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Item Type	Article
Authors	Maja, T.M.M.;Ehlers, V.J.
DOI	http://dx.doi.org/10.4102/hsag.v9i4.179
Publisher	AOSIS Publishing
Rights	Attribution-NonCommercial-ShareAlike 4.0 International
Download date	2025-03-27 01:31:26
Item License	http://creativecommons.org/licenses/by-nc-sa/4.0/
Link to Item	https://hdl.handle.net/20.500.14519/1489

CONTRACEPTIVE PRACTICES OF WOMEN IN NORTHERN TSHWANE, GAUTENG PROVINCE

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Keywords: adolescents' contraceptive use; emergency contraception; contraception; termination of pregnancy

SUMMARY

Despite the availability of free contraceptives in the Republic of South Africa (RSA), unwanted and unintended pregnancies continue to pose challenges to reproductive health services. Structured interviews were conducted with 83 women in the Northern Tshwane area of the Gauteng Province about their contraceptive practices. All the participants could gain more knowledge about the effective use of modern contraceptives. Knowledge about emergency contraceptives was extremely limited. Although most participants knew about legalised termination of pregnancy services in the RSA, they did not know how to access these services. The recommendations address ways in which contraceptive services could be improved.

OPSOMMING

Alhoewel voorbehoedmiddels vrylik beskikbaar is in die Republiek van Suid-Afrika (RSA), bied ongewenste en onbeplande swangerskappe steeds uitdagings aan voortplantingsgesondheidsdienste. Gestruktureerde onderhoude is met 83 vroue in die Noord-Tshwane-gebied van die Gauteng Provinsie gevoer oor hulle voorbehoedpraktyke. Al die deelnemers kon meer kennis bekom oor die doeltreffende gebruik van moderne voorbehoedmiddels. Kennis oor noodvoorbehoeding was uiters beperk. Alhoewel die meeste deelnemers geweet het van wettige swangerskapterminasiedienste in die RSA, het hulle nie geweet hoe om toegang tot die dienste te bekom nie. Die aanbevelings spreek wyses aan waarop voorbehoeddienste verbeter kan word.

List of abbreviations used throughout the article:

CDC - Centres for Disease Control

CTOP - choice on termination of pregnancy

IPPF - International Planned Parenthood Federation

IUCD - intra-uterine contraceptive device

LRA - linear regression analysis

MRC - Medical Research Council

RSA - Republic of South Africa

SPSS - Statistical Package for the Social Sciences

TOP - termination of pregnancy

WHO - World Health Organization

BACKGROUND INFORMATION AND RATIONALE FOR CONDUCTING RESEARCH ABOUT CONTRACEPTIVE PRACTICES OF WOMEN

Women are exposed to the risk of unwanted and unintended pregnancies globally as a result of ineffective contraceptive use or the non-utilisation thereof. Women who can access contraceptives, should be able to decide if, when and how many children they want. In South Africa every woman should be able to access and use free contraceptives correctly and consistently to prevent unwanted pregnancies.

The use of effective contraceptives are vital for the achievement of optimal health for all. At the International Conference on Population and Development in Cairo in 1994, and at the Fourth World Conference on Women in Beijing in 1995, the World Health Organization (WHO) and other inter-governmental, international and bilateral organisations committed themselves to the principles of promoting reproductive health and women's health by addressing specific contraceptive aspects including termination of pregnancy (TOP) services (WHO, 1995:10). Similar sentiments were expressed during the International Planned Parenthood Federation (IPPF) Conference held in Mauritius in 1994, requesting participating countries to address the problem of unsafe abortions. Countries were urged to strengthen contraceptive information, education and services, emphasise couples' responsibilities for using contraceptives to prevent unwanted pregnancies and to provide quality, prompt, humane treatment to women suffering from complications of unsafe abortions (<http://web2/purl.rcl.HRCA.9/22/99>).

The prevention of unwanted pregnancies can make a significant contribution towards improving the health of women. Fathalla (1997:64) envisioned contraception as being women's power to control their fertility, constituting women's basic freedom from which other freedoms flow. Such women would be able to complete their education, maintain gainful employment, and make independent marital decisions. These women should have more choices in all spheres of life than women coping with repeated unplanned pregnancies impacting negatively on their health, gainful employment, financial status and hampering their educational pursuits.

Controlled reproduction is necessary to ensure the continued existence of any species. However, uncontrolled or excessive population growth may not only lead to poverty in all its forms but, when all the available natural resources have been exhausted, the very continuation of the species may be threatened. Theron and Grobler (1998:1) warn that if the present population growth rate is maintained, then the population of the RSA could reach 70 million by 2020, and could escalate to 100 million by 2050, with far-reaching deleterious effects on the environment, the inhabitants, the economy and the country's capabilities for continued existence and growth. With low fertility assumptions the South African population is estimated to be 94 million by 2035, but with high fertility assumptions it could reach 119 million in 2035 (Marais, 1988:80). According to Popenoe, Cunningham and Boulton (1998:403) the RSA might be unable to support more than 80 million people, implying that a zero growth rate of two children per family should be attained by 2020, in order not to exceed that number.

PROBLEM STATEMENT

Unwanted/unplanned pregnancies pose problems for women throughout the world, including the RSA. An unknown number of unwanted pregnancies continue to be terminated legally or illegally. In the RSA reportedly between 30% and 50% of women requesting TOPs were not using contraceptives at the time of conception and similar percentages of pregnancies were unplanned (Bongaarts, 1997:283; Crossier, 1996:87). This situation continues to exist in the RSA despite the availability of free contraceptives, emergency contraceptives and TOP services. A study investigating reasons why men and women fail to use contraceptives effectively and identifying possible barriers preventing such effective use, could help men and women to make better informed decisions to have the children they want, and to avoid unplanned and/or unwanted pregnancies.

The following research questions guided this study:

- Are women knowledgeable about different contraceptives, which can prevent unwanted pregnancies?
- What are women's perceptions of different contraceptives?
- What are women's reasons for non-utilisation of contraceptives?

OBJECTIVES OF THE STUDY

The objectives of the study were to:

- explore the contraceptive knowledge, perceptions and practices of clients presenting for contraceptive and CTOP services at clinics in Northern Tshwane;
- determine which contraceptive methods were used by these clients; and
- identify clients' reasons for the use or non-use of contraceptives.

OPERATIONAL DEFINITIONS

The concepts used throughout this article are briefly defined so that readers can share the researchers' interpretations of these key terms.

Contraception implies the prevention of conception at impregnation. Contraception may be achieved by using traditional and/or modern contraceptive methods. Emergency contraceptives prevent the implantation of a potentially fertilised ovum within specified periods of time subsequent to unprotected sex. TOP procedures disrupt the development of a foetus (Theron & Grobler, 1998:15).

Contraceptive practices: For the purpose of this study contraceptive practices entail contraceptive use, non-use, discontinuation and failure to use any of the contraceptive methods according to a specified set of rules.

Emergency contraceptive methods are safe and effective methods of preventing an accidental pregnancy after unprotected sex or in the case of contraceptive failure. Emergency contraception works by inhibiting ovulation, or by preventing implantation of a fertilised ovum (Kubba, 1997:104; Quinn, 1999:39).

Modern contraceptive methods refer to contraceptives which are frequently used in Westernised health care services, including oral contraceptives and injections. In the RSA these may be prescribed by doctors, nurses or pharmacists.

Termination of pregnancy (TOP) refers to the abortion of a live foetus with the intent to kill such a foetus (Choice on Termination of Pregnancy Act 92 of 1996).

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 such prescriptions.

RESEARCH METHOD

A non-experimental, quantitative, exploratory, descriptive design was used to obtain more information about contraceptive practices and examine their relationships to identify and suggest improved contraception for women in the Northern Tshwane area of the RSA. A descriptive design was used to describe the women's prevailing contraceptive practices, "...providing a picture of the situation as it naturally happens" (Burns & Grove, 2001:268). A quantitative approach was used to enquire about women's contraceptive practices and to use statistical procedures to analyse and interpret the significance of variables affecting contraceptives practices (Creswell, 1994:2).

Research population and sample

The target population for the study comprised clients presenting for contraceptive and TOP services at hospitals and clinics in the Northern Tshwane area. Three clinics were approached to participate in the study. These clinics were selected because they were geographically accessible to the researcher and field workers and because more than 50 clients sought contraceptive services from each of these clinics on a daily basis. In order to collect data within the time and financial limitations, it was essential to select clinics where every field worker could conduct a number of structured interviews on specific days.

Convenience sampling was used because all females who attended specific health care centres on the days when the field workers were available, were requested to participate voluntarily in the survey. This sampling method was deemed appropriate as it implies selection of the most readily available persons as participants in the study (Polit & Hungler, 1999:281). It was impossible to predetermine which clients would attend contraceptive services on specific days. Therefore, participants were selected as they visited the participating health care centres during the data collection phase. Participants had to be:

- females aged 16 to 49 years;
- willing to participate in the study voluntarily; and
- capable and willing to provide informed consent.

Ethical aspects

Research to conduct the study was obtained from the Gauteng Department of Health as well as from the management teams of the three participating clinics. Each woman decided independently whether or not to participate. Every participant could terminate the structured interview at any stage and could refuse to answer specific questions, should she wish to do so. No remuneration was paid. In this survey 60 female adults and 23 female adolescents comprised the convenience sample. The youngest participants were 16 years old and deemed capable of providing informed consent. As these adolescents could visit the family planning clinics without parental consent, no permission was sought from the parents/guardians of these adolescents as that could be regarded to be a breach of confidentiality. Any adolescent who wished to consult with her parent/guardian prior to participation could do so.

Research instrument

Data were collected by means of structured interviews using open-ended questions to obtain as much information about these women's contraceptive practices as possible. These questions were selected after a literature review about contraception and contraceptive practices had been conducted. The structured interview schedule comprised sections attempting to obtain information about the participants' biographic data, their contraceptive use and/or non-use, including their knowledge attitudes and perceptions about specific contraceptive methods and any challenges or barriers they encountered in accessing and/or using contraceptives.

Validity and reliability

Validity refers to the degree to which a test or instrument measures what it purports to measure. Content and face validity were confirmed by the literature reviewed, as well as by pre-testing the instrument on 10 women who were excluded from the actual survey.

Experts in women's health and research, as well as nurses providing contraceptive services, and researchers from the Medical Research Council (MRC) scrutinised the questions (Polit & Hungler, 1999:255). The major changes suggested by the nurses related to language problems. Although the questions were translated into Setswana (the language spoken by the majority of persons living in Northern Tshwane) by a bilingual expert, the nurses indicated that the majority of women were unfamiliar with the Setswana contraceptive terms and suggested that these should be supplied in both Setswana and English. This was done. Three field workers were trained in conducting the structured interviews and were assisted by a researcher if and when necessary. At the end of each day all completed interview schedules were scrutinised and any ambiguities sorted out with the field worker concerned.

Permission to conduct the survey

Written permission to conduct this research was sought and granted from the authorities of the three health care centers concerned, as well as by the research ethics committee of the institution concerned. Each participant was protected from public disclosure. Anonymity and confidentiality were honoured at all times. No persons and no institution would be identified in the report compiled about the data obtained from the participating women.

Data analysis

Data were encoded and computerised by using the Statistical Package for Social Sciences (SPSS) by statisticians from the MRC. The results were analysed using descriptive and inferential analyses. Logistic Regression Analyses (LRA) were used to ascertain relationships among variables, where appropriate.

RESEARCH RESULTS

The research results were analysed according to the sections of the structured interview schedules. Biographic information was requested in order to contextualise the data against information about who the participating women were. The ages of participants ranged from 16 to 50, as displayed in Figure 1.

The majority of the participants, namely 93,2% (n= 55)

were not married. Out of 60 adult females, 31 (51,7%) had passed Grade 12, 26 (43,3%) had qualifications lower than Grade 12 and three (5,0%) had no schooling. Fourteen (60,9%) female adolescents had passed Grade 12, whilst nine (39,1%) had qualifications lower than Grade 12, implying that all adolescents had some schooling which should enhance their comprehension of contraceptive issues. Although 35 (43,8%) adult participants were employed, 25 (43,1%) adults and 10 (45,5%) adolescents were unemployed. As many as 18 (30,5%) adult and 13 (56,5%) adolescent females who attended the three participating contraceptive clinics had no children, whilst 15 (25,4%) adults and six (26,1%) adolescents had one child each; 15 (25,4%) adults and four (17,4%) adolescents had two children; five (8,5%) adults had three children and four (6,8%) adults had four children.

Figure 2 indicates that 25 (43,1%) adults and 11 (47,5%) adolescents wanted to have only two children and 15 (25,9%) adults and six (28,1%) adolescents wanted to have three children. Furthermore, eight (13,8%) adults and five (21,7%) adolescents wished to have only one child whilst six (10,3%) adults and one (4,3%) adolescent did not wish to have any children. Only four (6,9%) adults wanted to have four children and no adolescents

wanted to have four or more children.

For the majority of participants, the high cost of living was the main reason for not wishing to have more than three children. Only 4,2% wanted big families and 9,2% provided no reasons for the number of children they wanted. Dreyer, Hattingh and Lock (1997:49) stated similar reasons why young people preferred to limit their family sizes in order to have a higher material standard of living. Participants knew about the availability of contraceptives which could prevent unwanted pregnancies. Similar views are held by the Centre for Disease Control (CDC, 1999:232) which states that contraception allows persons to plan when to have children and how many children to have.

Knowledge about different contraceptive methods and their availability

Most of the participants, 48 (87,3%) adults and 16 (76,2%) adolescents, affirmed that they knew about the following contraceptives:

- condoms (40 adults, 21 adolescents);
- injections (36 adults, 16 adolescents);
- pills (20 adults, 15 adolescents); and
- lactational amenorrhoea (20 adults, six ado-

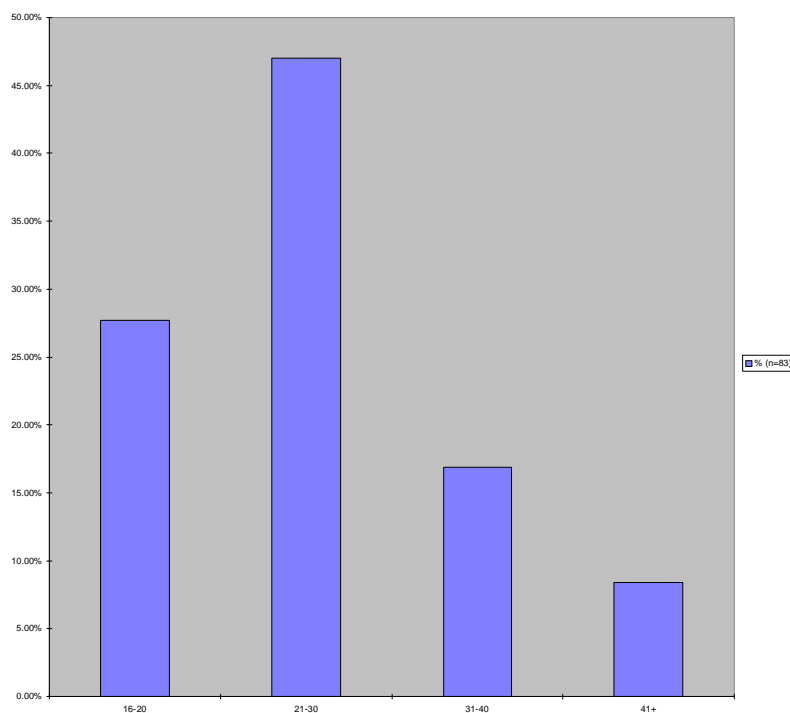


Figure 1: Ages of participants

lescents).

Only 32 (54,2%) adults and 14 (60,9%) adolescents had heard about the female condom and only three (15,8%) adolescents had bought these from pharmacies as there were no supplies at the health care centers. Most participants had never seen a female condom. Female condoms reportedly costed R14,00 per packet (containing two condoms). This was reported too costly for the majority of women to use female condoms effectively.

None of the participants indicated knowing about Norplant or about emergency contraceptives which could be used to prevent unwanted pregnancies in the event of contraceptive failure and/or unprotected sexual encounters.

Knowledge about contraceptives' side-effects

The participating women indicated that they knew about

the following side-effects of contraceptives:

- condom breakages (15 adults, eight adolescents);
- condom discomfort (16 adults, 10 adolescents);
- weight gain (20 adults, 13 adolescents);
- amenorrhoea (11 adults, eight adolescents); and
- prolonged menstruation (15 adults, six adolescents).

In addition, 75,0% of the participants had used one or more forms of contraception, whilst 25,0% had never used contraceptives despite being knowledgeable about contraceptives and despite participating in this survey during their visits to family planning clinics. However, some of these women might have participated in this survey at their first visit to the clinic, or they might have been too shy to admit using contraceptives to the field workers who might have been perceived to be strangers.

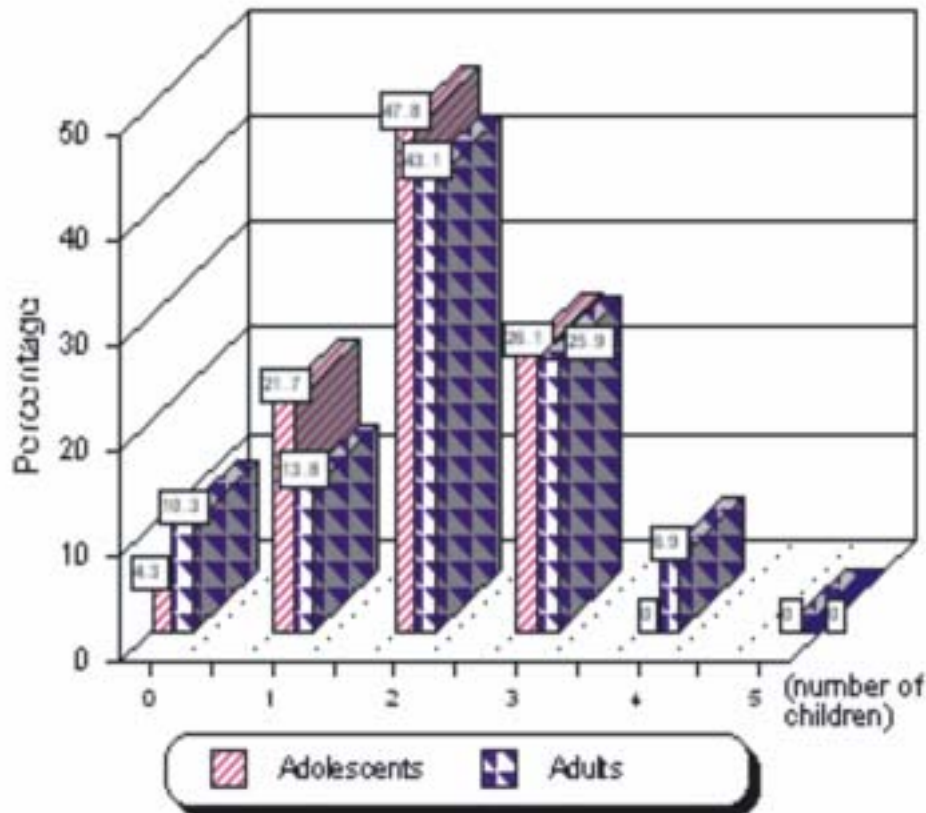


Figure 2: Total number of children female participants wished to have

Participants were informed about contraceptives by the media (14 adults and five adolescents) or by their mothers (15 adults, seven adolescents); sister(s) (seven adults, three adolescents); friends (seven adults, seven adolescents) or educators (12 adults, two adolescents). Mothers were reportedly the main source of information for most adults and young women. Health care centres, fathers and brothers did not play any role in discussing contraceptive issues with the participants.

As many as 53 (88,3%) and 18 (81,8%) adolescents reportedly used contraceptives; 26 (35,6%) adults used pills but no adolescent used pills. Furthermore, 47 (62,5%) adults and 12 (70,6%) adolescents used injections; 14 (25,4%) adults and seven (41,2%) adolescents used condoms; five (8,9%) adults and one (5,9%) adolescent used intra-uterine devices. None of the participants used diaphragms, hormonal implants or sterilisation. Other methods used by adults included abstinence and traditional contraceptives.

Out of 82 participants, 11 (13,4%) were not using contraceptives, despite having regular sex, because they lacked knowledge about contraceptives (six adults, five adolescents); their partners disliked contraceptives (four adults, five adolescents); it was against their religion (four adults, six adolescents); they did not have boy-friends at the time (two adults, six adolescents); or they did not trust contraceptives (three adults, two adolescents).

The results of the LRA of data indicated that knowledge about contraceptives exerted a significant effect ($p < 0,05$) on the use of contraceptives. This significant relationship suggested that individuals and couples who

were informed about contraceptives, were more likely to use contraceptives than those without such knowledge.

As indicated in Table 2, 20 (42,0%) participants felt positive about male sterilisation stating that males should limit their pro-creation by compulsory sterilisation after having two or three children. Injections were rated positively by 48 (59,3%) of the participants. Of these participants, 20 (41,6%) were adolescents who indicated that they preferred Nur-Isterate to Depo Provera, (because Depo Provera caused amenorrhoea unlike Nur-Isterate. As many as 42 (51,9%) participants revealed negative perceptions about oral contraceptives.

Almost half of the participants, namely 38 (46,9%), including all 23 (100%) adolescents and 15 (25,9%) adults, had negative perceptions towards intra-uterine contraceptive devices (IUCDs).

Fewer than half, 29 (30,5%) of the participants expressed positive perceptions about contraceptives stating that they would not be discouraged by side-effects from using contraceptives. Twenty-six (22,0%) females indicated negative perceptions and cited weight gain, amenorrhoea and irregular menstruation as some of their reasons for discontinued use of contraceptives. It should be emphasised that all contraceptives decrease the risk of maternal mortality from pregnancy-related causes.

Consultation of traditional healers for contraceptives

Only 11 (13,4%) participants acknowledged having con-

Table 1: Contraceptive methods used by the participants

CONTRACEPTIVE METHODS	ADULTS	ADOLESCENTS	F	%
Injection	35	12	47	64,4
Pill	26	-	26	35,8
Intra-uterine contraceptive device	5	1	6	8.2
Condoms	14	7	21	28.8
Diaphragm	-	-	-	-
Hormonal Implant	-	-	-	-
Withdrawal	-	-	-	-
Sterilisation	-	-	-	-
Other	2	-	2	2.7

Table 2: Perceptions about contraceptives

PERCEPTIONS ABOUT CONTRACEPTIVES	ADULTS	ADOLESCENTS	TOTAL	
			f	%
Female Sterilisation (n=72)				
Positive	8(13,8%)	14(60,9%)	22	27,0
Negative	11(18,9%)	9(39,1%)	20	24,7
Neutral	12(20,7%)	18(78,3%)	30	37,0
Male Sterilisation (n=76)				
Positive	1 (1,7%)	19(82,6%)	20	42,0
Negative	6(10,3%)	14(60,9%)	20	25,0
Neutral	8(13,8%)	14(60,9%)	22	27,0
Injections (n=72)				
Positive	28(58,3%)	20(41,6%)	48	59,3
Negative	12(20,7%)	8(34,8%)	20	24,7
Neutral	3 (5,2%)	1 (4,3%)	4	4,9
Oral contraceptives (n=78)				
Positive	15(25,9%)	21(9,3%)	36	44,4
Negative	16(27,6%)	16(27,6%)	32	51,9
Neutral	3 (5,2%)	7(30,4%)	10	23,0
Intra-uterine devices (n=79)				
Positive	3 (5,2%)	7(30,4%)	10	23,5
Negative	15(25,9%)	23 (100%)	38	46,5
Neutral	10(17,2%)	12(52,2%)	22	27,2

sulted traditional healers for contraceptive purposes. Prescribed traditional contraceptive measures included drinking prescribed medication prior to having sex; praying before and after sex for preventing unwanted pregnancies; wearing ropes medicated with herbs and soaked in the woman's menstruation around their waists. Some participants declined using medications prescribed by traditional healers because they assumed traditional healers lacked scientific knowledge, making their treatments untrustworthy.

Knowledge and perceptions about emergency contraceptives

Out of 82 participants, 25 (31,3%) had heard about "the morning after pill" which could be used after unprotected sex. Only 12,8% could provide information about emergency contraceptives, including that emergency contraceptives should be used within 72 hours after unprotected sex; could be obtained from clinics; and should only be used in cases of "accidents" and not as routine contraception.

Only 45 (62,7%) adults and eight (34,8%) adolescents

would use emergency contraceptives when necessary. Only a minority of adolescents knew about the dose, and/or under what circumstances emergency contraceptives could be used. Ehlers, Maja, Sellers and Gololo (2000:49) reported that 67,6% of the adolescent mothers in the Gauteng Province, did not know about the availability of emergency contraceptives. Netshikweta (1999:18) found that 73,1% of student nurses in the Limpopo Province of the RSA lacked knowledge about emergency contraceptives and that none of the participants managed to access it. These findings indicate a real need for more information about emergency contraception.

Knowledge about, perceptions towards and utilisation of termination of pregnancy services

Responding to knowledge about TOP services, 36 (61,0%) adults and 12 (52,2%) adolescents knew about these services. However, these participants only knew that they could go to a clinic or hospital if they needed TOP services. Most participants were negative towards legalised TOPs with only 20 (35,9%) indicating that

they would terminate unwanted pregnancies. Reasons favouring TOPs included that legalised TOPs were better than backstreet abortions and that women could be saved some misery resulting from unwanted pregnancies.

The majority of females who felt negative about TOPs would not utilise TOP services nor encourage others to do so. They regarded TOPs as being tantamount to murder; and against their moral views and/or religious doctrines. Inadequate knowledge regarding legalised TOP services indicated a need to educate women and adolescents about these services, reducing maternal mortality and morbidity statistics attributable to unsafe abortions.

As many as 26 (32,9%) women reportedly needed permission from their partners for using TOP services while 52 (65,8%) did not need such permission. Participants who were negative about obtaining permission from their partners argued that, in terms of the Choice on Termination of Pregnancy Act No 92 of 1996, they had the right to terminate a pregnancy without the permission of their partners.

Consistency in using contraceptives

The participants used various contraceptive methods including pills, injections, condoms and IUCDs. However, they did not use Norplant, the female condom nor emergency contraceptives, as they were unaware of the availability of these methods at their health care centres. Furthermore, 32 (39,2%) adults and 10 (44,6%) adolescents were not using contraceptives consistently; implying that they were at risk of unwanted pregnancies even though they were using contraceptives ineffectively. Consistent and correct use of contraceptives are important aspects in the prevention of unwanted pregnancies.

Nurses' attitudes towards clients' and accessibility to contraceptive services

Attitudes of staff seemed to play an important role in the clients' use of contraceptives. Table 3 indicates that 34 (63,0%) adults and 10 (47,1%) adolescents reported nurses to be helpful and polite, 17 (31,5%) adults and three (14,3%) adolescents indicated that nurses provided health education, and 15 (27,8%) adults and six

(28,6%) adolescents had received contraceptive education. Seven (13,0%) adults and six (28,6%) adolescents had not received any contraceptive information whilst only two (3,8%) adults and two (9,5%) adolescents reported nurses to be rude. Adult participants generally experienced nurses to be listening to their concerns regarding contraceptives, whereas adolescents felt that nurses did not take time to listen to them and that nurses seemed to be busy all the time.

With regard to adults, the findings correlated with Adanlawo and Moodley's (1999:99) as well as Engelbrecht, Pelsler, Ngwena and Van Rensburg's (2000:13) findings indicating that nurses maintained positive attitudes towards adult clients. Furthermore, findings from adolescents indicated that nurses were helpful and provided health education, but not contraceptive information.

Access to contraceptive services is critical for all women. Despite having adequate contraceptive knowledge, women might have unwanted pregnancies if appropriate and effective methods of contraception are not readily accessible. Only a minority of the participants spent more than 30 minutes traveling to the nearest contraceptive center, implying that health care centers were available in most residential areas. The closer the health care centres are to where the people live, attend school or work, the less time they will spend getting there and the less money will be spent on transport to these centres.

LIMITATIONS OF THE STUDY

Structured interviews were conducted with 83 women who visited three health care centres in the Northern Tshwane area. Although similar results might be obtained in other geographic areas, this might not necessarily be the case. Consequently the results might not be generalisable beyond the geographic area where the research was conducted.

As structured interviews were conducted, the participants' answers had to be accepted at face value. As the interviews were conducted anonymously, it was not possible to check any participant's answers against data in clinic records, which could have enhanced the validity of the research results.

CONCLUSIONS

Both adults and adolescents were reportedly not using contraceptives effectively. All participants had some information about contraceptives, which were available at health care centres but had no information about Norplant nor about the female condom as these were not available at their health care centres.

Traditional contraceptives were used by a minority of adults and a few adolescents who claimed to have been coerced by their mothers to do so. Emergency contraception was largely unknown to all clients. Although the participants were aware of legalised CTOP services in the RSA, they lacked information about accessing these services. The participants did not know which health care centres were designated to conduct the procedure, when to seek CTOP help and whom to contact in the event of unwanted pregnancies. Thus the mere legalisation of CTOP services did not enable women in the Northern Tshwane area of the Gauteng Province to access these services. The need existed for education about the effective use of contraceptives, emergency contraceptives and CTOP services.

RECOMMENDATIONS

The findings of this study led to the following recommendations which could help to improve contraceptive practices with resultant reduction of unwanted and unintended pregnancies in the Northern Tshwane area of the Gauteng Province.

Education about sexuality, pregnancy and how to prevent unwanted and unplanned pregnancies should commence during primary school, probably with scholars aged ten. Educators, parents and others involved in child rearing should participate actively in this role. A variety of topics including intimacy, gender role expectations, communication, contraception anatomy and physiology, should be addressed so that those who are at risk of unintentional pregnancy can prevent it.

Sexuality and contraceptive education should be an ongoing process using various approaches including mass media. The level of awareness can be maintained by giving constant attention to the need for mass media, public information campaigns and service delivery. Benefits of contraception and implications of effective

contraceptive practices should be highlighted to attract people's attention.

Policy makers should provide guidelines to health care providers, including nurses working at family planning and TOP units about providing contraceptives, emergency contraceptives and TOP services to all clients, including adolescents. Contraceptive services should be accessible to all and provided with accurate information, appropriate and compassionate counseling, and a disposition to listen to women's concerns.

Female condoms should be freely available to allow women to exercise their rights in self-protection against unwanted pregnancies and to afford women better decision-making powers in this regard.

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