Adolescent Mothers' Utilisation Of Reproductive Health Services In The Gauteng Province Of The Republic Of South Africa

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Summary

A financial grant was received from the World Health Organization (WHO) during 1998 to establish whether adolescent mothers (aged 19 or younger at the birth of their babies) utilized contraceptive, emergency contraceptive and termination of pregnancy (TOP) services in the Republic of South Africa (RSA). This report refers to data obtained from 111 questionnaires completed by dolescent mothers between January 2000 and May 2000 in the Gauteng Province; 61 in the Pretoria and 50 in the Garankuwa areas, and excluding the 12 completed questionnaires used foı pretesting the research instrument.

The biographic data of the 111 adolescent mothers indicated that the minority were married, employed or earned sufficient income to care for themselves and their babies. However, the minority used contraceptives prior to conception, none used emergency contraceptives or termination of pregnancy (TOP) services. The minority attended ante-natal clinics five or more times during their pregnancies, and a negligible number indicated that they had ever been treated for sexually transmitted diseases (STDs). These findings indicate that the 111 adolescent mothers in Gauteng who participated in this survey did not make optimum use of the available reproductive health (RH) care services. Education about sex, pregnancy and contraceptives should commence at the age of 10, but no later than the age of 12 as the majority of respondents did not have the necessary knowledge to make informed decisions about their futures.

The accessibility of contraceptive, emergency contraceptive and TOP services for adolescents should be investigated in specific areas and attempts made to enhance such accessibility. This might necessitate offering these services over weekends or during evenings when school girls could attend without fear of meeting their mothers, aunts or teachers at these clinics.

"Adolescent pregnancies imply adverse health, social and economic implications for the mothers and their offspring, but also for their families or extended families."

Background Information Of The RSA Of The Gauteng Province

The RSA occupies the southernmost tip of the African continent. Its total surface area is 1 209 090km^2. The total population is estimated to be 37,9 million people, comprising 76,3% Africans, 12,7% Whites, 8,5% Coloureds, and 2,5% Indians. Since the democratic elections in 1994, the country is divided into nine provinces, with Gauteng, meaning "place of gold", as the smallest province. Gauteng, comprising 1,4% of the RSA's total area, accommodates 7,17 million or 18,9% of the country's population. This small province produces 37,7% of the entire country's gross national product (GNP). This province has been hit very hard by the falling South African currency (RSA Rand) since 1994 coupled by the falling value of gold on the international markets, necessitating reductions among mine and industrial workers (Khunoethe 1999: 1-11).

Problem Identification

The rising incidence of adolescent mothers throughout the Republic of South Africa (RSA), causes concerns and is becoming a critical issue (Sellers 1993:1715). This happens in spite of free contraceptive services, including emergency contraception. Since 1996, changed legislation enables South African pregnant women (irrespective of age) to have their pregnancies terminated at their request during the first twelve weeks of pregnancy (Choice on Termination of Pregnancy Act No 92 of 1996).

The adolescent mothers thus failed to use the available family planning, emergency contraceptive or termination of pregnancy services. This is also reflected by the increased number of abandoned babies and the number of orphans in RSA which is expected to exceed 1 million by the year 2000 (Dept of Child Welfare, RSA. TV News:2 May 1998 At 20h00).

Objectives

The major objective of the research was to identify whether reproductive health services were utilised by adolescent mothers, and to establish possible reasons for this utilisation or non-utilisation. This information could be used to design a programme of information, education and counselling for schools, parents and health workers involved in reproductive health care especially health care workers in the reproductive health and youth health services (during a later phase of this research). In order to achieve the general objective specific objectives were formulated, namely to determine adolescent mothers'

-ages at menarche, first sexual encounters and initial utilization of contraceptives
-informants about sex and contraceptives
-attitudes towards Reproductive Health (RH) Services
-problems concerning the accessibility of these services
-knowledge about existing RH services
-actual use of contraceptive, emergency contraceptive, TOP and ante-natal services.

Justification For The Research Based On A Literature Reivew

Adolescent pregnancies imply adverse health, social and economic implications for the mothers and their offspring, but also for their families or extended families. These could be averted by the effective utilization of contraceptive services, as indicated by research conducted in the USA, claiming that the levels of contraceptive use in the USA "...averted an estimated 1.65 million pregnancies among the 15-19 year old women in the United States during 1995. If these women had been denied access to both prescription and over-the-counter contraceptive methods, an estimated additional one million pregnancies ... would have occurred. These pregnancies would have led to 480 000 live births, 390 000 abortions, 120 000 miscarriages, 10 000 ectopic pregnancies and 37 maternal deaths" (Kahn, Brindis and Glei 1999:29).

Adolescent mothers experience higher *morbidity and mortality* during pregnancy and labour than adult women. These increased health problems experienced by pregnant adolescents include anaemia, sexually transmitted diseases (including AIDS), prolonged labour due to cephalo-pelvic disproportion (CPD) and hypertensive disorders during pregnancy and labour (Goldberg & Craig 1983:863-864). A survey conducted among 128 adolescent mothers in the RSA, younger than 16 years of age, reported significant complications with regard to pregnancy induced hypertension, premature labour and anaemia (Goldberg & Craig 1983:863-864). Adolescents reportedly required more mechanical extractions during delivery than older women. In addition they also received significantly poorer antenatal care in Guadeloupe (Gallais, Robeillard, Nuisser, Cuirassier & Janky 1996:523-527).

Poorer neonatal outcomes of adolescent mothers' babies include prematurity, respiratory distress syndrome (RDS) congenital abnormalities and feeding problems. *Adolescent mothers' children* are more likely to suffer from malnutrition, be early school leavers, suffer financial hardships and end up as street children and prostitutes at an early age (Boult & Cunningham 1993:1). A statistically significant association between age and low birth weight babies was established in the Port Elizabeth area of the RSA during a 1993 study (Boult & Cunningham 1993:1). Research reports from other parts of the world seem to support this correlation, such as reflected by the following studies:

-A high incidence of low birth weight infants and pre-term deliveries have been reported in Turkey among adolescent mothers (Bozkaya, Mocan, Usluca, Beser & Gumustekin 1996:146-150).
-According to a study conducted by Hallerstedt, Pirie and Alexander (1995:1139-1142) in Minneapolis amongst 46 985 infants born to adolescent multiparas aged 11 to 19, compared to infants born to mothers older than 19 years of age, these infants with adolescent mothers were twice at risk for infant and neonatal death, two-three times at risk due to accidents, infections and SIDS (sudden infant death syndrome). This study would seem to emphasise the need to provide adequate contraception to adolescent mothers after delivery as adolescent multiparas' children seemed to face increased problems as the number of children increased.
-Research conducted in Ethiopia revealed that adolescent mothers' babies had a higher incidence of prematurity and low birth weight, and also exhibited lower other anthropometric parameters including length and head circumference. Furthermore, these babies had lower apgar scores reported at one and five minutes after birth than those born to non-adolescent mothers (Ali & Lulseged 1997:350-42).

Adolescent mothers frequently have to discontinue their *education,* causing difficulties in finding jobs leading to lifelong poverty. The only jobs available to unqualified or unskilled adolescent mothers are likely to offer salaries too low to provide for the baby's needs. These problems can be aggravated by the necessity of combining job and childcare responsibilities. Financial hardships can aggravate the mother's problems in coping with anxiety and social adjustment (Jones &

Mondt 1994:152-159).

Socio-economic problems encountered by adolescent mothers include financial problems and an increased likelihood of resorting to prostitution with its associated health risks, such as AIDS which can be fatal within a few years and STDs which can lead to infertility. Forced early marriages, due to pregnancy, can lead to social problems such as abuse among partners, and battering of children (De Villiers 1985:301-302; Sellers 1993:1719).

Socio-cultural problems of adolescent mothers include that they might be forced to leave their parents' homes, struggling to live alone with many responsibilities and few resources. Adolescent mothers in many societies still experience moral stigmas with consequences such as possible non-acceptance by future boyfriends with markedly reduced prospects of marriage (Sawchuk, Burke & Benady 1997:259-266). The adolescent mothers no longer share common interests with their peer groups aggravating their loneliness. They may also be rejected by their religious groups and be subjected to punitive measures including being banned from attending church services or using holy sacraments.

The problems encountered by the adolescent mothers and their babies "... are seen to be vast, very difficult to solve, and VERY FAR REACHING. Therefore, the increasing problem of teenage pregnancy MUST be addressed at the earliest opportunity in South Africa. The emphasis should be on the absolute necessity for finding solutions which will stem the tide of adolescent pregnancies..." (Sellers 1993:1719). "Teenage pregnancy usually has sad and tragic results.Having a baby when too young affects a girl for the rest of her life and the consequences are greater than she ever expected... She has to meet the dangers, the misery and often the utter loneliness of being pregnant..." (Sellers 1993:1715). This research attempted to identify factors preventing adolescent mothers from using the available RH services in Gauteng. Should a lack of knowledge be one of these factors a RH education programme specifically for adolescents can be designed and implemented.

Much has been written world-wide about teenage and adolescent pregnancies. This article cannot do justice by referring to a fraction of the research reported. Rather than attempting to provide a detailed literature overview, references will be made to relevant research to specific findings during the discussion of the findings.

"Despite developments in contraceptive technology and changes in societal norms, adolescent pregnancy remains a key issue for politicians, social scientists, health care providers and educators. The adolescents' access to contraception and termination of pregnancy services continues to spark legal debate" (Carter et al 1994:108-113). In the RSA family planning, emergency contraception and termination of pregnancy services are available free of charge at clinics, yet the incidence of adolescent mothers continue to increase in the RSA.

Research Design

A non-experimental descriptive design was used to obtain information about adolescent mothers' utilization of RH services. Questionnaires (with closed and open ended questions) were completed by the adolescent mothers themselves. Those respondents who experienced difficulties in reading the questions and/or responding to them, were assisted by a field worker or a nurse, depending on the research site. The questionnaire could not be translated into the eleven official languages of the RSA, (that would have consumed the entire budget for this survey) so only English questionnaires were dispersed, but the field workers or the nurses in the clinics translated aspects which the respondents did not understand.

The questionnaire's items were based on the literature search. These questionnaires were pretested by obtaining the co-operation of 12 adolescent mothers in the Pretoria and Johannesburg areas to complete the questionnaires during March and April 1999. The data from these questionnaires were coded and analyzed to identify any potential problems. (These 12 respondents did not form part of the 111 adolescent mothers comprising the convenience sample for this study). Neither the respondents nor the field workers experienced any problems in understanding the questions, but suggested removing questions about promiscuity, number of sexual partners, and HIV/AIDS knowledge (mainly because these questions were perceived as being irrelevant to the issue of adolescent motherhood). After further consultations, these questions were removed from the questionnaire. However, one issue which arose was the apparent level of discomfort of the adolescent mothers in responding to specific questions about their sexual practices which might not be openly discussed in their respective cultures. Each participant could decide whether or not to answer any specific question. This accounts for the apparently large number of non-responses, especially to open-ended questions. Another issue which arose was the question of anonymity because the adolescent mother was requested to sign permission on the first page of the questionnaire. This page, requesting signed consent, was accidentally numbered as number one of the questionnaire and stapled onto the rest of the questionnaire, annihilating the anonymity the questionnaire. After consultations with researchers, it was decided to save time and costs by supplying envelopes into which the signed consent form (detached from the rest of the questionnaire) could be placed, and a box for these envelopes, as well as envelopes for the completed questionnaires to be placed in another box.

Initially the investigators intended to gather data only through conducting interviews. This proved to be impractical because it took approximately fourty-five minutes to conduct one interview and complete the questionnaire. Furthermore, those pre-test participants who could read and understand the English questionnaire preferred (and insisted on) completing the questionnaires themselves because they saved time and found it to be less threatening than answering intimate questions to strangers. Therefore the research tool changed from structured interviews to self-completion questionnaires, when possible.

The target population was all the adolescent mothers aged 19 or younger who delivered babies during the first five months of 2000 in the Gauteng Province. However, due to time and financial constraints this research population was limited to adolescent mothers in the Pretoria and Garankuwa areas in the Gauteng Province. Due to problems of compiling a census of adolescent mothers in each of these areas, no random sample could be selected. At the participating clinics convenience sampling was used, where each adolescent mother was requested to consider completing a questionnaire. In other areas convenience sampling was used in contacting any known adolescent mother and requesting her to consider completing a questionnaire (in the presence of the field worker) or by being interviewed by a field worker. This convenience sampling was augmented by snowball sampling, where one adolescent mother referred the field workers to other adolescent mothers.

A quantitative method was used for conducting this explora-

tory decriptive research project. Limitations imposed on the study by this method of sampling imply that the findings might not be generalisable to adolescent mothers throughout the Gauteng Province, and not even to the areas in which the questionnaires were completed because no assurances about randomness could be provided. "Convenience sampling refers to the selection of the most readily available persons (or units) as subjects in a study, also known as *accidental sampling*" (Polit & Hungler 1997:392). Sampling bias, referring to the "... systematic over representation or under representation of some segment of the population" (Polit & Hungler 1997:185) could not be controlled, nor excluded in this study using convenience sampling. This lack of sampling rigor might imply serious limitations in generalizing the research findings because the population of the Gauteng Province is heterogenous, with eleven official languages and many more dialects, cultures and traditions. However, the potential value of the research remained obtaining information about adolescent mothers' knowledge about, attitudes towards, and utilisation of RH services in the Gauteng Province as experienced by these adolescent mothers themselves.

Definitions used in this report

An adolescent mother is any mother aged 19 or younger at the time of delivery irrespective of the pregnancy outcome, and irrespective of her marital status.

Contraception
This refers to the utilistion of contraceptives (defined below).

Contraceptives
Agents used to temporarily prevent the occurrence of conception, including (oral) pills, condoms, intra-uterine devices, diaphragms and injections (Ketting & Visser 1994:161).

Emergency contraception
Emergency contraception prevents pregnancy from occurring by preventing implantation of the fertilized ovum in the uterine wall (by using copper-containing intra-uterine devices (IUDs) within five days of unprotected coitus, or altering the woman's hormone levels to inhibit ovulation, ovum transportation and/or endometrial growth by using specific "morning after" pills or by using pre-calculated high doses of oral contraceptives.

Pregnancy
Pregnancy is the condition of a female after conception until the birth of the baby (Bennet & Brown 1998:248).

Reproductive Health (RH) Services:
"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes " (WHO 1998:1). These are health services providing any or all aspects of reproductive health services including, family planning clinics, emergency contraceptive services and terminations of pregnancies, but also antenatal, postnatal and maternity services as well as treatment for sexually transmitted diseases (STDs).

Termination of pregnancy (TOP)
The termination of pregnancy refers to the act of bringing a pregnancy to a final end, preventing the birth of a live baby. The legally approved method used mostly to terminate pregnancies in the RSA is known as the manual vacuum aspiration (MVA) technique (Dickson-Tetteh 1999:20).

The Choice on Termination of Pregnancy Act
The Choice on Termination of Pregnancy Act was introduced in the RSA on 1 February 1997 (Act 92 of 1996). The Act permits termination of pregnancy (TOP) upon the request of the woman up to and including 12 weeks of gestation, under certain defined conditions from 13 to 20 weeks and in rare cases even after 20 weeks. This Act affords "... every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs... The Act allows that a registered midwife as well as a medical practitioner may perform a TOP of less than 12 weeks' gestation" (Dickson-Tetth 1999:20). In terms of this act, TOP services should include the counselling of women before and after the TOP procedures, should be able to manage incomplete abortions, should provide contraceptive services after the TOP, and should link TOP services to other related RH services.

Research Results

Organisation Of The Presentation Of The Research Results

The first part of this report will portray the biographic data, so that the second part, focusing on the utilisation of RH services by the adolescent respondents could be placed within the perspective of this background data.

Biographic Data

As indicated in Table 1, the majority (93 or 83,78 per cent) of the 111 adolescent mothers (of whom only 3 or 2.70 per cent were married) who completed questionnaires fell within the age group of 17-19 years. Sixteen respondents were 16 years of age.

These age ranges seemed to correlate with their highest school grades passed, namely:

- 2 passed grade 6
- 7 passed grade 7
- 11 passed grade 8
- 5 passed grade 9
- 23 passed grade 10
- 30 passed grade 11
- 23 passed grade 12
- 10 provided no answers to this question.

From the above statistics, there might be a need to focus family planning information campaigns at secondary school children, especially during grades 10, 11 and 12. Those 53 adolescent mothers who reportedly passed grade 11, might have finished their schooling (grade12) successfully if they had used effective methods of contraception for at least one additional year. Successful completion of schooling prior to becoming mothers might enhance these young women's financial earning capacities for the rest of their lives.

Reportedly 24 of the respondents lived in cities, 35 in towns, 27 in rural areas and 12 in informal settlements. Divergent ethnic groups were represented by the participating adolescent mothers, namely:

- Northern Sotho (27)
- Tswana (22)
- Zulu (20)
- Tsonga (13)
- Xhosa (12)
- Southern Sotho (6)
- Swazi (6)
- Ndebele (3)

Concerning the remaining two respondents, one indicated that she came from the Comore Islands and another one from Moçambique. Concerning their religious affiliations, 78 ado-

lescent mothers indicated that they belonged to a Christian denomination.

Out of the 111 adolescent mothers, 58 were NOT working, 49 were students whilst one was a gardener, and two were domestic workers. Thirty-one of these mothers indicated that they had no income, whilst another 44 earned less than R500.00 per month. Although some respondents indicated on the questionnaires that they did not know what their family incomes were, only 30 (27.03 per cent) estimated their family incomes to exceed R1000.00 per month. Even this amount might be insufficient to sustain these adolescent mothers and their families, because they indicated that five or more persons lived in 70 (63.06 per cent) of their homes.

Knowledge About, Attitudes Towards And Utilisation Of Reproductive Health Services

Adolescent mothers can only utilize RH services if they know about these services, if they foster attitudes enabling them to use these services and if they can indeed access these services.

In the field of RH, it is important to know which age groups to target about sex and contraceptive education efforts. Table 1 reflects the ages of the adolescent mothers as well as other important ages in their lives. As participation was voluntary, a number of respondents failed to reply to specific questions. These non-responses are also indicated in Table 1, in the third last row.

The onset of menarche ranged from the age of 9 until the age of 17, with a mean of 14.03 years (similar to the age of menarche reported in the Gauteng Province to be 14.5 years by Magwentshu 1990:iii). The figures in Table 1 indicate that 41 (36.94 per cent) of the adolescent mothers started menstruating by the age of 14, whereas only 25 (22.52 per cent) had received any sex education by that time, whilst most seemed to have received such education at the ages of 15, 16 and 17 - by which time most of them were reportedly sexually active. The mean age of 15.37 years at their first sexual intercourse appeared to be later than that reported by Boult (1992:3) who found that adolescent mothers in the Port Elizabeth area reportedly started menstruating at an average age of 13.6 years and that 97.3 per cent of them were sexually active by the time they reached the age of 16.

Surprisingly 45 (40.54 per cent) of the adolescent mothers participating in the survey, received sex education from their parents or other family members, whilst 27 (24.32 per cent) did so from their friends, 28 (25.23 per cent) from their teachers, and six (5.41 per cent) from nurses. These findings seem to differ from those reported by Bailie (1991) who reported that pupils in the Cape Town area experienced difficulties communicating with their parents about sexuality and distrusted their teachers in the role as counsellors in this field. Another study (De Villiers 1991) reported that out of 209 pregnant school girls in the Paarl area of the Western Cape, 28.72 per cent had received sex education at home and 51.67 per cent at school. However, adolescents' and parents' attitudes could have changed over a period of nine years which elapsed between these two surveys and the current one - indicating that adolescents and parents might communicate more freely about sexuality than they did nine years ago.

Nurses, and other health care personnel, could play a more significant role in educating adolescents about practising safe sex, and about using contraceptives. Better utilization of radio and television broadcasts to inform adolescents about sexual realities, HIV/AIDS, contraceptives, emergency contraceptives and termination of pregnancy services should be investigated.

When asked why they engaged in sex for the first time, the adolescent mothers indicated that

- they were requested or coerced by their partners (28 or 25.23 per cent)
- they were curious about the experience (12 or 10.81 per cent)
- they succumbed to peer pressure (8 or 7.21 per cent)
- they loved their partners (13 or 11.71 per cent)
- they did not know or that "it just happened" (11 or 9.91 per cent)

Table 1 : Adolescent Mothers: Distribution Of Significant Ages:

Age in years (n = 111)	Age of adolescent mothers	Age at menarche	Sex education received	First sexual intercourse	Started using contraceptives	First visit to family planning clinics
up to 11		6		1	1	
12		13	8			
13		22	4		2	2
14	2	19	13	6	4	5
15	1	28	27	26	9	6
16	12	16	23	32	14	13
17	29	3	12	19	16	14
18	38		8	9	9	3
19	26		1	1	3	3
No response	3	4	15	17	53	65
Mean (x)	17.65	14.03	15.32	15.37	16.26	16.15
TOTAL	111	111	111	111	111	111

- they consented voluntarily (9 or 8.11 per cent).

Knowledge about, attitudes towards and utilization of contraceptive services

Out of the 111 respondents, 38 (34.23 per cent) did not know about contraceptives whilst 60 (50.05 per cent) knew about the following contraceptive methods (each respondent could mention more than one, therefore the total does not add up to 60):

- injections (46)
- pills (38)
- condoms (26)
- intra-uterine devices (6)
- sterilization (2).

Similar findings were revealed by a study done on 1 072 school girls in the former Transkei area (forming part of the Eastern Province of the RSA since 1994) which revealed that adolescent school girl pregnancy rate in that area was 31.1 per cent. Notwithstanding this high pregnancy rate only 23 per cent of the sexually active school girls had ever used contraceptives, and only 19.4 per cent used condoms (Buga, Amoko & Ncayiyana 1996).

The adolescent mothers learned about contraceptive methods from their

- mothers/sisters/aunts (22)
- clinics (10)
- friends (8)
- nurses (mostly school nurses) (10)
- teachers (8).

Although 60 respondents knew about contraceptive methods, only 48 (43.24 per cent) indicated that they had indeed used the following contraceptives (one person could have used several methods, therefore the total does not add up to 48):

- injections (32)
- condoms (19)
- pills (16).

Reasons provided by the adolescent mothers for NOT using contraceptives, included that

- their mothers did not approve (4)
- they were ignorant (2)
- they were afraid to go to the clinic because their mothers might find out (2)
- their boyfriends refused (2)
- they did not need to use contraceptives (3)
- they feared future reproductive problems, fearing that they might never have children should they use contraceptives during adolescence (2)
- she feared the clinic nurses' attitudes towards sexually active adolescent girls (1)
- she did not expect to become pregnant (1)
- she was advised to discontinue with the injections because of a vaginal discharge (1)
- she became pregnant when she forgot one single contraceptive pill (1).

These findings appeared to be similar to those reported by Abdool Karim et al (1992:107) who found that none of the secondary school students in their survey in the Natal Province used condoms at every sexual encounter although 47 per cent had used a condom at least once. The reasons for disliking condoms which became apparent during focus group interviews included that condoms limited sexual pleasure, challenged the male ego, were associated with STDs and indicated a lack of trust in their partners' faithfulness. However, a survey conducted in the rural Transkei (forming part of the Eastern Province since 1994) found that one-third of the 903 participating boys enjoyed using condoms (Buga et al 1996:523) - a finding not supported by this survey's findings.

In spite of the 111 adolescent mothers' apparent lack of contraceptive knowledge, one adolescent mother indicated that she successfully used contraceptives for seven years (from the age of 11 until 18), starting off with condoms but later changing to injections and pills. Maintaining effective contraception enabled her to complete her schooling despite being sexually active since the age of 11. One respondent managed to maintain effective contraception for six years (from the age of 12 until 18), four did so for three years, five for two years, and three for one year. Two indicated that they became pregnant three months after their first "injections", presumably Depo Provera. Another respondent claimed that she became pregnant despite the regular use of condoms, and another one despite the regular use of unspecified contraceptive "pills".

Knowledge about, attitudes towards and utilisation of emergency contraceptives

Surprisingly 75 out of the 111 respondents, amounting to 67.56 per cent, did NOT know about the availability of emergency contraceptives to be taken within 48 hours after unprotected sex. Only 42 (37.83 per cent) did know about the existence of emergency contraceptives, but only 15 (13.51 per cent) knew that "pills" could be taken to prevent pregnancies after unprotected sex. However, only one respondent could name such a product. In spite of knowing about emergency contraceptives, none of these adolescent mothers could succeed in obtaining these services. (Similar findings were reported by a survey conducted among 93 pregnant student nurses in the Northern Province (Netshikweta 1999) which revealed that 73.1 per cent of these student nurses had no knowledge about emergency contraceptives and none of the respondents managed to access emergency contraceptives despite the fact that they were all student nurses).

The other respondents indicated that they did NOT attempt to use emergency contraceptives because

- they feared that the baby might be malformed if they took pills (3)
- she did not have sufficient information to obtain these pills (1)
- their boyfriends wanted the babies (2)
- they did not believe that the pills would be effective (2)
- her mother discouraged her from using emergency contraceptives (1)
- she did not want the clinic sister to know about her sexual activities (1).

The above information could indicate a real need to educate adolescents about emergency contraceptives, and to make these services accessible to adolescents. Knowledge alone did not enable any of these 42 adolescent mothers to utilise emergency contraceptive services. However, the majority of respondents were unaware of the possibility of utilizing emergency contraceptives. Thus these services would need to be advertised in clinics, at schools, and possibly also during radio and television broadcasts. Investigations should be conducted into the feasibility of offering these services at 24-hour emergency care centers in all communities. Not one adolescent mother indicated that she knew that copper-containing IUDs could be used as emergency contraceptives. Better utilization of emergency contraceptives could reduce the need for termination of pregnancy services and could enable ado-

lescents to postpone having children until they are emotionally, socially and financially capable of caring for their children. Above all the availability of emergency contraceptives would enable all women, including adolescents, to have their babies when they wanted to have them, with minimum disruptions to their lives, and especially to their schooling. Further research should be conducted into the availability and accessibility of contraceptives, including emergency contraceptives, from private pharmacies as well because this might be the first place where the adolescents might turn for help. A survey done among pharmacies and pharmacists in the Gauteng Province found that 56.25 per cent of the pharmacists would not advocate the use of emergency oral contraceptives, and 12.5 per cent would only dispense these pills if the patient had a doctor's prescription (Harris 1999:5).

However, it needs to be emphasised that this study's research population comprised only of adolescent mothers, therefore it could not make any deductions about the availability and utilization of reproductive services among adolescents in the province generally. That would warrant another research project focusing on all adolescent girls aged 11-19 throughout the province.

Knowledge about, attitudes towards and utilization of termination of pregnancy (TOP) services

Women in the RSA have legalized choices to request the termination of their pregnancies during the first twelve weeks of gestation since 1996, in terms of *The Choice on Termination of Pregnancy Act, no 92 of 1996*. Out of the 111 adolescent mothers, 42 (46.85 per cent) knew about legally available termination of pregnancy (TOP) services, whilst 47 (42.34 per cent) did not know about these services. These statistics could indicate that the mere legalising of TOP services does not necessarily imply that women know about their rights, nor that women knowing about these services and wishing to use TOP services could access such services. Although the majority (73 or 65.77 per cent) did NOT wish to use TOP services, 28 (25.22 per cent) wanted to use such services. Only 15 (13.51 per cent) of the adolescent mothers asked about TOP services at the clinics they attended, but no one managed to obtain such services. Only three respondents indicated that they enquired too late (after twelve weeks' gestation) about TOP services. One adolescent mother was apparently told to return for a TOP appointment in three weeks' time, which she did, only to be informed that her pregnancy had progressed beyond twelve weeks and that she could no longer obtain a TOP. The other respondents did not provide any reasons for failing to obtain TOP services.

This would seem to be another area warranting further research about the accessibility of TOP services but also about educating women about their legal right to exercise their choice concerning the termination of their pregnancies within the first twelve weeks of gestation. Within two years of the passing of the Choice on the Termination of Pregnancy Act No 92 of 1996, public health facilities conducted 69 894 TOPs in the RSA, with 49 per cent of these TOPs conducted in the Gauteng Province (Varkey 1999:11). However, this author found that most women who used TOP services were older than 20 (thus not adolescents), and that they lacked information about the women's rights to sole consent although they knew about legally available TOP services in the RSA.

Knowledge about, attitudes towards and utilisation of contraceptives after the birth of the adolescent mothers' babies

Out of the 111 respondents, 105 (94.59 per cent) indicated that they used contraceptives after the birth of their babies:

- 69 (62.16 per cent) used injections, mainly because they would not need to take daily pills, the family members and boyfriends would not need to know that they used injections, and visits to the family planning clinic every three months would be more feasible than monthly visits
- 27 (24.32 per cent) used condoms, because they would be protected against pregnancies and sexually transmitted diseases
- 6 (11.71 per cent) used contraceptive pills because they were familiar with pills and because they continued to menstruate regularly.

Only nine (8.1 per cent) of the adolescent mothers indicated that their pregnancies were planned, apparently correlating with a study conducted in the USA indicating that 80-85 per cent of one million teenage pregnancies per year in the USA are unplanned (Rhinehart & Gabel 1998:61). Subsequent to the birth of their babies, 105 (94.59 per cent) used contraceptives, but five (4.50 per cent) did not consider using contraceptives. Further research would need to investigate reasons for non-utilization of contraceptives in specific areas so that relevant health education could be provided.

Perceptions of visits to family planning clinics

Many respondents failed to reply to the questions pertaining to their visits to family planning clinics, probably because these questions appeared towards the end of the questionnaire, or because they might have regarded these questions as being irrelevant to their pregnancies. Consequently these results should be re-investigated and could merely be regarded as potential indicators. However, out of the few replies the following aspects emerged:

- 15 respondents indicated that they waited less than 30 minutes
- 4 respondents indicated that they waited two hours or longer
- 3 indicated that they waited "very long" but did not specify the time.

Although 10 respondents did not perceive the nurses to be helpful at the family planning clinics, 29 experienced the nurses to be very helpful indeed. Twenty-nine respondents indicated that they were satisfied with the services rendered to them at the family planning clinics. Only 10 respondents were dissatisfied with the services received and indicated that the reasons included that:

- she became pregnant despite using condoms received at the clinic - she did not complain about the service as such (1)
- the nurses were "not friendly with teenagers at the clinics " and should be friendlier especially towards teenagers (6)
- the clinics were overcrowded and lacked privacy (2).

An open-ended question requested the adolescent mothers to indicate what advice they received at the family planning clinics. Their replies included:

- no advice (10)
- information about contraceptive methods and their side effects (10)
- "not to sleep around and get pregnant" (4)
- "never have sex without a condom" (4)

- "you are too young to use contraceptives" (one respondent who was 18 years old)
- that the clinic should be attended regularly (2)
- information about breast feeding (1)
- education about personal hygiene (1)
- "you don't have to give any man a lot of children to prove your love" (1).

These adolescent mothers' comments about advice received at the family planning clinics could merely reflect their interpretations of actual advice received. However, if an 18-year old sexually active young woman had indeed been told that "too young to use contraceptives", the policy of the family planning clinics and the nurses' attitudes need to be addressed. This 18-year old woman did become pregnant and compromised her schooling, which could have been avoided if they had received contraceptives as requested by her at a family planning clinic.

When asked who informed them about the family planning clinics, they indicated that the following persons supplied this information:

- their mothers (15)
- sisters (8)
- nurses (2)
- friends (9)
- aunts (6).

Perhaps the family planning clinics' services, locations and times could be better advertised. Including a pamphlet in the monthly water and electricity bills could reach many households. Leaving pamphlets at clinics and shops in all areas, including informal settlements, at youth clubs, and beer halls might succeed in informing more adolescents about contraceptives, emergency contraceptives and TOP services. Reaching schools might be problematic, but means and ways should be explored to educate school going children about sex, sexually transmitted diseases, contraceptives, emergency contraceptives and TOP services ideally as from the age of 10, or at the latest the age of 12, if the issue of adolescent pregnancies is to be addressed successfully throughout the RSA. The desirability of commencing with sex education as from the age of 10 has also been supported by researchers in the USA (Rhinehart & Gabel 1998:61).

Fifty-five (49.55 per cent) respondents knew during which days and hours their family planning clinics operated. Only 31 (27.93 per cent) of the respondents would prefer to attend family planning clinics during evenings whilst 61 (54.95 per cent) would NOT do so, probably for reasons of safety. On the other hand 70 (63.06 per cent) would indeed prefer to attend family planning clinics over the weekend, whilst 25 (22.52 per cent) would NOT prefer weekend clinics. Those who would prefer to attend clinics during the evenings and/or over weekends indicated that they experienced problems reaching their family planning clinics during week without their parents' or teachers' knowledge. However, these aspects warrant further research amongst adolescents attending family planning clinics before operational decisions can be based on them.

All the respondents, except 10 (9.01 per cent of the respondents) indicated that they could walk to their nearest family planning clinics or that the transport costs would not exceed R10.00.

Attendance of ante-natal clinics

In view of the previous indications that clinics were within walking distance for the majority of the respondents, the poor attendance of ante-natal clinics among adolescent mothers require further investigations. Out of the 111 adolescent mothers, the following ante-natal clinic attendances were indicated:

- 8 never attended
- 10 attended once only
- 17 attended twice
- 11 attended three times
- 1 attended four times
- 16 attended five or more times
- 4 attended "several times" without specified numbers of attendances
- 6 failed to respond to this question.

The respondents did not provide reasons for their poor ante-natal attendances. However, as the majority were still at school, they probably attempted to continue with their schooling as long as possible and might have experienced problems to attend ante-natal clinics after school. On the other hand the importance of regularly attending ante-natal clinics should be emphasized - not only to adolescents but also to their mothers and to entire communities. The indication that 8 (7.21 per cent) never attended and 10 (9.01 per cent) attended once only, should alert health care professionals that at least 16 per cent of these adolescent mothers received inadequate ante-natal health care, with potential detrimental consequences for the health of both the adolescent mothers and their babies. These results seem to correlate with those reported by other researchers, including (Netshikweta 1999) who found that 44,1 per cent out of 93 pregnant student nurses in the Northern Province did not attend ante-natal clinics during their pregnancies despite knowing about these free services; a further 18,3 per cent of these pregnant student nurses only started attending ante-natal clinics after 36 weeks' gestation. Research done among pregnant students at the University of Port Elizabeth found that only 20 per cent of these students commenced attending ante-natal clinics during the first trimester of their pregnancies (Boult & Cunningham 1992:303). Adolescents might fear attending ante-natal clinics when they were mixed with adult women and might fear meeting their mothers, aunts and teachers at these clinics. More teenagers might attend ante-natal clinics if they could attend these services specifically for adolescents (Makhetha 1996).

7.3.7Treatment for sexually transmitted diseases

Only 20 (18.01 per cent) of the 111 adolescent mothers admitted to having received treatment for sexually transmitted diseases, which they indicated as being:

- vaginal discharge (9)
- genital ulcers (2)
- syphilis (2)
- gonorrhea (1)
- "pimples in the vagina" (1)
- "drop" (1) - a local term often related to gonorrhea.

One respondent indicated that she got an unspecified sexually transmitted disease from using public toilets, whilst another one indicated that she "received condoms to use for an infection". It could not be ascertained from the replies on the questionnaire whether the condoms were intended to protect her from contracting an infection.

If only 20 out of 111, amounting to 18.01 per cent, adolescent mothers, the majority of whom became sexually active between the ages of 14 and 17, reported being treated for sexually transmitted diseases, it might warrant further investigations, especially since only 26 of them reportedly used condoms prior to their pregnancies. A survey conducted among 300 primigravidas in the Port Elizabeth area found evidence of STDs among 22.3 per cent of the respondents (Boult & Cunningham 1993). This questionnaire did not request the respondents to indicate the number of sexual partners they had encountered, consequently no deductions could be made about potential

promiscuity or faithfulness amongst these 111 adolescent mothers. However, sex and contraceptive education should definitely inform adolescents about sexually transmitted diseases.

Summary Of Research Findings

The majority of the 111 adolescent mothers who participated in this survey did not have sufficient knowledge about contraceptives prior to their pregnancies. This lack of knowledge prevented them from utilizing effective contraceptives and contributed towards the harbouring of false fears about contraceptives, further inhibiting their contraceptive use.

Although the family planning clinics were within walking distance from almost all participants' homes, the majority did not use contraceptives prior to their pregnancies. The ability to attend clinics after school, during weekends or in the evening might enhance the utilization of these services. The health care professionals, especially nurses, working in family planning clinics should not maintain judgmental attitudes towards adolescents' sexual practices.

The minority of respondents used contraceptives effectively for more than one year prior to becoming pregnant. Adolescents' knowledge about and access to emergency contraceptives and TOP services seemed to be almost non-existent. These aspects should be addressed during health education sessions, by supplying pamphlets to all persons and by leaving pamphlets (with telephone numbers) at strategic places such as shops, dance halls and youth clubs. Adolescents required emergency contraceptives over weekends when the clinics were closed and could not access these services. Knowledge about as well as how to access TOP services should be provided to all women, including adolescents.

Recommendations For Enhancing The Utilisation Of Reproductive Health Services By Adolescents

In agreement with Boult & Cunningham (1992b:159) these exploratory descriptive research findings indicate "... an urgent need for a multi-disciplinary and holistic approach to age-related sex education for adolescents of both sexes and their parents". Adolescents' utilization of RH services, including contraceptive, emergency contraceptive and TOP services might be enhanced if the health care providers could

- educate school girls as from the age of 10 about these aspects
- emphasize the possibility of accessing emergency contraceptives, but also to indicate that adolescents who require emergency contraceptives, require contraceptives and should be advised to continue using contraceptives until they plan to have a babies
- re-assess the availability of these services to adolescents, especially in terms of accessibility to school going adolescents
- investigate the feasibility of providing family planning services over weekends, especially for school going and/or working adolescents
- provide policy guidelines to health care providers, including nurses working at family planning clinics, about providing contraceptives, emergency contraceptives and TOP services to all clients, but especially to adolescents. The issue of parental consent needs to be clearly addressed as well as guidelines about adolescents' ages and the types of contraceptives to be offered
- investigate whether private pharmacists and medical practitioners do provide contraceptives and emergency contraceptives to women requesting them, including adolescents.
- revise and refine policy guidelines and stipulate clearly under what conditions contraceptives, emergency contraceptives and TOP services should be supplied to adolescents
- provide clinics exclusively for adolescents wherever possible so that they need not fear encountering their mothers, teachers and aunts at these clinics.

The possibility should be investigated for changing current health care policies so that school health nurses could disseminate information about family planning services (preferably pamphlets), but also that the school health nurses could provide condoms, contraceptive pills and injections to adolescents requesting them.

Women in the RSA should become knowledgeable about their rights so that they can claim these rights for themselves and their daughters to enhance their own and their families' lives as well as the well-being of their children and grand children.

Conclusion

The findings of this survey apparently confirmed those reported by Bodibe (1994:iii) who found that the survey conducted among 157 school children in the RSA indicated moderate correlations between sexual knowledge, attitudes and behavior, but that no cause and effect relationships could be identified.

The RSA has made major political progress since 1994 but some basic rights' problem seem to continue - that women are still not in a position to decide if and when they want to have children. Margaret Sanger, a founding member of the Planned Parenthood Federation claimed that the basic freedom of the world is a woman's freedom: "A free race cannot be born of slave mothers. Women enchained cannot choose but to give a measure of that bondage to her sons and daughters. No woman can call herself free until she can choose ... whether she will or will not be a mother" (Roberts & Group 1995.

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