FACTORS IMPACTING ON CONTRACEPTIVE PRACTICES: INTRODUCTION AND LITERATURE REVIEW: PART 1

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ABSTRACT

Contraceptive practices entail a wide spectrum of concepts, namely, contraceptive methods, the use of contraceptives, the discontinuation of such use, and the non-use of contraceptives or failure to use them. The use of contraceptives and contraceptive services is influenced by a number of factors that either motivate or demotivate women to use contraceptives effectively. The aim of this literature review is to identify and describe factors impacting on the contraceptive practices of women. The discussion includes factors impacting positively or negatively on contraceptive practices in terms of age-related issues, education and status, religion, socio-cultural beliefs, values and norms, knowledge about contraceptives, contraceptive providers and the accessibility of contraceptive services.

OPSOMMING

Voorbehoedpraktyke behels 'n wye spektrum begrippe, naamlik, voorbehoedmetodes, die gebruik van voorbehoedmiddels, die staking van sodanige gebruik, en die nie-gebruik van voorbehoedmiddels of versuim om sulke middels te gebruik. Die gebruik van voorbehoedmiddels en voorbehoeddienste word beïnvloed deur 'n aantal faktore wat vroue óf motiveer óf demotiveer om voorbehoedmiddels doeltreffend te gebruik. Die doel met dié literatuuroorsig is om faktore te identifiseer en te beskryf wat 'n impak op die voorbehoedpraktyke van vroue het. Die bespreking sluit faktore in wat positief of negatief op voorbehoedpraktyke inwerk in terme van ouderdomsverwante kwessies, opvoeding en status, godsdiens, sosio-kulturele beskouings, waardes en norme, kennis van voorbehoedmiddels, voorbehoedverskaffers en die toeganklikheid van voorbehoeddienste.

INTRODUCTION AND BACKGROUND

In the second half of the 20th century, perhaps the most significant and personal change that occurred to women was the evolution of "contraceptive technology". The expanded availability of modern contraceptive methods and the involvement of governments lends support to this notion (Bongaarts & Westhoff, 2000:193; Centres for Disease Control and Prevention, 1999:12). Every potentially fertile couple should therefore take cognisance of this giant stride by utilising contraceptives effectively and consistently to prevent unplanned and unwanted pregnancies. Contraceptive practices entail a wide spectrum of concepts, namely, contraceptive methods, the use of contraceptives, the discontinuation of such use, and the non-use of contraceptive methods or failure to use such methods (Ahman & Shah, 2006:128; Maja & Ehlers, 2004:50). A number of factors impact on contraceptive practices, effectively or ineffectively, resulting in planned or unplanned pregnancies respectively. For the purposes of this article, those factors include age-related issues, level of education and status, cultural values, beliefs and norms, religious affiliations, knowledge about contraceptives, contraceptive providers and the accessibility of contraceptive services.

Effective contraceptive practices have the potential, not only to improve the lives of the women, men and children involved, but also to benefit couples, families and communities. If used consistently and effectively, contraception offers women the freedom to determine the number of children conceived and the timing of such conceptions; it empowers them to control their fertility, manage their reproductive lives, and maintain a basis for self-respect and social dignity (The Alan Guttmacher Institute, 1999:2; World Health Organization (WHO), 1995:5).

The effective use of contraceptives ensures that a couple can postpone having children until they are financially stable. Thus, parents can ensure that their children are adequately planned for and receive those material requirements that are necessary for their health and welfare, such as food, housing, education and medical care. Furthermore, effective and consistent contraception benefits the youth, giving them protection against too early or unwanted pregnancies and childbirth, against sexually transmitted infections, and also HIV/AIDS, thus affording them better opportunities for education, better job possibilities and the prevention of unsafe abortion (Bongaarts & Westhof, 2000:193; Centres for Disease Control and Prevention, 1999:10). In addition, the WHO (1995:6) suggests that environmental resources, such as water, land and food, may have reduced strain, community resources, such as health services and education, will also have reduced strain, and finally, there will be greater participation by individuals in community affairs if couples utilise contraceptives effectively.

On the contrary, the ineffective use of contraceptives or failure to use contraceptives often result in ill-effects, such as unplanned pregnancies among adult women and young girls as well as termination of pregnancies. The Alan Guttmacher Institute (1999:4) estimated that worldwide, 38% of pregnancies are unplanned and some 25% of births are thought to be unwanted or mistimed. Further estimates were that 46 million induced abortions are procured annually worldwide, as a result of unplanned and unwanted pregnancies. In the Republic of South Africa (RSA), Badenhorst (in Poggenpoel & Myburgh, 2006:4) reported that since February 1997 more than 160 000 termination of pregnancies were performed. Such termination of pregnancies could have been prevented if contraceptives were used consistently and appropriately.

Unplanned or unintended pregnancies adversely affect individuals, families and communities. The implications of unplanned pregnancies may include financial hardships, since the woman might have to take maternity leave with a limited or no source of income and thus deprive her family, financially, if she is a breadwinner. Furthermore, women who have unplanned pregnancies may experience psychological problems, social isolation and family disorganisation (Fessler, 2003:178; WHO, 1995:5).

Unplanned and unwanted pregnancies also pose problems to adolescents or teenagers who may lack knowledge about parenting as well as caring for themselves as adolescent/teen mothers. Various studies have shown that adolescent or teen pregnancies have far-reaching consequences in respect of the teenagers themselves, their families, and their communities, and they are regarded as one of the major factors in the perpetuating of poverty in communities, worldwide, including the RSA (Ehlers, Maja, Sellers & Gololo,

2000:53; Modungwa, Poggenpoel & Gmeiner, 2000:62; Silberschmidt & Rasch, 2001:1816). Estimates by the WHO (1998:6) indicate that close to 17 million girls under the age of 20 years give birth each year. Most of those pregnancies are unplanned, and, annually, as many as 4.4 million adolescent girls seek to effect the termination of pregnancies. It was therefore in view of these consequences, that the researcher sought to identify and describe the factors impacting on contraceptive practices of women during reproductive ages, using reviewed literature for justification. If these factors could be clarified and considered when utilising contraceptive services, perhaps the number of unplanned and unwanted pregnancies among young and old women could be reduced.

PROBLEM STATEMENT

Unplanned and unwanted pregnancies continue to be a major public health concern, because of their impact on maternal–child health and the social and economic wellbeing of the nation. Despite the globally acclaimed potential benefits of contraception, the effective use of contraceptives has reportedly been hampered by a number of factors. This literature review aims to identify and describe factors impacting on contraceptive practices among women of reproductive ages. If these factors are identified and clarified, perhaps the increasing problem of adolescent pregnancies as well as unplanned pregnancies among women, may be better addressed. The increasing rise of unplanned and unwanted pregnancies in the RSA and the high rate of termination of pregnancies, has prompted the researcher to identify and describe the factors impacting on contraceptive practices in Part 1, and Part 2 of this research will focus on the factors impacting on contraceptive practices and utilisation of contraceptive services among the youth in Northern Tshwane.

OBJECTIVES OF THE RESEARCH

The objectives of the research were to:

- identify and describe the factors impacting on contraceptive practices among women – Part 1, and
- determine factors impacting on contraceptive practices and the utilisation of contraceptive services among the youth in Northern Tshwane – Part 2.

SIGNIFICANCE OF THE RESEARCH

Individuals, families and communities could benefit if factors impacting on contraception should be apparent, considered and understood when using contraceptives. Unplanned and unwanted pregnancies as well as termination of pregnancies may also be reduced.

Having knowledge of the factors that impact positively on contraception could enhance women's use of contraceptives to prevent unplanned pregnancies and the complications thereof.

Knowledge of the factors impacting negatively on contraception could help individuals, families, health-care planners and policy makers to address the anticipated complications, hardships and ill-effects resulting from adolescent, unintended and repeated pregnancies.

FACTORS IMPACTING ON CONTRACEPTIVE PRACTICES

Contraceptive services have been expanded and improved in most countries, however, the effective use of contraceptives has been reportedly influenced by a number of factors. These factors either motivate or discourage women to use contraception consistently and effectively. In efforts to promote "Optimal health for all", factors impacting on contraceptive practices should be identified and be addressed accordingly.

Studies that specifically address contraceptive practices among women and young girls were noted. Although most factors are interrelated, for the purposes of this paper, they have been considered under the following:

Age-related issues

Elderly women

Age has been identified as an important factor that influences contraceptive practices. Women at each end of the child-bearing continuum may have age-related reasons for the use or non-use of contraceptive services and contraception. Elderly, multiparous women may not seek or use contraceptives believing that they already have enough children and cannot have more children even without using contraceptives effectively. This false belief has been refuted, since many elderly,

multiparous women conceived and had unintended pregnancies due to the non-use of contraceptives. Piccino and Mosher (1998:6) found that women over 35 years of age did not use contraceptives even though they had regular sex, because they believed that fertility rates declined as age increased. In this regard, women are urged to use contraceptives consistently irrespective of their ages as long as they engage in sex to prevent unplanned pregnancies.

Adolescents

A significant number of adolescents become sexually active at an early age, globally, implying that they need to protect themselves against unintended pregnancies. Previous studies have reported a high rate of unplanned pregnancies among adolescents due to impediments in contraceptive use, which included lack of knowledge about contraception, a partner's dislike of contraceptives, the mother's disapproval of the use of contraceptives, and the inaccessibility of contraceptive services (Ehlers *et al.* 2000:53; Erken & Desiderio, 2004:1). Such pregnancies could have been avoided if factors impacting negatively on contraceptive practices were identified and addressed appropriately.

Furthermore, adolescent pregnancies have adverse health, social and economic implications for mothers, their families and communities. Reported implications of adolescent pregnancies are, *inter alia*, the following:

- High morbidity and mortality during pregnancy or labour, which include anaemia, prolonged labour due to cephalo-pelvic disproportion, and hypertensive disorders during pregnancy and labour (Kumbani & McInery, 2002:43).
- Poorer neonatal outcomes, such as prematurity, respiratory distress syndrome, congenital abnormalities and feeding problems (Chandria, Schiavello, Ravi, Weinstein & Hook, 2002:12).
- Psychological, social and maternal health problems (Akin & Ozaydin, 2005:203; Fessler, 2003:192).

If these complications of adolescent pregnancies are to be avoided, then sexually active young girls must be fully informed about the different contraceptive methods and be responsible to take charge of their lives including reproductive health.

Women's level of education and status

Factors, such as literacy level, determine the status of women and their level of empowerment, which subsequently influence both their use of contraceptives and their control over reproductive matters. An educated woman may be more capable of avoiding the severe consequences of an unintended pregnancy and the risks of complications if an abortion is induced, whilst an uneducated woman could have difficulty in understanding her own body and the consequences of an unplanned pregnancy and its health risks. Such women's status further restricts their mobility and decision-making abilities on matters including their own reproductive health (Akin & Ozaydin, 2005:203; Department of Health, 1999:15).

In the RSA, nearly two million women over the age of 20 years have had no schooling, compared to the total number of women, namely 21.3 million (Census, 2001:6). This then implies that those women were indirectly affected, for they could not read or even understand pictorial messages of contraception on noticeboards. The Department of Health (1999:15) argues that fertility levels will decrease significantly only when 70% of the country's women become literate, implying that women would be in a better position to make informed decisions about their lives.

The United Nations Population Fund (UNPF) has expressed similar concerns over the education backlog of women in Africa and Asia. It has been established that seven years of education, especially for girls, is the critical threshold for a decrease in the total fertility rate (TFR). In Brazil, women with no education have an average of 6.5 children, whilst those with secondary school education have only 2.5 children (UNPF, 1998:10). Improving women's educational opportunities can have an important impact on their effective use of contraceptives.

Religious affiliations

Religious affiliations may impact on the use of contraceptives due to differing beliefs regarding birth control. Some Christian denominations are against birth control, since they maintain that it goes against God's word that people shall multiply and be many. According to Popenoe, Cunningham and Boult (1998:411) Christian

churches had, in the past, generally believed that procreation was one of the primary goals of marriage and, as a result, they were opposed to the use of contraceptives.

Other religions lack sharply defined doctrines on fertility control, or show support for contraception. In Thailand, for instance, Buddhism encourages and respects the autonomy of women, and, therefore, it is believed that they are entitled to make their own decisions about the use of contraceptives (Popenoe *et al.* 1998:412).

Popenoe *et al.* (1998:412) indicate that Islam, with a strong patriarchal history, considers the use of contraceptives as a sin, encourages couples to have large families and regards being a wife and mother as the woman's primary role in life. The authors noted that traditional Muslim values may be changing, for Egypt and Pakistan, two Muslim countries with serious population problems, have embarked on successful national family planning. Research conducted in the RSA, found that some women resorted to abortion, even though they acknowledged their communities' strict disapproval, on conventional religious grounds, of pregnancy terminations (Maforah, Woods & Jewkes, 1997:82). Women had failed to use contraceptives to prevent unwanted pregnancies on religious grounds, but had to terminate such pregnancies in order to comply with their religious doctrines. Such women are often in a dilemma of not knowing which actions will be right or wrong when making decisions about contraception.

Knowledge about contraceptives

Adequate information

It is generally assumed that having knowledge about contraception might encourage women to use contraceptives effectively. However, this assumption could depend on the type of information women have about contraception. Women should be adequately informed about contraceptive methods, how and when to use such methods, where to obtain contraceptives, as well as the side-effects associated with specific contraceptive methods and their management. Various studies have shown that the majority of women know about commonly used contraceptive methods, such as the Pill, injections, condoms, sterilisation and abstinence (Maja & Ehlers, 2004:44; Mbokane & Ehlers, 2006:44), but that some of them, despite having knowledge about contraceptives, still had unintended pregnancies and terminated such pregnancies (Mbokane & Ehlers, 2006:45; Myburgh, Gmeiner & Van Wyk, 2001:39). This could suggest that women who terminated pregnancies might not have been adequately informed to prevent unplanned and unwanted pregnancies.

Sources of information regarding contraceptives

The home remains the primary source of socialisation in families. It should be within this socialisation process that children receive sexuality education from the young age of five years, and continue to receive such education throughout their lives. The Alan Guttmacher Institute (2001:8) refers to sexuality education as a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. Parents are therefore challenged to take the initiative of imparting information about sexuality issues, the developmental stages of their children and the prevention of risky sexual behaviours as well as giving appropriate explanations, where necessary. Such open communication among parents and children could allay myths and unfounded stories about contraception and prepare children to become better informed adults. Youth are more at risk if there's poor communication with their parents regarding issues affecting their lives.

Studies have shown that girls and boys are mainly informed about contraceptive issues by their mothers, the media and sisters. On the other hand, fathers had reportedly not shared any contraceptive information with their children (Maja & Ehlers, 2004:44; Mbokane & Ehlers, 2006:51). Teachers, health-care providers, churches, and other social groups could also play a continuous role in informing children about sexually related issues and ways of preventing risky behaviours. Reportedly, some young girls and boys had received contraceptive information from such sources (Ehlers & Maja, 2001:10; Seekoe, 2005:28).

Misconceptions about contraceptives

Misconceptions about contraceptives are closely linked with side-effects experienced by women when using certain contraceptive methods. Misconception about a contraceptive, such as Depo Provera, which causes amenorrhoea, may lead to the rejection of effective modern contraception (Maforah *et al.*1997:80*).* Amen-

orrhoea should be explained as a side-effect of Depo Provera that could be considered normal, especially after the first year of use. Silberschmidt and Rasch (2001:1819) found that some girls who had tried oral contraceptives had stopped using them because of side-effects, such as irregular bleeding. It is imperative that clients seeking contraceptives be informed about contraceptive methods, their side-effects and how to manage such side-effects. Having such knowledge may reduce fears and misconceptions about contraceptives and may subsequently encourage clients to use contraceptives consistently.

Socio-cultural values and beliefs about contraception

Gender issues

Certain cultural groups have restrictive laws and traditions that impact on the effective use of contraceptives. For instance, in some African cultures, women and young girls seek their husband's or partner's approval for using contraceptives. In Swaziland, the minority status of women was identified as contributing to the high rate of unplanned adolescent pregnancies (Ziyani, Ehlers & King, 2003:39). Similarly, Akin and Ozaydin (2005:203) found that in families where a man's opinion was dominant, women could not discuss contraceptive issues with their husbands. In relationships where the female partner is very young and has no decision-making powers, safer sex practices, especially the use of condoms (MacPhail & Campbell, 2001:1613), may not be easy every time. Maforah *et al.* (1997:80) noted that in some instances, women's partners disapproved of contraception and women were consequently, unwilling to use contraceptives. This was an indication of disempowerment and the powerlessness of women within many sexual relationships.

In communities where contraceptives are not socially accepted, women may fear disapproval or retribution. Instances of violence suffered at the hands of their husbands, disdain shown by relatives and friends, or being held up to ridicule by their communities were reported in Mali and Bangladesh by women who were the first in their villages to use contraceptives (Waliullah *in* Caldwell, Barkat-e-Khuda, Ahmed, Nessa & Hague, 1999:134). A similar study (Wingood & DiClemente, 1998:1267) showed that African-American women were less likely to use condoms than other contraceptive methods and were likely to experience abuse when they discuss condoms with their partners. In efforts to improve women's communication with their partners, women should be empowered with skills to be able to make informed decisions about their sexual practices, use of contraceptives, and planning of their future lives (Varga, 2003:162).

Partner support

Partner support is a significant variable influencing effective contraceptive practices. Lack of communication between husbands and wives or partners about sexual matters, the value men place on large families as a sign of virility, and the view that many children mean prosperity have been cited (Noone, 2000:336; Ziyani *et al.* 2003:39) as reasons for the failure of effective contraceptive practices. In some instances, women had to hide contraceptives from their partners or even discontinue their use, thus exposing themselves to unprotected sex (Jewkes, Vundule, Maforah & Jordaan, 2001:743; Maforah *et al.*1997:80). Open communication between women and men about contraception may actually contribute to the effective use of contraceptives.

The involvement of men in reproductive health issues could have a significant impact on women's health as was emphasised at the International Conference on Population Development (ICPD) in Cairo in 1994 and the Hague Forum in 1999. The essence of the report was that the health and socio-economic problems of women cannot be solved without involving men (Akin & Ozaydin, 2005:205; Silberschmidt & Rash, 2001:1826).

Women need their partner's support, also in the case of termination of pregnancy (TOP), since they have traumatic experiences during and after the procedure. Shostak and McLouth (*in* Myburgh *et al.* 2001:39) noted that men experience deep feelings – usually of anger – directed against themselves and their partners, because of their being put in a situation where a pregnancy has to be terminated, and they feel guilty for being accomplices in the procedure. The authors maintain that men see their detachment as resulting in ill-effects for the woman and for the couple's relationship. Perhaps, if men could be involved in supporting their partners during TOP, they could also play a significant role in preventing unintended pregnancies, so that the number of TOPs could then be reduced.

Contraceptive providers

Perceptions about contraceptive providers

Contraceptive providers may contribute positively or negatively to a patient's/client's utilisation of health services. Patient satisfaction is a significant measure of assessing the effectiveness of care from health services. It is imperative, therefore, that contraceptive providers be well trained and fully knowledgeable, continuously updating their knowledge with the latest developments in contraceptive services to meet the health needs of their clients. Good interpersonal relations with clients should also be paramount when imparting information to clients. These dimensions may strongly influence clients' confidence in their choices, their satisfaction with services, the probability of a return visit, and the consistence and continuation of the contraceptive method.

Research indicates that the majority of women who use contraceptives perceive their contraceptive providers as friendly, helpful and approachable (Maja & Ehlers, 2004:50; Mbokane & Ehlers, 2006:54). Although findings of some studies conducted among the youth indicated that contraceptive providers were rude, judgmental and negative towards young clients (Jaganen, 1999:78; Jewkes *et al.* 2001:740). Health care providers should treat clients equally regardless of their ages, race or nationality to ensure satisfactory utilisation of services.

Counselling

Contraceptive providers should be fully informed on how to counsel clients presenting for contraceptives. In addition, clients should be afforded counselling, privately and confidentially, as well as be allowed to choose a contraceptive method voluntarily. Suggested guidelines are the following:

- Uphold an attitude of empathy, respect and non-judgment towards clients, regardless of their race, sex, age, religion, culture, disability or social status.
- Listen to clients' needs and establish an open, interactive communication.
- Use appropriate language, information, education and communication materials.
- Provide impartial information on the available contraceptives and method mix.
- Help the client choose an appropriate contraceptive method that suits her personal circumstances and is medically safe, and let her consider the possibility of exposure to STDs/HIV.
- Give complete information on the chosen method, including how to use it, supply or removal requirements, common side-effects and how to deal with them, warning signs of complications, and emergency follow-up procedures (DoH, 2000:18).

Following such counselling, the client should feel satisfied with her choice of method, know how to use the method correctly and what follow-up is needed.

Accessibility of contraceptive services

Accessibility implies that regular health care should be provided at all health-care facilities, at all times (DoH, 1999:15).

Geographic accessibility

Access to services remains paramount for all clients. Even with sufficient knowledge of the means to avoid pregnancy, women may still have unintended pregnancies if appropriate and effective methods of contraception are not readily available to them, at the time they are needed. The WHO (1996:25) points out that despite the advances in contraceptive technology, large numbers of people and couples have only limited, if any, access to reliable methods of contraception.

The distance between the home and the clinic impacts on the effective utilisation of services, especially if clients live in remote areas where transport is non-existent or expensive. Clients would therefore be required to walk long distances to seek contraceptives, which may be another deterrent, leading to discontinuation of the use of contraceptives or failure to use them (DoH, 1999:15; Richter, 2000:75).

Functional accessibility

Mainly in disadvantaged areas and in many high-density urban, peri-urban areas and informal settlements (UNPF, 1998:49), an inequality exists in the accessibility of contraceptive services. Rigid and relatively short clinic hours for client consultations (generally from Monday to Friday, from 08:00 to 13:00 or 16:00) reduce service availability and can contribute to many hours of waiting, which may be unacceptable to cli-

ents.

A number of studies have reported that contraceptives were inaccessible to clients over weekends when they were desperately needed (Ehlers *et al.* 2000:52; Mbokane & Ehlers, 2006:52; Richter, 2000:78). In order to address these problems, the feasibility of providing contraceptives over weekends, especially for school-going and working clients, should be investigated and considered. Emergency contraceptives and the female condom could also be made available to clients in need and more information about modern contraceptives should be provided at all at health care centres, schools and community centres.

CONCLUSION

From this literature review, it became evident that multiple factors impact on contraceptive practices either positively or negatively. Factors influencing contraceptive practices positively should be implemented and enhanced, whilst those deterring the use of contraceptives must be discouraged and discarded if "Optimum health for all" is to be achieved.

The discussion included factors impacting on the use of contraceptives in terms of age, level of education and status, religion, socio-cultural beliefs, values and norms, knowledge about contraceptives, contraceptive providers, and the accessibility of contraceptive services. Part 2 of this research will focus on factors impacting on contraceptive practices and the utilisation of contraceptive services by the youth of Northern Tshwane.

REFERENCES

AHMAN, EA & SHAH, I 2006: Contraceptive use, fertility and unsafe abortion in developing countries. **European Journal of Contraception and Reproductive Health Care**, 11(2):126-131.

AKIN**,** L & OZAYDIN, N 2005: The relationship between males' attitudes to partner violence and use of contraceptive methods in Turkey. **European Society of Contraception**, 10(3):199-206.

BONGAARTS, J & WESTOFF, CF 2000: The potential role of contraception in reducing abortion. **Studies in Family Planning**, 31(3):193-202.

CALDWELL, B; BARKAT-e-KHUDA, L; AHMED, S; NESSA, M & HAGUE, I 1999: Bridging the gap. **International Family Planning Perspectives**, 25(1):34–37, 43.

CENSUS, 2001: The people of South Africa: Population census. Pretoria: Statistics, South Africa.

CENTRES FOR DISEASE CONTROL AND PREVENTION 1999: Family Planning methods. Africa. Atlanta: Department of Health and Human Services.

CHANDRIA, C; SCHIAVELLO, PP; RAVI, B; WEINSTEIN, AG & HOOK, FG 2002: Pregnancy outcomes in urban teenagers. **International Journal of Gynaecological and Obstetrics**, 79:117–122.

DEPARTMENT OF HEALTH 1999: National framework and guidelines for contraceptive services. Pretoria: Government Printers.

DEPARTMENT OF HEALTH 2000: National contraception policy guidelines. Pretoria: Government Printers.

EHLERS, VJ; MAJA, T; SELLERS, E & GOLOLO, M 2000: Adolescent mothers' utilisation of reproductive health services in the Gauteng Province of South Africa. **Curationis**, 23(3):43–53.

EHLERS, VJ & MAJA, T 2001: Adolescent mothers' knowledge and perceptions of reproductive health services in the Ga-Rankuwa area. **Africa Journal of Nursing and Midwifery**, 3(2):9–13.

ERKEN, A & DESIDERIO, R 2004: Meeting the reproductive health needs of young people: UNFP initiatives in Europe. Baltimore: International planned parenthood Federation.

FESSLER, KB 2003: Social outcomes of early childbearing: Important considerations for the provision of Clinical care. **Journal of Midwifery and Women's Health**, 48(3):178-185.

JAGANEN, PD 1999: Adolescent health care: Is it a forgotten and neglected field? Challenges for the 21st Century: A review of the literature. **Health SA Gesondheid**, 4(3):74–78.

JEWKES, R; VUNDULE, C; MAFORAH, F & JORDAAN, E 2001: Relationship dynamics and teenage pregnancy in SA. **Social Sciences and Medicine**, 52:733-744.

KUMBANI, L & McINERY, P 2002: The knowledge of obstetric complications among primigravidae in a rural health care centre in the district of Blantyre, Malawi. **Curationis**, 25(3):43-54.

MAFORAH, F; WOOD, K & JEWKES, R 1997: Backstreet abortions: Women's experiences. **Curationis**, 20(2):79–82.

MAJA, TMM & EHLERS, VJ 2004: Contraceptive practices among women in Northern Tshwane. **Health SA Gesondheid**, 9(4):42–52.

MBOKANE, AN & EHLERS, VJ 2006: Contraceptive challenges experienced by women who requested termination of pregnancy at services in the Mpumalanga Province. **Health SA Gesondheid**, 11(1):43–55.

MACPHAIL, C & CAMPBELL, C 2001: "I think condoms are good, but Aai, I hate those things": Condom use among adolescents and Young people in a South African Township. **Social Science and Medicine**, 52:1630-1627.

MODUNGWA, N; POGGENPOEL, M & GMEINER, A 2000: The expe-

rience of mothers caring for their teenage daughter's young children. **Curationis**, 23(2):62-70.

MYBURGH, M; GMEINER, A & VAN WYK, A 2001: Support for adult biological fathers during termination of pregnancy. **Health SA Gesondheid**, 6(1):38–48.

NOONE, J 2000: Cultural perspectives on contraception: A literature review. **Clinical Excellence for Nurse Practitioners**, 4(6):336–340.

PICCINO, L & MOSHER, WD 1998: Trends in contraceptive use in the United States: 1982–1995. **Family Planning Perspectives**, 30(1):4–10, 46.

POGGENPOEL, M & MYBURGH, CPH 2006: Women's experience of termination of pregnancy. **Curationis**, 29(1):3-9.

POPENOE, D; CUNNINGHAM, P & BOULT, B 1998: Sociology: South African Edition. Cape Town: Prentice Hall.

RICHTER, S 2000: Accessibility of adolescent services. **Curationis**, 23(2):76–82.

SEEKOE, E 2005: Reproductive health needs and the reproductive health behaviour of the youth in Mangaung in the Free State: A feasibility study. **Curationis**, 28(3):20-30.

SILBERCHMIDT, M & RASH, 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.

THE ALAN GUTTMACHER INSTITUTE, 1999: Sharing responsibility: Women, society and abortion worldwide. New York: Alan Guttmacher Institute.

THE ALAN GUTTMACHER INSTITUTE, 2001: Sex education: Politicians, parents, teachers and teens. **The Guttmacher Report on Public Policy**, 4(1):1-25.

UNITED NATIONS POPULATION FUND 1998: Republic of South Africa: Program and strategy development report. United Nations Population Fund. New York: United Nations.

VARGA, C 2003: How gender roles influence sexual and reproductive health among South African adolescents. **Studies in Family Planning**, 34:160-172.

WINGOOD, GM & DiCLEMENTE, RJ 1998: The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. **American Journal of Public Health**, 88(8):1267-1268.

WORLD HEALTH ORGANIZATION 1995: Health benefits of family planning. Geneva: World Health Organization.

WORLD HEALTH ORGANIZATION 1996: Improving access to quality care in family and reproductive health. Geneva: World Health Organization.

WORLD HEALTH ORGANIZATION 1998: Reproductive Health: Strategy for the African Region. 1998–2007. Harare: WHO Regional Office for Africa.

ZIYANI, IS; EHLERS, VJ & KING, LJ 2003: Socio-cultural deterrents to family planning practices among Swazi women. **Curationis**, 26(4):39–50.