved something of a limitation.
- During the collection of data the adolescents were extremely impatient, which is normal for this age; they were impatient with regard to the questions presented, and the time required. Many felt shy with respect to some issues, especially those related to sex, and some withdrew from the study at the time of the interview.
- Only adolescent females who had not had children yet participated in this study. Consequently the results might not be generalisable to adolescent girls who have

already had children and to male adolescents (who did not participate in the study).

- To date, no literature is available on the knowledge of female adolescents on contraception in the Cazenga District, Luanda Angola; thus the researcher had no data for comparison.

Despite these limitations this study attempted to identify the knowledge female adolescents in the Cazenga area in Luanda have of contraception. The recommendations and the findings should be viewed against these limitations.

## **5.8 CONCLUSION**

This study was focused on the Angolan background, noting that the country's health ministry is in a post-war phase. A quantitative approach was applied using an exploratory and descriptive design, utilising a structured interview schedule to collect the data.

The findings indicated that the majority of the adolescents had limited knowledge about contraception and sexually transmitted infections, of which HIV/AIDS is one. The major knowledge gaps that were identified in this study were the female adolescents' knowledge about most of the contraceptives (oral, injectables, IUCDs and emergency contraceptives). Most of the adolescents received their sex education from their mothers, most of whom failed to teach them about contraceptives. Empowering the mothers to provide health education to their daughters might enhance the adolescents' utilisation of this knowledge in the Cazenga area in Luanda, Angola.

Recommendations were made with a view to enhancing the knowledge of female adolescents with regard to contraception in order for them to be able to make safe and appropriate decisions about their sexual and reproductive lives.



## BIBLIOGRAPHY

A, África. 2004. *Expanding family planning and reproductive health services in Africa*. <http://www.advanceafrica.org/publications>.

Afonso, E & Lucas, AP. [s.a.] *Sexuality in adolescence*. <http://honupage.oninet.pt/517mbw/> Sexuality in Adolescence.Pdf.

African Region. Brazzaville. Regional Office for Africa.

AIDS Network. 2005. Angola. <http://www.redesida.org/verpais.asp?Idpais=1>

Angola. 1998. National Directorate for Public Health (Direcção Nacional de Saúde Pública). Directorate General for Health.

Angola. 1999. Ministry of Health (Ministério da Saúde).

Angola. 2000. Ministry of Health. Act no. 21-B/92 of 28 August 2000, which establishes the Policies and Norms for the Provision of Services in Reproductive and Sexual Health.

Angola. 2002. General norms for the health units of the National Health Services. Article 2:2. Luanda.

Angola. 2004a. *Annual Report. 47<sup>th</sup> Session of the International Conference on Education*. Luanda: Ministry of Education.

Angola. 2004b. *Coordination of obstetric services in Luanda* ((Coordenação do Atendimento Obstétrico de Luanda CAOL). Luanda.

Angola. 2004c. National Directorate for Public Health (Direcção Nacional de Saúde Pública) *Report*. Luanda: DNSP.

Angola. 2005. Cazenga Municipal Committee for Education. Luanda.

Angola. *Project SSR/ST/HIV/AIDS adolescents and youngsters*. 2001–2004. Centre for Support to the Youth (Centro de Apoio aos Jovens – CAJ). Luanda.

Anticoncepcionais na adolescência. 2005.

Azevedo, G. 2001. *Adolescence*. 2<sup>nd</sup> edition. São Paulo: Scipione Publishers.

Baptista, EM. 2001. Sexuality: metaphorically speaking. *Association for Family Planning* (31)

Belfield, T. 1998. The future of contraception and you. *Nursing Times* 94(29):26-32.

Bellamy, C. 2005. *World situation of threatened childhood*. Brasilia: UNICEF.

Bradley, J & Dubinsky, H. 1995. *Adolescence: How to understand your child 15–17 years*. Rio de Janeiro: Imago.

- Brink, H. 2006. *Fundamentals of research methodology for health care professionals*. 2<sup>nd</sup> edition. Cape Town: Juta.
- Buga, GA, Amoko, DHA & Ncayiyana, DJ. 1996. Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei. *South African Medical Journal* 85(5):523-527.
- Burns, N & Grove, SK. 2005. *The practice of nursing research: conduct, critique and utilization*. 5<sup>th</sup> edition. St Louis: Saunders.
- Casterline, JB, Sathar, ZA & UL Haque, M. 2001. Obstacles to contraceptive use in Pakistan: a study in Punjab. *Studies in Family Planning* 32(2):95-110.
- Cavasin, S & Arruda, S. 2005. *Pregnancy in adolescence: another focus*. Brazil. <http://www.intelecto.Net/cidadania/gravidez.htm>.
- Chagas, A. 2005. Adolescence: a contradictory phenomenon. <File/F:/rensta%20Catharsis%20-%20artigos%20Hoje.htm>, accessed 29-03-2005.
- Collins English Dictionary*. 1991. 3rd ed. Glasgow: Harper Collins.
- Cronje, HS & Grobler, CJF (eds). 2003. *Obstetrics in Southern Africa*. 2<sup>nd</sup> edition. Pretoria: Van Schaik.
- Contraceptives in adolescence – Pregnancy in adolescence*. 2005. <http://estudmed.com.sapo.pt/trabalhos/anticoncepcionais-adolescência-4.htm>.
- Ehlers, VJ. 1999. Factors influencing women's health in developing African countries. *Health SA Gesondheid* 4(2):48-55.
- Ehlers, VJ. 2003. Adolescent mothers' knowledge and perceptions of contraceptives in Tshwane, South Africa. *Health SA Gesondheid* 8(1):13-25.
- Ehlers, VJ, Maja, T, Sellers, E, Gololo, M. 2000. Adolescent mothers' utilization of reproductive health services in the Gauteng Province of South Africa. *Curationis* 23(3):43-51.
- Family Planning Manual (Manual de Planeamento Familiar) 1999.
- Fernandes, MC. 2005. *Woman in the process of development*: 1-8. <http://www.uea - angola. org/ artigo.cfm?ID = 86>.
- Fraser, DM, Cooper, MA & Nolte, AGW (eds). 2006. *Myles textbook for midwives*. African Edition. London: Churchill Livingstone.
- Furlani, J. 2000. *Sexual education*. NBR 6023. [www.Jimena.net](http://www.Jimena.net).
- Garcia, SJ. 2005. *Sexuality in adolescence*. [http://www.lbrase.com.br/textos/2005/adolescente\\_surupi](http://www.lbrase.com.br/textos/2005/adolescente_surupi).
- Ghouayel, HB. 2001. Reproductive health and reproductive rights: a case of human rights. *Association for Family Planning* (32).

Ghouayel, HB. 2001. Saúde reprodutiva e direitos de reprodução: um caso de direitos humanos. *Associação para Planeamento Familiar* (32).

Gmeiner, A, Van Wyk, S & Mpshe, WS. 2002. Educational support for adolescents who opted for termination of pregnancy. *Health SA Gesondheid* 7(4):14-23.

Hatcher, RA, Rhinehart, W, Blackburn, R, Geller, JS & Shelton, TD. 1997. *The essentials of contraceptive technology*. Baltimore: The John Hopkins University, School of Public Health.

Heaven, PCL. 2001. *Contemporary adolescence: a social psychological approach*. New York: Palgrave.

Helman, CG. 2007. *Culture, health and illness*. 5<sup>th</sup> edition. London: Hodder Arnold.

<http://pt.wikipedia.org/wiki/Angola>, accessed 26-04-2007.

<http://www.redesida.org/verpais.asp?idpais=1>, accessed 11-03-2005.

Houaiss, A & Salles, VM. 2001. *Houaiss Dictionary of the Portuguese Language*. Rio de Janeiro: Objectiva.

Hulton, CA, Cullen, R & Khalokho, SW. 2000. Perceptions of risks of sexual activity and their consequences among Ugandan adolescents. *Studies in Family Planning* 31(1):35-46.

IPPF Declaration/International Medical Advisory Panel (IMAP). 1995. Contraceptive Effectiveness. *Association for Family Planning* (5).

Leal, I. 2001. Voluntary interruption of pregnancy. *Association for Family Planning*. (28/30).

Leal, MM & Saito, MI. 2003. *The exercise of sexuality in adolescence: contraception in question*. São Paulo,

Lemba, A. 2002. *Knowledge, attitudes and practices related to prevention of HIV in small children and adolescents*.

[www.sarpn.org.za/documents/d0001099/index.php](http://www.sarpn.org.za/documents/d0001099/index.php)

Lisboa. 2001. *Reproductive health – family planning*. General Health Directorate. Lisbon: Department of Maternal, Child and Adolescent Health.

LoBiondo-Wood, L & Haber, J. 2001. *Research in nursing; methods, critical evaluation and use*. 4<sup>th</sup> edition. Rio de Janeiro: Guanabara-Koogan.

Lowdermilk, DL, Perry, SE & Bobak, IM. 2002. *Care in maternal nursing*. 5<sup>th</sup> edition. Porto Alegre: Artmed.

Mbambo, OE, Ehlers, VJ & Monareng, LV. 2006. Factors influencing adolescent mothers' non-utilization of contraceptives in the Mkhondo area. *Health SA Gesondheid* 11(4):22-30.

MICS (Multiple Inquiry Cluster Survey). 2003. *Evaluation of the situation of Angolan children and women at the beginning of the millennium*. Luanda: National Statistics Institute.

Miller, DF. 1992. *Dimensions of community health*. Dubuque: Wm Brown.

Morgado, LM, Pereira, M & Canavarro, MCA. 2005. *Adolescence, woman and AIDS*. [http://www.Aidscongress.net/article.php?id\\_comunicaçao=176](http://www.Aidscongress.net/article.php?id_comunicaçao=176).

Moura, HA. 2005. *Reproductive health and the condition of women in the Republic of Angola*. <http://www.claso.org>.

Mwaba, K. 2000. Perception of teenage pregnancies among South African adolescents. *Health SA Gesondheid* 5(3):30-34.

Municipal Education Delegation of the Municipality of Cazenga. 2006.

Neto, ACS. 2005. *Pregnancy in adolescence*. <http://www.ilustrados.com>.

Nodin, N. 2001. Adolescents, sex and the others. *Association for Family Planning* (31).

Onega, LL. 2000. *Educational theories, models and principles applied to community and public health nursing*, in *Community and public health nursing* edited by L Stanhope and J Lancaster. 5<sup>th</sup> edition. St Louis: Mosby.

Paikoff, KL. 1990. Attitudes towards consequences of pregnancy in young women attending a family planning clinic. *Journal of Adolescent Research* 5(4):467-484.

Pera, SA & Van Tonder, S. 2005. *Ethics in health care*. 2<sup>nd</sup> edition. Cape Town: Juta.

Pitman, T & Barrett, J. 2000. *Pregnancy and childbirth: the best proofs*. 1<sup>st</sup> edition. Lisboa: Livraria Escolar.

Polit, DF & Beck, CT. 2004. *Nursing research: principles and methods*. 7<sup>th</sup> edition. Philadelphia: Lippincott.

Polit, DF, Beck, CT & Hungler, BP. 2004. *Research principles in nursing: methods, evaluation and use*. 5<sup>th</sup> edition. Porto Alegre: Artmed.

Portugal. 1998. *Reproductive health – Family Planning* 9. Lisbon: General Directorate for Health.

Praça, SN. 2005. *Nursing manual STD/AIDS, woman's sexuality and self-care*. [www.ids-saude.org.br/enfermagem](http://www.ids-saude.org.br/enfermagem), accessed 2006.

Provincial Director of Health, Luanda (Direcção Provincial de Saúde de Luanda) 2004.

RHRU. 2000. *Adolescent Sexual and Reproductive Health Rights document* 2000. National Directorate of Public Health: Angola.

Rita, F, Feio, R & Fagundes, A. 2004. *Policies and norms for the provision of services in sexual and reproductive health*. 2<sup>nd</sup> edition. Luanda: National Directorate for Public Health.

*Sexuality in adolescence*. 2005. [http://Saúde.sapo.pt/gkBF/2813\\_38html](http://Saúde.sapo.pt/gkBF/2813_38html).

Silberschmidt, M & Rasch, V. 2001. Adolescent girls, illegal abortions and “sugar-daddies” in Dar es Salaam: vulnerable victims and active social agents. *Social Science and Medicine* 52:1815-1826.

Silva, A, Martins, A, Neves, D & Lopes, S. 1999. Sexual education; Whose responsibility is it? *Association for Family Planning* (23/23).

Teacher's Pedagogical Guide. 2000. *Pedagogic outlines*. Luanda:

Tiba, I. 1994. *Adolescence and the awakening of sex: guide to understand sexual and affective development amongst the new generations*. São Paulo: Gente.

Trindade, MJ. 2002. Sexual and reproductive rights in primary health care. *Association for Family Planning* (34).

United Nations International Conference on Population Development (ICPD). 1994. 5-13 September. Cairo, Egypt. <http://www.iisd.ca/Cairo.html>.

Vicente, L & Lopes, J. 1999. Condom: speaking so as not to forget. *Association for Family Planning* (23/24)

Vilar, D. 1994. Communication: parents, adolescent children on sexuality. *Association for Family Planning* (29/30).

Vitalle, MSS & Amâncio, OMS. 2005. *Pregnancy in adolescence*. São Paulo. [http://www.brasilpedenews.Org.br/set\(2001\)./bnpar101.htm](http://www.brasilpedenews.Org.br/set(2001)./bnpar101.htm).

Vitoria, C,G, Knauth, DR & Hassen, MNA. 2000. *Qualitative research in health*. Porto Alegre: Editorial volume

Watt, CD. 2001. Pregnancy prevention in primary care for adolescent males. *Journal of Pediatric Health Care* 15(5):223-228.

WHO (World Health Organization). 1988.

WHO (World Health Organization). 2005.

WHO (World Health Organization). 2001. *Adolescents' health in the African Region* (Saúde dos Adolescentes para a Região Africana). WHO.

Williams, CX & Mavundla, TR. 1999. Teenage mothers' knowledge of sex education in a general hospital of the Umtata district. *Curationis* March:58-62.

Zapian, J,G. 2002. Sexual-affective education. *Association for Family Planning* (35).

**REPÚBLICA DE ANGOLA  
UNIVERSIDADE AGOSTINHO NETO  
INSTITUTO SUPERIOR DE ENFERMAGEM**

Exmo. Sr. Director do  
Centro de Saúde  
Asa Branca

**Assunto:** AUTORIZAÇÃO PARA A REALIZAÇÃO DE PESQUISA

Os nossos respeitosos cumprimentos.

Solicita-se, pela presente, autorização de V. Exa. para se efectuar pesquisa no Centro de Saúde Asa Branca, para um projecto de dissertação sobre o tópico “Conhecimento das Adolescentes sobre Contracepção numa área seleccionada de Luanda, Angola”.

Encontro-me presentemente matriculada na Universidade da África do Sul onde estou a finalizar o grau de mestrado em Ciências de Saúde (com especialização em Obstetrícia e Neonatologia). O projecto de pesquisa integra-se nos requisitos para finalizar o referido grau de Mestrado.

A minha proposta para o projecto de pesquisa foi já aprovada pelo departamento de Estudos de Saúde da Universidade da África do Sul.

O objectivo do projecto de pesquisa é identificar e escrever os conhecimentos das adolescentes com relação à contracepção numa área seleccionada de Angola. Para tal é necessário o preenchimento de um questionário, de forma a proporcionar à pesquisadora a recolha dos dados necessários para a pesquisa. Assim, solicitava a V. Excelência autorização para distribuir o referido questionário a possíveis participantes na pesquisa.

A pesquisadora assegura o cumprimento rigoroso de todas as condições e medidas éticas na realização da pesquisa e de modo a evitar quaisquer danos e a proteger a confidencialidade dos participantes.

Muito agradecia a cooperação e apoio de V. Excelência neste sentido, conferindo-me autorização para realizar a pesquisa.

Com os melhores cumprimentos

Subcrevo-me atenciosamente

\_\_\_\_\_  
Engrácia da Glória Gomes de Freitas  
Mestranda

Luanda, aos 9 de Julho de 2006

**REPUBLIC OF ANGOLA  
UNIVERSITY AGOSTINHO NETO  
HIGHER INSTITUTE FOR NURSING**

**The Director  
Asa Branca Health Centre**

**RE: AUTHORIZATION TO CONDUCT RESEARCH**

Our most cordial greetings.

We herewith would like to request your permission to conduct research at the Asa Branca Health Centre for purposes of a dissertation on the topic "Knowledge of Female Adolescents on Contraception in a selected area of Luanda, Angola".

I am presently registered at the University of South Africa where I am completing the Master's degree on Health Sciences (with specialization in Obstetrics and Neonatology). The research project is part of the requirements to complete the referred Master's degree.

My research proposal has already been approved by the Department of Health Studies at the University of South Africa.

The aim of the research project is: to identify and report on the knowledge of female adolescents with regards to contraception in a selected area of Angola. For such it is necessary to fill in a questionnaire so as to enable the researcher to collect the necessary data for the research.

Therefore I hereby request your permission to distribute the above mentioned questionnaire to potential participants in the research.

The researcher undertakes to rigorously adhere to all ethical considerations and measures in conducting the research so as to prevent any potential damage and in order to protect the confidentiality of participants.

I would be very grateful if you assist me in this regard by granting me permission to conduct the research.

Yours truly,

Signed)  
Engrácia da Glória Gomes de Freitas  
MA Student

Luanda, 9 July 2006





REPÚBLICA DE ANGOLA  
MINISTÉRIO DA SAÚDE

CENTRO DE SAÚDE ASA BRANCA

À  
Direcção da Universidade Sul Africana (UNISA)

Luanda

Assunto: Nota 12 / 007

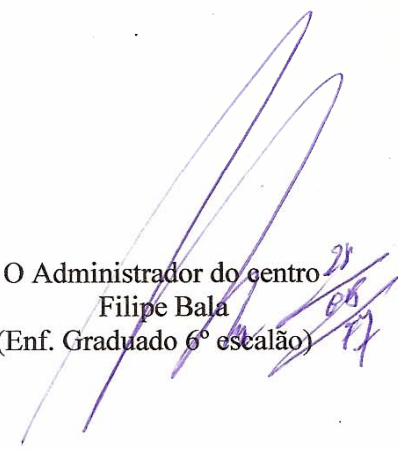
Em resposta a carta datada no dia 9 de 7 de 2006 , da senhora Engrácia da Glória Gomes de Freitas , estudante do mestrado em obstetrícia e Neonatologia da instituição acima citada , essa direcção do centro não tem qualquer inconveniência sobre a sua solicitação.

Sem outro assunto de Momento

Saudações Laborais.

. Luanda , aos 28 de Maio de 2007

O Administrador do centro  
Filipe Bala  
(Enf. Graduado 6º escalão)





[LOGO]

**REPUBLIC OF ANGOLA  
MINISTRY OF HEALTH**

**ASA BRANCA HEALTH CENTRE**

**The University of South Africa  
(UNISA)**

Luanda

Re: Notification 12 / 007

In reply to your letter dated 9 / 7 / 2006, submitted by Mrs Engrácia da Glória Gomes de Freitas, a masters' student in obstetrics and in the above mentioned institution, this centre's management committee does not have any objection to the request.

With regards

Luanda, 28 May 2007

The Centre Administrator  
Signed) Filipe Bala  
(Level 6 Professional Nurse)  
28/05/07

## Consentimento de Participação em Pesquisa

1

Eu, abaixo-assinado, .....,  
Concordo pelo presente documento a:

- Participar no estudo de pesquisa sobre o (tópico)

Conhecimento das adolescentes sobre contracepção numa área seleccionada de Luanda, Angola

- preencher o questionário relevante;
- autorizar o pesquisador a utilizar, a sua descrição, os dados por mim proporcionados no referido questionário, para fins de elaboração do relatório do pesquisador sobre a pesquisa realizada

Afirmo também ser o meu entendimento que

- Posso, em qualquer altura, terminar o meu envolvimento nesta pesquisa ou rescindir o meu consentimento para participar na mesma.
- a informação por mim providenciada até a altura em que rescindir a minha participação nesta pesquisa pode, no entanto, continuar a ser utilizada pelo pesquisador;
- o pesquisador manterá sempre, rigorosa confidencialidade e que a identidade do participante não será nunca ligada a informação providenciada;
- não receberei qualquer recompensa ou compensação financeira pela informação aqui providenciada ou pelo meu envolvimento neste projecto;
- tenho a opção de me recusar a responder a (quaisquer) pergunta (s) caso considere que esta (s) constitua/constituam violação da minha própria privacidade;
- ao assinar o presente consentimento de participação comprometo-me a responder honestamente a todas as perguntas razoáveis e a não

providenciar informação errónea ou de qualquer outra forma induzir,  
propositadamente, em erro o pesquisador;

- ser-me-á providenciada uma copia original deste consentimento de participação após a minha assinatura do mesmo.

Declaro pelo presente que o pesquisador

- me explicou em detalhes o objectivo deste projecto de pesquisa
- me informou e explicou-me o conteúdo deste consentimento de participação
- me esclareceu sobre a implicação da assinatura deste consentimento de participação

Ao co-assinar este consentimento de participação, o pesquisador compromete-se a

- manter confidencialidade e privacidade relativamente à identidade do participante e à informação proporcionada pelo participante na pesquisa
- organizar, antecipadamente, um local e hora apropriada para a realização da minha participação neste projecto
- a guardar em seguro o duplicado do presente consentimento de participação.

Assinado em-----, aos-----de-----2006

-----

Assinatura do Participante

-----

Assinatura do Pesquisador

-----

Assinatura do Pai/ Mãe/ Encarregado de Educação

## Consent to Partake in Research

I, the undersigned, .....  
herewith agree to:

- partake in the research on the (topic)  
Knowledge of female adolescents on contraception in a selected area of Luanda, Angola;
- fill in the relevant questionnaire
- authorize the researcher, to use, at her discretion, the data that I have provided in the questionnaire, for purposes of writing the researcher's report on the research that was carried out.

Furthermore I also state that it is my understanding that

- I may, at any time, discontinue my involvement in this research or withdraw my consent to partake in this research;
- the information that I have provided until such time as I withdraw my participation in this research can, however, still be used by the researcher;
- the researcher will, at all times, maintain strict confidentiality and that the identity of the participant will never be linked to the information provided;
- I will not receive any financial reward or payment for the information herewith provided or for my involvement in this project;
- I have the option to refuse to answer (any) question(s) should I feel that this/these question(s) constitute a violation of my own privacy;
- when signing this consent form to partake in the research I undertake to answer in an honest manner to all reasonable questions and not to provide any false information or in any other way purposely mislead the researcher
- I will be provided with a signed original copy of this consent form

I herewith declare that the researcher

- has explained to me the objective of this research
- has informed and explained to me the content of this consent to partake in the research
- has elucidated me on the implications of signing this consent to partake in the research

By co-signing this consent to partake in the research, the researcher undertakes to

- maintain confidential and private the identity of the participant and the information provided in the research
- organized, beforehand, an appropriate venue and time for me to partake in this project
- to keep in a safe place the duplicate of this consent to partake in the research

Signed in ..... on ..... 2006.

.....  
PARTICIPANT'S Signature

Signed) illegible  
RESEARCHER'S Signature

-----

Signature of Father/Mother/Legal Guardian

## THE KNOWLEDGE OF ADOLESCENT'S REGARDING CONTRACEPTION IN A SELECTED AREA IN LUANDA, ANGOLA

Number of questionnaire:

1	2	3

### 1 OBJECTIVES

- To evaluate the knowledge of adolescents about contraception.
- To determine the source of information about the use of contraception.
- To make recommendations for guidelines for educational programmes on contraception.

### 2 ETHICAL CONSIDERATIONS

All information herewith provided will be treated confidentially. It is not necessary to indicate your name in this questionnaire.

### 3 INSTRUCTIONS

- 3.1 Please answer all questions.
- 3.2 Answer the questions by providing an "X" in the box corresponding to the chosen alternative.
- 3.3 Please answer all questions as honestly, frankly and objectively as possible.
- 3.4 Answer according to your own personal opinion and experience.
- 3.5 Please return the questionnaire by ..... 2006.

Answer the questions by placing an “X” in the box corresponding to the alternative which is applicable to you or write down your response in the space provided.

## SECTION A: DEMOGRAPHIC DATA

1 How old are you?

*For official use only*

Age	ANSWER
1.1 13 years or younger	1
1.2 14 years	2
1.3 15 years	3
1.4 16 years	4
1.5 17 years	5
1.6 Older than 17 years	6

	4
--	---

2 Do you attend school?

*For official use only*

	YES	NO
School attendance	1	2

	5
--	---

3 If YES, what is the highest grade you have passed to date?

*For official use only*

Level of schooling	ANSWER
3.1 5 <sup>th</sup> grade	1
3.2 6 <sup>th</sup> grade	2
3.3 7 <sup>th</sup> grade	3
3.4 8 <sup>th</sup> grade	4
3.5 9 <sup>th</sup> grade	5
3.6 10 <sup>th</sup> grade	6
3.7 11 <sup>th</sup> grade	7
3.8 12 <sup>th</sup> grade	8
3.9 Other (please specify) .....	9

	6
--	---

4 If you do not attend school, what do you do?

*For official use only*

Activities	YES	NO
4.1 Work at a market	1	2
4.2 Work at home	1	2
4.3 Assist parents	1	2
4.4 Look after children	1	2
4.5 Nothing	1	2
4.6 Other (please specify) .....	1	2

	7
	8
	9
	10
	11
	12

5 If you do not attend school, state the reasons.

*For official use only*

Reasons	YES	NO
5.1 Have no money	1	2
5.2 Not encouraged by parents	1	2
5.3 Pregnant	1	2
5.4 Not motivated	1	2
5.5 Bad experience at school	1	2
5.6 Bullying or abuse by teaching	1	2
5.7 Other (please specify) .....	1	2

	13
	14
	15
	16
	17
	18
	19

6 To what ethnic group do you belong?

*For official use only*

Ethnic group	ANSWER
6.1 Kindundo	1
6.2 Umbundu	2
6.3 Ganguela	3
6.4 Kuanhama	4
6.5 Other (please specify) .....	5

	20
--	----

7 What is your religious affiliation?

*For official use only*

Church which you belong to	ANSWER
7.1 Catholic	1
7.2 Evangelical	2
7.3 Mana	3
7.4 Simao Toco	4
7.5 Messianic	5
7.6 Universal do Reino de Deus	6
7.7 Jehovah Witness	7
7.8 None	8
7.9 Other (please specify) .....	9

	21
--	----



8 What language do you speak?

*For official use only*

Language spoken	YES	NO
8.1 Kimbundu	1	2
8.2 Kikongo	1	2
8.3 Fiole	1	2
8.4 Tchiokwe	1	2
8.5 Other (please specify) .....	1	2

	22
	23
	24
	25
	26

9 Who does your immediate family consist of?

*For official use only*

Family structure	YES	NO
9.1 Father	1	2
9.2 Mother	1	2
9.3 Brothers	1	2
9.4 Sisters	1	2
9.5 Adoptive parents	1	2
9.6 Grandparents	1	2
9.7 Other (please specify) .....	1	2

	27
	28
	29
	30
	31
	32
	33

10 Do you discuss sex with your family?

*For official use only*

	YES	NO
Discussion of sex	1	2

	34
--	----

11 If YES, what do you discuss? Write down your discussion.

.....

.....

.....

12 If your answer is NO to question 10, state the reasons.

*For official use only*

Reasons	YES	NO
12.1 Parents are old fashioned	1	2
12.2 I am shy	1	2
12.3 Do not want family to know I am interested	1	2
12.4 Family might think I am promiscuous	1	2
12.5 Family do not understand me, will be rejected	1	2
12.6 Conflict with family	1	2
12.7 Other (please state) .....	1	2

	35
	36
	37
	38
	39
	40
	41

13 To whom in your family are you the closest?

*For official use only*

Family which are the closest	ANSWER
13.1 Mother	1
13.2 Father	2
13.3 Brother	3
13.4 Sister	4
13.5 Adoptive parents	5
13.6 Other (please specify) .....	6

	42
--	----

14 Do you discuss sex with your friends?

*For official use only*

	YES	NO
Discuss sex with your friends	1	2

	43
--	----

15 If your answer is YES, state reasons.

*For official use only*

Reasons	YES	NO
15.1 We are the same age	1	2
15.2 My friends understand me	1	2
15.3 I feel more free to talk to them	1	2
15.4 Friends are faithful to me	1	2
15.5 Other (please specify) .....	1	2

	44
	45
	46
	47
	48

- 16 If your answer is NO to question 14, explain in your own words the reasons why you do not discuss sex with your friends.

.....

.....

- 17 What do you understand by the menstrual cycle?

***For official use only***

Menstrual cycle	YES	NO
17.1 Cycle of 28 days	1	2
17.2 Bleeding to cleanse body	1	2
17.3 Period in which you are fertile	1	2
17.4 Time in which you can ovulate and fall pregnant	1	2
17.5 Other (please specify) .....	1	2

	49
	50
	51
	52
	53

## SECTION B: ADOLESCENCE

18 What do you understand by the term “adolescence”?

*For official use only*

Term “adolescence”	YES	NO
18.1 It is a period in the life of an individual during which you are neither a child nor an adult	1	2
18.2 It is a period of childhood of the individual	1	2
18.3 It is a period of the adult life of the individual	1	2
18.4 It is a period of latency	1	2
18.5 Acquiring a masculine or feminine social role	1	2
18.6 Accepting one’s physique and using the body effectively	1	2
18.7 Becoming emotionally independent of parents and other adults	1	2
18.8 Preparing for marriage and a family life	1	2
18.9 Selecting and preparing for a career	1	2
18.10 Acquiring values and an ethical system as a guide to behaviour	1	2
18.11 Period of emotional development	1	2
18.12 Joining a peer group	1	2
18.13 Other (please specify) .....	1	2

	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66

19 At what age does adolescence start?

*For official use only*

Beginning of adolescence	ANSWER
19.1 8-10 years of age or younger	1
19.2 11-12 years	2
19.3 13-14 years	3
19.4 15-16 years or older	4

	67
--	----

20 Do adolescents experience physical changes?

*For official use only*

	YES	NO
Experience physical changes	1	2

	68
--	----

21 If your answer is YES on the previous question, what are the physical changes?

*For official use only*

Physical changes	YES	NO		
21.1 Growth of eyes	1	2		69
21.2 Breast development	1	2		70
21.3 Change in voice	1	2		71
21.4 Pubic hair growth	1	2		72
21.5 Onset of menstruation	1	2		73
21.6 Other (please specify)	1	2		74

22 What emotional changes can you expect during the adolescent phase?

*For official use only*

Emotional changes	YES	NO		
22.1 Mood swings	1	2		75
22.2 Depression	1	2		76
22.3 Anger	1	2		77
22.4 Guilt	1	2		78
22.5 Inferiority complex	1	2		79
22.6 Isolation	1	2		80
22.7 Identify confusion	1	2		81
22.8 Shame and doubt	1	2		82
22.9 Despair	1	2		83
22.10 Other (please state) .....	1	2		84

23 Do you discuss sex with your mother?

*For official use only*

	YES	NO		
Discuss sex with your mother	1	2		85

24 If YES, state the topics.

*For official use only*

Topics	YES	NO		
24.1 Menstruation	1	2		86
24.2 Dating and boyfriends	1	2		87
24.3 Sexual morality	1	2		88
24.4 Conception	1	2		89
24.5 Birth control	1	2		90
24.6 Sexual intercourse	1	2		91
24.7 Bodily changes	1	2		92
24.8 Homosexuality	1	2		93
24.9 Abortion	1	2		94
24.10 Other (please specify) .....	1	2		95

## SECTION C: SEXUALITY

25 Which sexual behaviours are part of your orientation?

*For official use only*

Sexual behaviours	YES	NO
25.1 Premarital sex – couple casually acquainted	1	2
25.2 Premarital sex – couple in love	1	2
25.3 Premarital sex – couple engaged	1	2
25.4 Premarital sex – one night stand	1	2
25.5 Masturbation	1	2
25.6 Homosexuality	1	2
25.7 Oral-genital sex	1	2
25.8 Anal sex	1	2
25.9 Sexual fantasising	1	2
25.10 Other (please specify) .....	1	2

	96
	97
	98
	99
	100
	101
	102
	103
	104
	105

26 Have you had sexual intercourse?

*For official use only*

	YES	NO
Sexual intercourse	1	2

	106
--	-----

27 If YES, how old were you?

*For official use only*

Age	ANSWER
27.1 8 years and younger	1
27.2 9 years	2
27.3 10 years	3
27.4 11 years	4
27.5 12 years	5
27.6 13 years	6
27.7 14 years	7
27.8 15 years	8
27.9 16 years and older	9
27.10 Other (please specify) .....	10

	107
--	-----

28 If your answer was YES to question 26, state reasons for sexual intercourse.

*For official use only*

Reasons for sexual intercourse	YES	NO
28.1 I love the boy	1	2
28.2 Wanted to find out what it was about	1	2
28.3 For love	1	2
28.4 Raped	1	2
28.5 Peer pressure	1	2
28.6 Other (please specify) .....	1	2

	108
	109
	110
	111
	112
	113

29 What are the consequences of having unprotected sex?

*For official use only*

Consequences of unprotected sex	YES	NO
29.1 Pregnancy	1	2
29.2 Sexually transmitted infections	1	2
29.3 HIV	1	2
29.4 Will not be able to attend school	1	2
29.5 Other (please specify) .....	1	2

	114
	115
	116
	117
	118

30 If your answer to question 26 was YES, state the contraceptive methods used.

*For official use only*

Contraceptive method used	YES	NO
30.1 Intra-uterine device	1	2
30.2 Male condom	1	2
30.3 Female condom	1	2
30.4 Oral contraceptive (pills)	1	2
30.5 Spermicides	1	2
30.6 Diaphragm	1	2
30.7 Cultural herbs	1	2
30.8 Other (please specify) .....	1	2

	119
	120
	121
	122
	123
	124
	125
	126

31 Have you ever had an abortion?

*For official use only*

	YES	NO
Abortion	1	2

	127
--	-----

32 If your answer is YES on the previous question, where did you have it?

*For official use only*

Place of abortion	YES	NO
32.1 At home	1	2
32.2 At a hospital	1	2
32.3 At a clinic	1	2
32.4 In the bush	1	2
32.5 At a friends' place	1	2
32.6 Other (please specify) .....	1	2

	128
	129
	130
	131
	132
	133

33 If your answer was YES to question 31, state your age at the time.

*For official use only*

Age of abortion	ANSWER
33.1 8 years or younger	1
33.2 9 years	2
33.3 10 years	3
33.4 11 years	4
33.5 12 years	5
33.6 13 years	6
33.7 14 years	7
33.8 15 years	8
33.9 16 years	9
33.10 17 years and older	10

	134
--	-----



## SECTION D: CONTRACEPTION

34 Have you ever heard of contraception?

*For official use only*

	YES	NO
Hearing of contraception	1	2

	135
--	-----

35 If your answer is YES, what do you understand by contraception?

*For official use only*

Meaning of contraception	YES	NO
35.1 It is a method to have children	1	2
35.2 It is a method to get to know your partner	1	2
35.3 It is a method to show love and affection to your partner	1	2
35.4 It is prevention of unwanted pregnancy	1	2
35.5 Protects against sexuality transmitted infections	1	2
35.6 Protects me against HIV	1	2
35.7 Other (please specify) .....	1	2

	136
	137
	138
	139
	140
	141
	142

36 Who informed you about contraception?

*For official use only*

Information	YES	NO
36.1 Father	1	2
36.2 Mother	1	2
36.3 Friends	1	2
36.4 Doctor	1	2
36.5 Nurse	1	2
36.6 School	1	2
36.7 Radio	1	2
36.8 Television	1	2
36.9 Newspaper	1	2
36.10 GIRO	1	2
36.11 CAJ	1	2
36.12 Church	1	2
36.13 Other family members	1	2
36.14 Grandparents	1	2
36.13 Other (please specify) .....	1	2

	143
	144
	145
	146
	147
	148
	149
	150
	151
	152
	153
	154
	155
	156
	157

37 Do you believe in the use of condoms as a contraceptive?

*For official use only*

	YES	NO
Believe in condoms	1	2

	158
--	-----

38 What are your beliefs?

*For official use only*

Condom beliefs	YES	NO
38.1 Condoms interfere with sex	1	2
38.2 Condoms are unpleasant to use	1	2
38.3 Condoms are inconvenient	1	2
38.4 Condoms are not freely available	1	2
38.5 Condoms have undesirable implications, that is you do not trust you partner	1	2
38.6 Condoms prevent pregnancies	1	2
38.7 Other (please specify) .....	1	2

	159
	160
	161
	162
	163
	164
	165

39 Do you use contraceptives?

*For official use only*

	YES	NO
Using contraceptives	1	2

	166
--	-----

40 How did you acquire the contraceptives that you use?

*For official use only*

Acquiring contraceptives	YES	NO
40.1 Pharmacy	1	2
40.2 Hospital	1	2
40.3 Family planning	1	2
40.4 Boyfriend	1	2
40.5 A friend	1	2
40.6 Bought it on the street	1	2
40.7 Picked up a used contraceptive	1	2
40.5 Other (please specify) .....	1	2

	167
	168
	169
	170
	171
	172
	173
	174

41 What contraceptive do you use?

*For official use only*

Using contraceptives	YES	NO
41.1 Male condom	1	2
41.2 Female condom	1	2
41.3 Injection	1	2
41.4 Pill	1	2
41.5 Condom	1	2
41.6 Other (please specify) .....	1	2

	175
	176
	177
	178
	179
	180

42 If you use vaginal contraceptives, what information did you receive?

*For official use only*

Information received	YES	NO
42.1 Benefits and risks of the methods	1	2
42.2 Help prevent some STDs and conditions caused by STDs	1	2
42.3 Prevent pregnancy	1	2
42.4 Can be stopped at any time	1	2
42.5 Easy to use with a little practice	1	2
42.6 No side-effects from hormones	1	2
42.7 No guidance received	1	2

	181
	182
	183
	184
	185
	186
	187

43 Does your partner agree with the guidance provided?

*For official use only*

	YES	NO
Agree with guidance	1	2

	188
--	-----

44 What is the method you would normally use to prevent unwanted pregnancy?

*For official use only*

Method use	YES	NO
44.1 Pill	1	2
44.2 Male condom	1	2
44.3 Female condom	1	2
44.4 I do not have sexual intercourse	1	2
44.5 Depo provera (injection)	1	2
44.6 Apply the IUD	1	2
44.7 Spermicides	1	2
44.8 Barrier method	1	2

	189
	190
	191
	192
	193
	194
	195
	196

45 In your view, how do spermicides work?

*For official use only*

Working of spermicides	YES	NO		
45.1 Spermicides kill sperm	1	2		197
45.2 Spermicides make sperm unable to move toward the egg	1	2		198
45.3 I don't know	1	2		199
45.4 Other, (please specify) .....	1	2		200

46 In your view, how do diaphragms and cervical caps work?

*For official use only*

Working of diaphragms and cervical caps	YES	NO		
46.1 Block sperm from entering the uterus and tubes where sperm could meet an egg	1	2		201
46.2 I don't know	1	2		202
46.3 Other, (please specify) .....	1	2		203

47 If you use oral contraceptives, what information did you receive?

*For official use only*

Information receive	YES	NO		
47.1 Very effective when used correctly	1	2		204
47.2 No need to do anything at time of sexual intercourse	1	2		205
47.3 Monthly periods regular, lighter monthly bleeding	1	2		206
47.4 Can be used as long as woman wants to prevent pregnancy	1	2		207
47.5 Can be used at any age from adolescence to menopause	1	2		208
47.6 User can stop taking pills at anytime	1	2		209
47.7 Fertility returns soon after stopping	1	2		210
47.8 Can be used as an emergency contraceptive after unprotected sex	1	2		211
47.9 Should be taken every day to be most effective	1	2		212
47.10 No information received	1	2		213
47.11 On side-effects				214
47.11 Other (please specify) .....	1	2		215

48 In your view, how do oral contraceptives work?

*For official use only*

Working of oral contraceptives	YES	NO
48.1 Stop ovulation (release of eggs from ovaries)	1	2
48.2 Thicken cervical mucus, making it difficult for sperm to pass through	1	2
48.3 I don't know	1	2
48.4 Other (please specify) .....	1	2

	216
	217
	218
	219

49 If you use injectable contraceptives, what information did you receive?

*For official use only*

Information of injectable contraceptives	YES	NO
49.1 Very effective	1	2
49.2 Private – no one else can tell that a woman is using it	1	2
49.3 Long-term pregnancy prevention, but reversible	1	2
49.4 Does not interfere with sex	1	2
49.5 No daily pill taking	1	2
49.6 Can be used at any age	1	2
49.7 Long period before the next injection	1	2
49.8 No information received	1	2
49.9 Other (please specify) .....	1	2

	220
	221
	222
	223
	224
	225
	226
	227
	228

50 In your view, how does injectable contraception work?

*For official use only*

Working of injectable contraceptives	YES	NO
50.1 Mainly stops ovulation (release of eggs from ovaries)	1	2
50.2 Thickens cervical mucus, making it difficult for sperm to pass through	1	2
50.3 I don't know	1	2
50.4 Other (please specify) .....	1	2

	229
	230
	231
	232

51 Have you ever heard of emergency contraception?

*For official use only*

	YES	NO
Hearing of emergency contraception	1	2

	233
--	-----

52 If YES, what is emergency contraception?

*For official use only*

Meaning of emergency contraception	YES	NO
52.1 It is an intramuscular injection	1	2
52.2 It is the use of an oral pill taken up to 72 hours after sexual intercourse	1	2
52.3 It is the barrier method	1	2
52.4 It is the use of an oral pill taken 72 hours after sexual intercourse	1	2
52.5 After unprotected sex can prevent pregnancy	1	2
52.6 I don't know	1	2
542.7 Other (please specify) .....	1	2

	234
	235
	236
	237
	238
	239
	240

53 For which reason would you use emergency contraception?

*For official use only*

Reason for using emergency contraception	YES	NO
53.1 After being raped	1	2
53.2 After casual sex/unprotected sex	1	2
53.3 After a party and getting drunk	1	2
53.4 After sexual violence	1	2
53.5 After forced sex	1	2
53.6 A condom has broken	1	2
53.7 An IUD has come out of place	1	3
53.8 Woman has run out of oral contraceptives or is late with injectable contraceptive	1	2
53.9 I don't know	1	2
53.10 Other (please state) .....	1	2

	241
	242
	243
	244
	245
	246
	247
	248
	249
	250

54 Where is emergency contraception available in your area?

*For official use only*

Availability of emergency contraception	YES	NO
54.1 Clinic	1	2
54.2 Hospital	1	2
54.3 Doctor	1	2
54.4 Other (please specify) .....	1	2

	251
	252
	253
	254

## SECTION E: SEXUALLY TRANSMITTED INFECTIONS “STIs”

55 What is AIDS?

*For official use only*

Definition of AIDS	YES	NO		
55.1 A disease that kills	1	2		255
55.2 A disease caused by a virus which affects the immune system	1	2		256
55.3 It is an infection caused by HIV which renders the organism incapable of defending against infections	1	2		257
55.4 A terminal disease	1	2		258
55.5 Disease which causes weight loss	1	2		259
55.6 A disease which causes shame	1	2		260
55.7 I don't know	1	2		261
55.8 Other (please specify) .....	1	2		262

56 What is HIV?

*For official use only*

Definition of HIV	YES	NO		
56.1 Disease	1	2		263
56.2 Virus	1	2		264
56.3 Bacteria	1	2		265
56.4 Microbe	1	2		266
56.5 Virus which causes AIDS	1	2		267
56.6 I don't know	1	2		268
56.7 Other (please specify) .....	1	2		269

57 How is HIV transmitted?

*For official use only*

Transmission of HIV	YES	NO		
57.1 Through sexual intercourse	1	2		270
57.2 Orally	1	2		271
57.3 By breast feeding	1	2		272
57.4 By kissing someone with a sore in the mouth	1	2		273
57.5 By using utensils of HIV patients	1	2		274
57.6 Semen	1	2		275
57.7 Blood	1	2		276
57.8 I don't know	1	2		277
57.9 Other (please specify) .....	1	2		278

58 How would you prevent transmitting HIV?

*For official use only*

Preventing HIV	YES	NO
58.1 Abstain from sex	1	2
58.2 Being mutually faithful	1	2
58.3 Consistently use condoms	1	2
58.4 Share needles and syringes	1	2
58.5 I don't know	1	2
58.6 Other (please specify) .....	1	2

	279
	280
	281
	282
	283
	284

59 Have you ever heard of Sexually Transmitted Infections (STI)?

*For official use only*

	YES	NO
Hearing of STI	1	2

	285
--	-----

60 If YES, what is Sexually Transmitted Infection (STI)?

*For official use only*

Meaning of STI	YES	NO
60.1 It is an infection which affects the woman's skin	1	2
60.2 It is an infection which affects men and women	1	2
60.3 It is an infectious disease transmitted through sexual contact	1	2
60.4 Other (please specify) .....	1	2

	286
	287
	288
	289

61 If your answer to question 59 is YES, what STI diseases do you know?

*For official use only*

STI diseases	YES	NO
61.1 Gonorrhoea	1	2
61.2 Pelvic inflammation	1	2
61.3 Syphilis	1	2
61.4 Cancroids	1	2
61.5 AIDS	1	2
61.6 Other (please specify) .....	1	2

	290
	291
	292
	293
	294
	295



62 How are STIs transmitted?

*For official use only*

STI transmission	YES	NO
62.1 Unprotected sex	1	2
62.2 Having more than one sexual partner	1	2
62.3 Sexual intercourse	1	2
62.4 Prostitution	1	2
62.5 I don't know	1	2
62.6 Other (please specify) .....	1	2

	296
	297
	298
	299
	300
	301

63 Have you ever been raped?

*For official use only*

	YES	NO
Raped	1	2

	302
--	-----

64 Is YES, how old were you?

*For official use only*

Age	ANSWER
64.2 9 years or younger	1
64.3 10 years	2
64.4 11 years	3
64.5 12 years	4
64.6 13 years	5
64.7 14 years	6
64.8 15 years	7
64.9 16 years and older	8

	303
--	-----

65 What measures did you take after the rape?

*For official use only*

Measures taken	YES	NO
65.1 I was taken to the hospital	1	2
65.2 I was taken to a health centre	1	2
65.3 I was taken to the police	1	2
65.4 I was taken to a family home	1	2
65.5 I was taken to the "Promoção da Mulher" (Woman's Promotion)	1	2
65.6 I kept quiet	1	2
65.7 Other (please specify) .....	1	2

	304
	305
	306
	307
	308
	309
	310

- 66 In your socio-cultural milieu, are there taboos (religious, social, cultural) against using artificial contraception?

*For official use only*

	YES	NO
Taboos against using artificial contraception	1	2

	311
--	-----

- 67 If your answer is YES, in your own words state these taboos.

.....  
 .....

- 68 Who in your social circle, makes the decisions about contraception?

*For official use only*

Decisions about contraception	YES	NO
68.1 Yourself	1	2
68.2 Your partner	1	2
68.3 The family	1	2
68.4 Community or religious leaders	1	2
68.5 Other (please specify) .....	1	2

	312
	313
	314
	315
	316

- 69 Are children seen as proof of ...

*For official use only*

Proof of ...	YES	NO
69.1 Adulthood	1	2
69.2 Virility	1	2
69.3 Social status	1	2
69.4 Other (please state) .....	1	2

	317
	318
	319
	320

- 70 Are there preferences of children of a particular gender in your culture?

*For official use only*

	YES	NO
Preferences of children	1	2

	321
--	-----

- 71 If your answer is YES, please state the gender.

*For official use only*

Gender	YES	NO
71.1 Male	1	2
71.2 Female	1	2

	322
	323

73 Is menstrual blood seen as “polluting”?

*For official use only*

	YES	NO
Menstrual blood seen as “polluting”	1	2

	324
--	-----

74 If your answer is YES, does it affect the acceptance of ....

*For official use only*

Acceptance of ...	YES	NO
74.1 Oral contraception	1	2
74.2 Intra-uterine contraception devices (IUCD)	1	2
74.3 Other (please specify) .....	1	2

	325
	326
	327

75 Are beliefs about female anatomy related to the acceptance of IUCDs?

*For official use only*

	YES	NO
Anatomy related	1	2

	328
--	-----

76 If YES, in your own words describe the beliefs.

.....

.....

**THANK YOU FOR YOUR PARTICIPATION**