

# CONTRACEPTIVE CHALLENGES EXPERIENCED BY WOMEN WHO REQUESTED TERMINATION OF PREGNANCY SERVICES IN THE MPUMALANGA PROVINCE

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## ABSTRACT

*Although contraceptives are available free of charge throughout South Africa, the number of requests for termination of pregnancy (TOP) services continues to increase. This research investigated challenges preventing women from using contraceptives effectively. Structured interviews were conducted with 55 women who requested TOP services. As many as 85.5% of these women had used contraceptives. They discontinued using contraceptives when side-effects occurred, necessitating them to request TOP services. Knowledge about, access to and the actual use of contraceptives did not enable these women to prevent unwanted pregnancies. More effective counseling about contraceptives' side-effects and enhanced accessibility of contraceptives over weekends and during lunch breaks could enable more women to prevent unwanted pregnancies, reducing the number of requests for TOP services.*

## OPSOMMING

*Alhoewel voorbehoedmiddels gratis dwarsdeur Suid-Afrika beskikbaar is, word die aanvraag vir dienste vir die beeindiging van swangerskap al groter. Die navorsing het die uitdagings, wat vroue verhoed om voorbehoedmiddels effektief te gebruik, nagevors. Gestruktureerde onderhoude is met 55 vroue, wat dienste vir die beeindiging van swangerskap versoek het, gevoer. Soveel as 85.5% van hierdie vroue het voorbehoedmiddels gebruik. Hulle het die gebruik van voorbehoedmiddels gestaak toe nuwe-effekte voorgekom het, wat veroorsaak het dat hulle hulle tot dienste vir die beeindiging van swangerskap moes wend. Kennis omtrent, toegang tot en die werklike gebruik van voorbehoedmiddels het nie die vroue in staat gestel om ongewenste swangerskappe te voorkom nie. Meer effektiewe berading oor die nuwe-effekte van voorbehoedmiddels en verbeterde toegang tot voorbehoedmiddels gedurende naweke en etensure kan meer vroue in staat stel om ongewenste swangerskappe te voorkom, wat die aanvraag vir dienste vir die beeindiging van swangerskap sal verminder.*

## INTRODUCTION AND BACKGROUND INFORMATION

Throughout recorded history women have resorted to abortions to terminate unwanted pregnancies despite legal and religious sanctions and personal risks involved. Termination of pregnancy (TOP) is universally practised and no other elective procedure has evoked political, moral and/or emotional debates similar to the heated debates surrounding TOP issues globally (Jali, 2001:25; Suffla, 1997:214).

The WHO (2000:1) estimated that 30 million women worldwide used legal TOP services during 1995; but that annually an estimated additional 20 million women ended their pregnancies outside their countries' legal systems. It has been estimated that approximately 100 000 women terminated first trimester pregnancies from 1996 to 1999 in the Republic of South Africa (RSA) (Kenny, 2000:16). Based on the estimated numbers of abortions procured annually, the question asked by Walker (1996:56) was: "Why not use contraceptives to prevent an unwanted pregnancy?" This same question stimulated the current research but focused on women who requested TOP services in the Mpumalanga Province (MP). Their requests for TOP services indicated that these women did not plan these pregnancies, yet failed to use contraceptives effectively to prevent pregnancies. If more women could use contraceptives effectively, then fewer requests for TOP services could be expected, with reduced expenses for the health care services.

Women who fail to use contraceptives effectively and who conceive unwanted pregnancies can resort to legalised termination of pregnancy (TOP) services in the RSA since 1996 in terms of the provisions of Act 92

of 1996 (South Africa 1996). Since February 1997 to July 1998, an estimated 61 389 TOPs were reportedly performed in the RSA (Ngweni, 1998:38). The demand for choice on termination of pregnancy (CTOP) services in the Gert Sibande District in the Mpumalanga Province (MP) where the research was conducted, continued to increase in spite of freely available contraceptives, as portrayed in Table 1.

### Definitions of key terms

A **challenge** is defined as a demanding or a difficult task (Oxford Handy Dictionary, 1991:128). Thus "contraceptive challenges" can be defined as difficulties experienced in preventing unplanned and/or unwanted pregnancies.

**Contraception** implies the prevention of conception by either temporary or permanent means (Foy, Gabriel, Cindi & Dickson-Tetteth, 2001:2).

**Contraceptive methods** include hormonal contraceptives (injections, pills and implants); barrier methods (male and female condoms and cervical caps); intra-uterine contraceptive devices (IUCDs); emergency contraception such as "morning after pills", high doses of oral contraceptives, or the insertion of a copper containing IUCD within 48-72 hours after unprotected sexual intercourse; voluntary surgical sterilisation (VSS); natural family planning (NFP) and traditional methods of family planning (Foy *et al.* 2001:2).

**CTOP** refers to the choice of women in the RSA to end their pregnancies in terms of the provisions of Act 92 of 1996 (South Africa 1996), and to access legalised TOP services.

**Table 1: TOPs performed in the Gert Sibande District, Mpumalanga Province**

YEAR	NO OF TOPs
1998	668
1999	891
2000	929
2001	1 094

(Mpumalanga Department of Health, 1998–2001)

**TOP** refers to the ending of a pregnancy by expelling (aborting) the fetus from the uterus. The CTOP Act (No 92 of 1996), stipulates circumstances under which a pregnancy may be terminated upon the request of a woman during the first 12 weeks' gestation, or even after 12 weeks' gestation provided specific requirements are met.

**Termination of pregnancy services** are provided in terms of the Choice of Termination of Pregnancy (CTOP) Act (No 92 of 1996) and should include the counseling of women before and after the CTOP procedure(s). The TOP services should be able to handle incomplete abortions, should provide contraceptive services after the TOP and should link TOP services to other related reproductive health services, including contraceptive services.

An **unwanted pregnancy** refers to a pregnancy that may not have been planned, and that may be unintentional and unwelcome for the pregnant woman. Such a pregnancy may occur as a result of contraceptive failure or non-utilisation of contraceptives" (Maja, 2002:20-21).

## PROBLEM STATEMENT

Factors existing in women's lives that might negatively impact on their contraceptive use, include culture, religion, educational and socio-economic status, accessibility to contraceptive services, gender issues and level of education. Contraceptive services are available free of charge throughout the MP. Despite this availability the number of TOPs continues to increase in the Gert Sibande District of this province. Non-availability of certain contraceptive methods, counseling received about the method of choice, the attitudes of the providers, lack of equipment and resources, side-effects occurring as a result of using contraceptives, political issues, inadequate contraceptive knowledge of the providers and shortages of personnel, comprise some of the contraceptive challenges during contraceptive use.

## PURPOSE OF THE RESEARCH

The purpose of the research was to determine contraceptive challenges experienced by women in the Gert Sibande District which resulted in their requests

for TOP services.

## OBJECTIVES OF THE STUDY

The objectives of this study were to identify and describe contraceptive challenges experienced by women who requested TOP services in the Gert Sibande District of the MP. The research results should help to identify measures that could be implemented to address some contraceptive challenges faced by women who requested TOP services and to enhance their future effective contraceptive use, reducing the risk of unwanted pregnancies and the number of TOPs performed in the Gert Sibande District.

## RESEARCH QUESTIONS

The research questions which guided this research were:

- What are the contraceptive challenges experienced by women who requested TOP services in the Gert Sibande District during August and September 2003?
- What measures can be implemented to address contraceptive challenges experienced by women in the Gert Sibande District of the MP?

## METHODOLOGY

A quantitative method was followed. An exploratory and descriptive study was conducted to identify the contraceptive challenges experienced by women who requested TOPs in the Gert Sibande District of the MP. This was a quantitative study since it was concerned with the numbers and frequencies with which contraceptive challenges were experienced by women who requested TOP services in terms of the CTOP Act (No 92 of 1996) in the Gert Sibande District, during August and September 2003. It was descriptive and exploratory because it aimed to establish an initial database about women's reasons for failing to use contraceptives, necessitating them to request TOPs in Gert Sibande District.

## Population and sampling

Polit and Hungler (1999:37) refer to the population as an aggregate or totality of all the objects, subjects or members that conform to a set of specifications. The

population comprised all women who requested TOPs under the CTOP Act (No 2 of 1996) in the Gert Sibande District during August and September 2003. A non-probability convenience sampling method was adopted. De Vos (2001:199), as well as LoBiondo-Wood and Harber (1998:253) describe a convenience sample as the use of readily accessible persons in a study.

Every woman who requested a termination of her pregnancy at the Bethal Hospital, and who consented to be interviewed by a researcher during August and September 2003, was interviewed. A total of 55 participants comprised the convenience sample for this research (Polit & Hungler, 1999:226). However, some participants refused to answer specific questions, explaining why the total number of responses for specific questions could vary. In order to provide clear portrayal of the results the number of participants (n) will be indicated wherever percentages are used in the discussion of the research results. Out of the 55 participants, 54 were Zulu-speaking and only one indicated her home language to be English. The majority (76.4%) of these participants were unemployed, 76.3% were reportedly single and 72.7% had acquired secondary school education. The demographic information of the sample will be discussed in detail in the section on the analysis and discussion of the research results.

## Data collection

A structured interview schedule was used to capture data relevant to the study's objectives and research questions. One researcher conducted all the interviews. The structured interview tool was formulated to capture contraceptive challenges faced by women before contraceptive use can be initiated, and those that are experienced during the use of contraceptives. The structured interview schedule comprised the following sections:

Section 1 requested demographic information from the participants in order to contextualise the research findings against this background information.

Section 2 asked questions related to contraceptive challenges existing before contraceptives could be initiated.

Section 3 concerned contraceptive challenges experienced during the use of contraceptives.

Section 4 contained questions related to TOPs.

## Validity and reliability of the research instrument

Validity is defined as a measure of truth or falsity of the data obtained through using the research instrument (Burns & Grove, 2001:226). In this study validity refers to the measure of truth or falsity of the assumed contraceptive challenges as experienced/reported by women who requested TOP services. The instrument's validity can be regarded as the extent to which "... the instrument actually reflects the abstract construct being examined" (Burns & Grove, 2001:814). Several factors could influence the internal and external validity of the structured interview schedule used to gather data.

The most important threats to the internal validity of this study were factors related to the history of the participants' contraceptive use and the selection processes of the women who were interviewed.

The process involved in the selection of participants to be involved in a study and the type of group selected might influence the results obtained, and therefore the validity might be compromised (Burns & Grove, 2001:229). The selection of a group of women who requested their pregnancies to be terminated, to participate in a study to describe contraceptive challenges might have compromised the internal validity of this study. Some women in this selected group of participants might have felt guilty for having conceived unwanted pregnancies in the face of freely available contraceptives.

## External validity

External validity refers to the extent to which the research results can be generalised beyond the sample used in the study (Burns & Grove, 2001:798). Being aware that they were involved in a study of contraceptive challenges, the women who requested TOPs might have given answers to please the interviewer, instead of providing information about their real life experiences (Polit & Hungler, 1999:252). This type of threat to external validity was minimised by not pressurising participants to provide responses and by requesting them to be as honest as possible.

The structured interview schedule was given to colleagues to check whether the questions were

relevant, unambiguous and clear. The joint supervisor and the supervisor further critically evaluated the interview schedule. Suggestions which were implemented included that simpler and shorter sentences were used and that double-barreled questions were rephrased to ask single questions only.

Content validity is the extent to which the content of the instrument appears to comprehensively examine the scope it is intended to measure (Bowling, 1997:133). A thorough literature review was done on contraceptive challenges, and in this way relevant items were identified.

Reliability is the degree of consistency with which the instrument measures an attribute (Polit & Hungler, 1999:255). In ensuring reliability in this study the responses obtained through the interview schedule was split into two equal halves, they were then scored independently to check correlations between related aspects.

## **ETHICAL CONSIDERATIONS**

When humans participate in research investigations, care must be exercised that the rights of those individuals are protected (Polit & Hungler, 1999:132–134). Psychological discomfort may have resulted from the nature of the questions asked. An opportunity was provided for each participant to ask questions and to air her feelings. Each participant received some information about contraceptives during the interview, which might have enhanced her knowledge, enabling her to make better informed decisions in future.

Freedom from exploitation was observed by respecting each participant's vulnerability. The women who requested TOP services were regarded as a vulnerable group as they were carrying unwanted pregnancies, which they intended to terminate. Careful explanations were provided to these women about their right to refuse to participate in the study, and that their participation, or their refusal to do so, would not influence the care provided to them in any way.

Pertaining to the risk benefit ratio, the risk implied the anticipated psychological discomfort resulting from the questions asked. The benefit was the body of knowledge that highlighted the contraceptive challenges

experienced by women in this situation. This information could be utilised to reduce the number of women requesting CTOP services in future. The right to self-determination was followed by providing the participants with the right to refuse to participate in the study, the right to discontinue the study if they felt uncomfortable, the right not to answer specific questions if they did not want to disclose that information and the right to ask for clarification if they were unsure about any aspect of the research project, any specific question, or the use of contraceptives in general. Addressing the participants' right to full disclosure, the researcher described the nature of the study.

The right to privacy was respected because each interview was conducted individually in a private area and by treating data collected confidentially. Anonymity was adhered to by ensuring that no completed structured interview schedule could be linked to any specific participant. The completed interview schedules were only accessible to the researcher and the statistician, and were kept locked up by the researcher. Data collected were used for the purpose of this study only, and the completed interview schedules would be destroyed as soon as the research report had been finalised. The research report would provide facts, figures, graphs and tables but no names of individuals nor of institutions would appear in this report. The researcher would treat all information in the strictest confidence and not divulge any information to any other person or institution.

Consent was obtained for conducting the survey from the Department of Health of the Mpumalanga Province and from the health care authorities of Gert Sibande District; as well as from the Research and Ethics Committee of the Department of Health Studies, Unisa.

Each woman who agreed to participate signed a form, or put a thumb mark on it if she could not write her name. As most participants were Zulu-speaking, the consent form was available in English as well as in Zulu. These signed consent forms were kept in a sealed box separately from the completed structured interview schedules so that no specific consent form could be matched with any specific completed interview schedule - in an attempt to maintain confidentiality and anonymity.

As most participants were Zulu-speaking, the struc-



tured interview schedule was translated into Zulu by the researcher who is fluent in both English and Zulu. A professional nurse and a secondary school teacher, fluent in both languages, checked the translations and agreed that the Zulu translations implied the same meanings as those conveyed by the English interview schedule. However, the professional nurse suggested that some English contraceptive terms should also be included on the Zulu interview schedule as most women only knew contraceptive terms in English. Both the English and Zulu contraceptive terms were included in the Zulu structured interview schedule.

## ANALYSIS AND DISCUSSION OF THE RESEARCH RESULTS

It should be noted that frequencies and percentages will be displayed as calculated by the Microsoft Excel program, implying that not all percentages total 100.0%, but sometimes 100.1% or 99.9%. Responses to closed-ended items were assigned numbers and coded by a statistician. Responses to open-ended items were grouped according to similarities. No attempt was made to analyse the responses to open-ended items in a qualitative manner.

### Demographic data

The first section of the structured interview schedule attempted to obtain demographic information from the participants in order to contextualise the information about contraceptive challenges against the background knowledge of who the participants were. Demographic issues which were addressed in the structured interview schedule included age, level of education, marital status, race, residential area, employment, income, religion and the number of children that each participant had.

### Age

According to the statistics portrayed in Table 2 as many

as 60.0% (n=33) of the women's ages ranged from 20 to 30 years, while only 7.2% (n=4) were 41 years or older. As many as 18.2% (n=10) of the women were adolescents, who were 19 years of age or younger. "Effective use of family planning techniques can definitely help girls and women plan when to have their children and plan their lives so that they are not destined to poverty and hopelessness" (Ehlers, 1999:53). Similar age distributions of women who underwent TOPs in the RSA, were reported by other researchers. A study conducted in the KwaZulu-Natal (KZN) Province of the RSA reported that teenagers comprised 17.8% and only 8% were 40 years of age or older (Adanlawo & Moodley, 1999:102) of the women who requested TOPs.

Research done in the Free State Province of the RSA, indicated that 18.7% of the women who participated in that study were teenagers while only 2.7% were 40 years of age or older (Engelbrecht, Pelser, Ngwena & Van Rensburg, 2000:14). These results from studies conducted in the RSA seem to be in line with the statistics from 27 different countries, as analysed and reported by Bankole, Singh and Haas (1998:117-127).

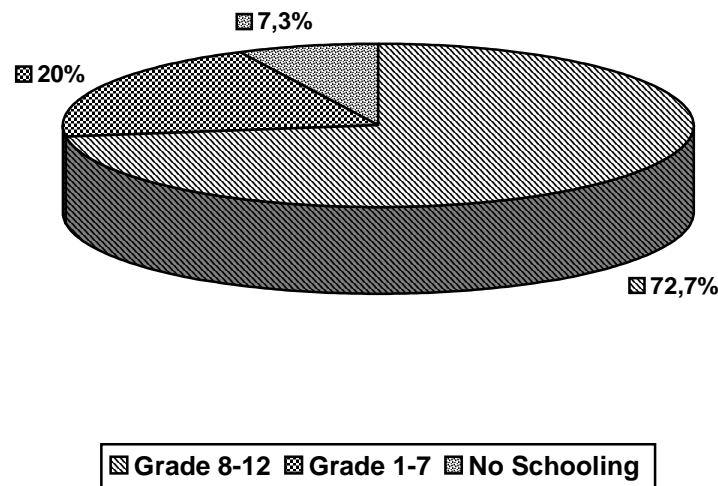
### Level of education

According to Chimere-Dan (1997:15-16) women need to have completed a minimum of seven years' schooling successfully before they can successfully use contraceptives.

As portrayed by Figure 1 the majority of the women who underwent TOPs, namely 72.7% (n=40), acquired secondary school education, 20.0% (n=11) obtained primary school education and only 7.3% (n=4) had no schooling at all. In terms of Chimere-Dan's (1997:15-16) assertion, those women who acquired secondary school education, should have been capable of utilising contraceptives effectively. However, they failed to do so as they ended up obtaining TOPs for unwanted pregnancies. Thus it could be surmised that these women might have encountered contraceptive challenges which

**Table 2: Age in years at previous birthday**

AGE	FREQUENCY (n)	PERCENTAGE (%)
13-19 years	10	18.2
20-30 years	33	60.0
31-40 years	8	14.5
41-50 years	4	7.3
<b>TOTAL</b>	<b>55</b>	<b>100.0</b>



**Figure 1: Participants' levels of education (n = 55)**

they could not overcome successfully, in spite of their relatively high levels of education.

### **Marital status**

The majority (76.4%; n=2) of the participants were single while only 18.2% (n=10) were married, 3.6% (n=2) were divorced and 1.8% woman (n=1) was widowed. Thus the expectation, based on the literature reviewed, that marriage partners' expectations that their wives should not use contraceptives in order to bear as many children as possible, was not supported by these research results. A number of other researchers indicated that single women constituted the largest group seeking TOPs, followed by married women, and to a lesser extent by divorced and widowed women (Adanlawo & Moodley, 1999:99; Bankole *et al.* 1998:117-127; Engelbrecht *et al.* 2000:8). No specific details were asked about the type of marriage and/or co-habitation. Women's answers as to their marital status were recorded without any further probing.

### **Participants' residential areas**

Most of the women who requested TOPs came from towns surrounding the Bethal hospital where the interviews were conducted in the Gert Sibande District, amounting to 90.9% (n=50) and rural areas (9.1%; n=5). None of these women came from cities elsewhere in the RSA. This question was asked because it is possible that women might request TOP services from hospitals or clinics far away from their own residential areas. This was not the case in this study as all women came from the Gert Sibande

District and most came from the urban area.

### **Employment and income**

As many as 58.2% (n=32) of these women were unemployed. Those who were employed constituted 12 women (or 21.8%) of whom 11 were students. The total number of women who were not working (comprising those who were unemployed and those who were students) was 43 (78.2%). Previous studies conducted in the RSA reported that the majority of women who requested TOPs, did so for socio-economic reasons (Bankole *et al.* 1998:117-127; Engelbrecht *et al.* 2000:14; Maforah, Wood & Jewkes, 1997:80; Suffla, 1997:216-218). In this study the poor socio-economic status of women who requested TOPs was confirmed. As many as 78.2% (n=43) of the women in this study were unemployed or students, and the other 21.8% (n=12) earned less than R1 000,00 per month.

Although 78.2% of the participants had no income and the other 21.8% earned too little to sustain themselves and their families, they failed to use contraceptives effectively to prevent unplanned pregnancies.

### **Religion**

All the women who underwent TOPs in the Gert Sibande District during September and October 2003 were reportedly Christians. No other religion was mentioned. Bankole *et al.* (1998:117-127) compared the religious affiliations of women who requested TOPs in South Africa. These authors reported Christians to constitute 39 per 1 000 and Muslims 17 per thousand women

who requested TOPs. From the available data it could not be ascertained why all 55 participants in this study were reportedly Christians.

As many as 27.3% (n=15) of the women did not have any children. Women who do not desire pregnancies have access to free contraceptives, emergency contraceptives and sterilisation services. It is not known why 38.2% (n=21) of the women who had three or more children resorted to TOPs rather than to contraceptives, emergency contraceptives or sterilisations to prevent unwanted pregnancies. Seen against the joblessness and the poor socio-economic status of the majority of these women, their failure to use freely available, temporary, permanent or emergency contraceptives could indicate that they failed to access these free services and/or that they encountered challenges during its use (Bankole *et al.* 1998:117-127; Maforah *et al.* 1997:80).

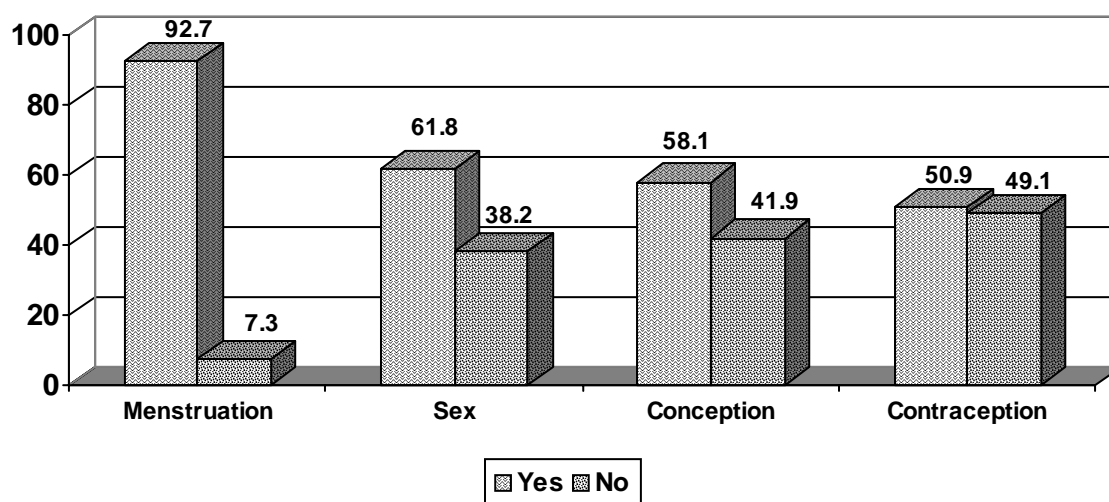
## SEXUALITY EDUCATION

Participants who received sexuality education from their parents (mainly mothers) were 52.7%. Only 3.6% reported involvement of their fathers in this education process. The main sexuality education received by women was on menstruation, by 92.7% (n=51) but 7.3% (n=4) did not receive this information. As many as 61.8% (n=34) of these women received information about sexual intercourse but only 58.1% (n=32) received information about conception.

Each participant could report more than one source of information. Therefore the total number of responses exceeds the total number of participants (n=55). Parents who gave sexuality education in this study constituted 52.7%, though fathers who contributed were only 3.6%.

**Table 3: Number of children**

NUMBER OF CHILDREN	FREQUENCY (n)	PERCENTAGE (%)
None	15	27.3
One	12	21.8
Two	7	12.7
Three	12	21.8
Four	5	9.1
Six	3	5.5
Seven	1	1.8
<b>TOTAL</b>	<b>55</b>	<b>100.0</b>



**Figure 2: Sexuality education received (n = 55)**



**Table 4: Age at which sexuality education was given**

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

According to Table 4, 40.0% (n=22) of these women received information when they were between the ages of 15 and 17 years, 29.1% (n=16) received it when they were between 10 to 14 years and 7.3% (n=4) received it when they were between the ages of 18-19 years.

This result is similar to that obtained by Maja (2002:197) where information on sexuality education to adolescents was provided mainly by mothers (42.3%). In this study, 23.6% (n=13) of the participants indicated that they received sex education from their teachers, 20.0% (n=11) from nurses while 16.4% (n=9) received sex education from their friends and relatives.

Reportedly as many as 69.1% (n=38) of the participants received their sexuality information at home, mostly given by mothers. The school gave 23.6% (n=13) of the sexuality information, the media 9.1% (n=5), the church 1.8% (n=1) and other (unspecified) institutions 14.5% (n=8). Lack of or inadequate sexuality education during the teenage years could contribute to women's lack of appropriate contraceptive knowledge, negative attitudes and perceptions about contraceptives and women's perceived inability to access contraceptive services.

## **PARTICIPANTS' CONTRACEPTIVE KNOWLEDGE**

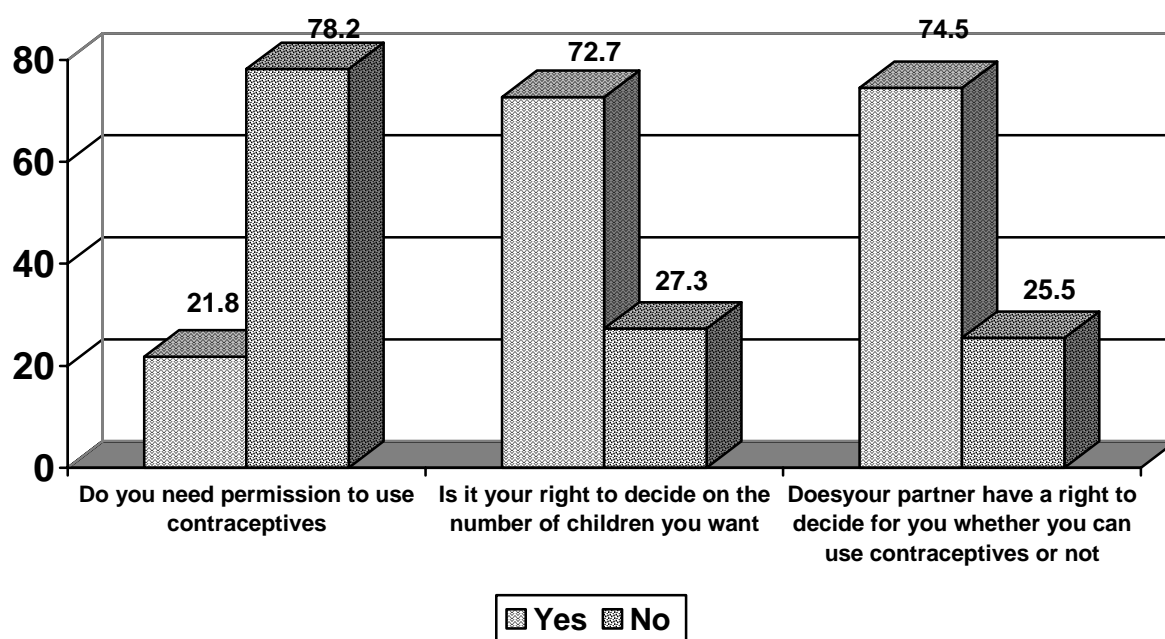
The women participating in this study were aware of hormonal contraceptives. As many as 96.4% (n=53) of these women were aware of injections, followed by 94.5% (n=52) about pills, IUCDs (65.5%; n=36), the male condom (49.1%; n=27), the female condom (27.3%; n=15), emergency contraceptives (14.5%), voluntary surgical sterilisation (VSS) (9.9%) and the "other" methods were mentioned by only one (1.8%) of these women. In the study by Ehlers and Maja (2001:10), 64.0% of the adolescent mothers could mention pills and injections. These were adolescent

mothers who, irrespective of knowing about contraceptive methods, ended up being pregnant and being adolescent mothers. The level of knowledge, especially about hormonal contraceptives, was high but knowledge does not necessarily imply actions based on knowledge. According to the DOH (2001:19) mentioning a method is not always sufficient to imply its use. A woman should be told about the method's function, anticipated side-effects, how to use the method effectively and what to do if side-effects are experienced. This allows a woman to make an informed choice.

## **KNOWLEDGE ABOUT EMERGENCY CONTRACEPTIVES**

As many as 80,0% (n=44) of these women who requested TOPs in Gert Sibande District, reportedly did not know about emergency contraceptives, while only 20.0% (n=11) knew about emergency contraceptives. Emergency contraceptives could reduce the number of unwanted pregnancies, if women could know about its existence, availability and action (Quinn, 1999:42). This result supports that obtained in Tshwane in the RSA, where 67.5% of the adolescent mothers did not know about emergency contraceptives (Ehlers, 2003:24).

Out of the 11 women who mentioned that they knew about emergency contraceptives, only 10.9% (n=6) had used this method after an episode of unprotected sex. Knowledge about and accessibility of emergency contraceptives could have prevented many of these women to resort to TOP services. Out of the 55 women, 31 (56.4%) indicated that education would have helped them to use emergency contraceptives while 4 (7.3%) indicated that posters and radio broadcasts could have helped them to gain knowledge about emergency contraceptives.



**Figure 3: Women's rights to decide about the use of contraceptives (n = 55)**

## GENDER ISSUES

As women's views about their rights to decide on the number of children they wanted, their right to use contraceptives and/or emergency contraceptives as well as TOP services could be influenced by their male partners'/husbands' expectations and cultural situations, questions to this effect were asked. However, as no probing questions were asked, the women's answers indicating that they were married, single, divorced or widowed were accepted as given by each participant.

According to Figure 3, as many as 78.2% (n=43) of these women did not require permission from anyone to use contraceptives; 72.7% (n=40) believed it was their right to decide on the number of children they wanted; and 74.5% (n=41) believed their partners had no right to decide whether they could use contraceptives. These results should be viewed under the consideration that 76.4% (n=42) of these women were unmarried, while only 18.2% (n=10) were married.

## ACCESSIBILITY OF CONTRACEPTIVE SERVICES

The majority of these women 96.4% (n=53) had access to contraceptive services. Most of these women 65.5% (n=36) could access contraceptive services at permanent (fixed) clinics, followed by the number of women who could access contraceptives at hospitals

16.4% (n=9), then mobile clinics could be accessed by 14.5% (n=8), pharmacists and doctors hardly ever supplied contraceptives to these women. The findings that only a few women obtained contraceptives from chemists or doctors correlate with the earlier findings that these women came from low socio-economic backgrounds and did not earn sustainable wages.

The estimated number of kilometres that were traveled to reach contraceptive services ranged from one to five kilometres by 85.5% (n=47), between five to ten kilometres by 12.7% (n=7) women, and more than ten kilometres was traveled by only one woman. According to these results, contraceptive services were within the majority of these women's geographic accessibility ranges.

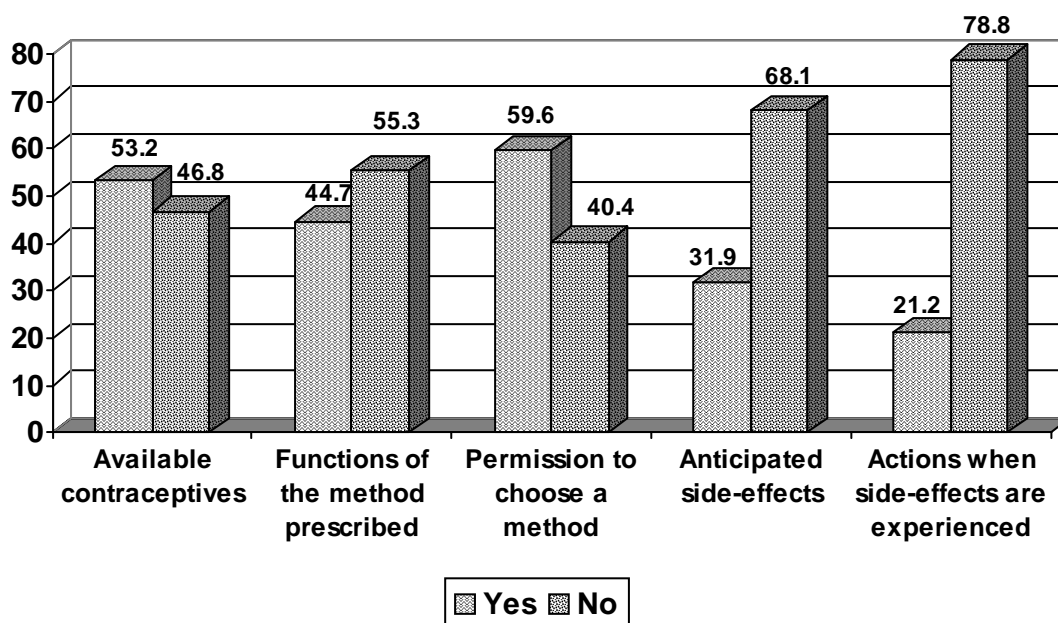
As many as 85.5% (n=47) of these women did not have access to contraceptive services over weekends; but would be willing to use contraceptives if they were available over weekends (81.8% (n=45)). Furthermore, 52.7% (n=29) of the participants indicated that non-availability of contraceptive services over lunch periods was an inconvenience, and 16.4% (n=9) posed challenges to sustain the effective utilisation of contraceptives.

## PARTICIPANTS' UTILISATION OF CONTRACEPTIVES

Although these women requested that their present

**Table 5: Contraceptive methods used**

METHOD USED	FREQUENCY (n)	PERCENTAGE (%)
Pill	23	41.8
Injectables	32	58.2
IUCD	2	3.6
Male condom	8	14.5
Female condom	1	1.8
Emergency contraceptives	3	5.5



**Figure 4: Counselling received (n = 47)**

pregnancies should be terminated, 85.5% (n=47) had used some form of contraception previously, 14.5% (n=8) never used contraceptives. These results support those of Adanlawo and Moodley (1999:101) where 75.0% of the women who requested TOPs did use contraceptives prior to their latest pregnancies. The numbers in Table 5 exceed the total number of the sample, because some women had used more than one contraceptive method.

Hormonal contraceptives seem to be the most commonly used method of contraception, injections being the most favoured, followed by pills. This was observed in various studies conducted in the RSA. In the Transkei region of the RSA, Mofokeng, Hoffman, Jacobs and Snow (1996:50) found that 90.0% of the women in their study were using contraceptive injections. In Tshwane, Maja (2002:199) said 64.4% of women in her sample used injections, 35.6% pills, 8.4% IUCDs, 8.0% condoms and only 2.7% used other methods.

The problems reported by women who used

contraceptive injections, included amenorrhoea and menorrhagia, loss of libido, headaches and dizziness. Potential misconceptions which were reported, included that contraceptive injections led to yellow offensive vaginal discharges and to the swelling of the whole body. Those women who used contraceptive pills, reportedly forgot to take their pills regularly. They also reported nausea, vomiting, headaches and dizziness. Women whose partners used male condoms stated that the main problem was the tearing of the condom during intercourse. All these side-effects were also reported in previous studies (Maforah *et al.* 1997:80; Mofokeng *et al.* 1996:13; Maja, 2002:204; Wood, Tortu, Rhodes & Deren, 1998:159).

## COUNSELLING RECEIVED ON CONTRACEPTIVE METHODS

Questions were asked about counseling the women might have received concerning contraceptives' utilisation, operation, side-effects and remedies for side-effects. Some of the women (59.6%; n=28) who

requested TOPs, were allowed to choose their own contraceptives but 40.4% (n=19) of the women's contraceptive methods were chosen by the contraceptive service providers, not by the women themselves.

Although some women (53.2%; n=25) were counseled about available contraceptives, 46.8% (n=22) of these women did not receive this information. In spite of the fact that more than half of the women (55.3%; n=26) were told how their method of contraception operated, the other 44.7% (n=10) failed to receive this information. Information about side-effects was not communicated to 68.1% (n=32) of the women. Furthermore, 78.8% (n=37) of these women were not told what to do if side-effects occurred.

## **ATTITUDES AND PERCEPTIONS CONCERNING CONTRACEPTION**

Although many of these 47 women experienced problems with the contraceptive method used, they nevertheless continued to believe in using contraceptives. As many as 85.1% (n=40) of these women were still willing to recommend contraceptives to somebody else. Their main preference was for injections, followed by condoms, pills and IUCDs.

## **PERCEPTIONS ABOUT THE CONTRACEPTIVE PROVIDERS**

The majority of these 47 women who had used contraceptives, 61.7% (n=29) perceived their contraceptive providers to be friendly and 48.9% (n=23) perceived them as always being approachable. A minority, 14.9% (n=7) perceived their contraceptive providers never to be approachable and 6.4% (n=3) as being aggressive. Only 2.1% (n=1) said the nurses at the contraceptive clinics were impolite. These results are consistent with those of Ehlers (2003:23) where most of the adolescent mothers regarded nurses in the reproductive services as being helpful and only a minority of adolescents were dissatisfied with the services they received. Maja (2002:217) also obtained positive results in terms of clients' perceptions concerning contraceptive providers.

## **PERCEPTIONS OF THE CONTRACEPTIVE SERVICES**

As many as 51.1% (n=24) of these women regarded contraceptive services as being very busy and felt that the staff in their contraceptive services were inadequate. When asked how long they waited at their clinics, 59.6% (n=28) indicated that they usually waited for less than 30 minutes and no one waited for more than an hour.

In terms of privacy the majority of these women, namely 95.7% (n=45) had a private room where they could talk to their contraceptive providers without the next person overhearing what they were saying.

## **KNOWLEDGE ABOUT TERMINATION OF PREGNANCY (TOP) SERVICES**

Most of the participating 55 women (29.1% (n=16)) decided on their own to request a TOP, 27.3% (n=15) were advised by friends to do so, 21.8% (n=12) were advised by their partners, 10.9% (n=6) were advised by medical doctors, 5.5% (n=3) were advised by their mothers and 5.5% (n=3) by clinic nurses.

The majority of these women, 90.9% (n=50) reportedly requested a TOP for the first time and only 9.1% (n=5) said it was not their first but their second time. However, these findings could neither be confirmed nor refuted. The participants' answers were accepted without further questions from the interviewer.

As many as 94.5% (n=52) of these women were willing to use contraceptives after their TOPs, to prevent future unwanted pregnancies. These results are consistent with those of Adanlawo and Moodley (1999:100) where 95.8% of women were willing to use contraceptives subsequent to their TOPs. Those women (5.5%; n=3) who did not intend using contraceptives indicated that they would prefer to refrain from future sexual activities.

As many as 58.2% (n=32) of these women would not consider undergoing another TOP, 36.3% (n=20) said they would do so and 5.5% (n=3) were unsure. Those who would not consider another TOP said:

- They did not want to get used to doing this procedure (n=15).
- This was not the right thing to do (n=11).
- They would never have sex again (n=2).

Those that would consider another TOP said:

- They already had the required number of children,

another pregnancy would mean another TOP (n=13).

- The service was good (n=5).
- The service was close to them (n=1).
- There were no problems with the current TOP (n=1).

## **LIMITATIONS OF THE STUDY**

- The sample of this study comprised only pregnant women, who requested TOPs at the Bethal Hospital in the Gert Sibande District of the MP. (The Bethal Hospital was the only place where TOP services could be obtained in this district when the study was conducted during 2004). Obtaining information from pregnant women was difficult, because being pregnant, and requesting TOPs, put these women in difficult emotional and psychological states.
- The type of information that was required by the structured interview schedule was private and confidential, so great care had to be exercised not to threaten persons' privacy. Careful explanations were provided about the purpose of the study.
- The study was conducted in a hospital setting where the clients could find it difficult to relax.
- In attempting to deal with their own failures to use freely available contraceptives, these women might have resorted to some under and/or over reporting of specific issues addressed in the structured interview schedule.
- The study was only conducted on women requesting TOPs, indicating the failure of contraceptive use. It is not known whether non-pregnant women, using contraceptives in the Gert Sibande District, encountered similar and/or different challenges.
- As no probing questions were asked about the participants' marital status, it could not be ascertained how each woman defined her marital status.

## **RECOMMENDATIONS ARISING FROM THE STUDY**

Effective use of contraceptives has the potential to improve not only the lives of men, women and children, but also the lives of their families and communities. The following recommendations, if implemented, could enhance women's effective use of contraceptives.

- Education on contraceptive options as well as discussions on side-effects of different

contraceptives should feature prominently in all primary health care (PHC) strategies.

- Contraceptive services should be made accessible over weekends and during lunch breaks.
- Contraceptive services should be provided concurrently with all PHC services at all PHC clinics.
- Contraceptive providers should receive regular in-service education sessions.
- Peer reviews (audits) should be done to evaluate the provision of contraceptive services.
- Strategies should be devised to ensure that the available human and material resources are used effectively to avoid overcrowding at the clinics and staff burnout.

## **RECOMMENDATIONS FOR FUTURE RESEARCH**

While conducting the research and compiling the report, it became apparent that further research is required about:

- Women's contraceptive knowledge, attitudes and perceptions on different contraceptives.
- The extent of the impact of side-effects on proper contraceptive use.
- The major use of hormonal contraceptives and apparent under-utilisation of other contraceptive methods.
- Attitudes and perceptions about female condoms.
- The providers' knowledge and attitudes about emergency contraceptives.
- The users' views about emergency contraceptives.
- The financial implications of performing TOPs for the health care services.
- An investigation into long-term psychological and emotional implications of TOPs on specific women.

## **CONCLUSION**

The 55 women who participated in this research required more information about contraceptives, including the possible side-effects of using specific contraceptives. The major challenge to their effective use of contraceptives appeared to be the women's lack of understanding about contraceptives' side-effects, followed by their inability to access contraceptive services over weekends and during lunch hours. Their reported inability to cope with the side-effects of contraceptives caused them to discontinue using



contraceptives, resulting in unwanted pregnancies and requests for TOPs.

Nurses in the Gert Sibande District of the MP should teach women about contraceptives' side-effects. If more women could use contraceptives effectively, in spite of experiencing some side-effects, then the demand for TOPs in this district should decline. In this way nurses could help to save money for the health services (by reducing the number of TOPs) and enhance women's quality of life as well as women's basic freedom to decide whether or not to conceive a child at any particular time during their lives.

"Despite the difficulties in interpreting the relationship between abortion, contraceptive use and fertility, quantifying levels of abortion, even in approximate terms, is essential for determining women's access to and use of contraceptives and family planning services" (Singh & Sedgh, 1997:4). It remains a matter of grave concern for the contraceptive providers in the Gert Sibande District that 85,5% of the participants, who requested TOP services, had indeed used contraceptives but failed to prevent unplanned pregnancies. This poses a major challenge to PHC clinics in the area to provide more effective health education so that women who use contraceptives can succeed in preventing unplanned and/or unwanted pregnancies.

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