

**KNOWLEDGE AND ATTITUDES OF PREGNANT TEENAGERS WITH  
REGARD TO USAGE OF CONTRACEPTIVES AT PIETERSBURG  
HOSPITAL, LIMPOPO PROVINCE, SOUTH AFRICA**

**By**

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## DECLARATION

I declare that this work is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institutions.

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KL MOHLAKE

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DATE

## DEDICATION

I would like to dedicate this work to my family; my parents; my husband, Calvin; my two sons, Kwena and Nare; my daughter, Thupetši; and to all the staff in the Department of Obstetrics and Gynaecology.

## ACKNOWLEDGEMENT

I thank the Almighty who gave me the strength to complete the study.

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## **ABSTRACT**

### **Background**

The use of contraceptives among sexually-active teenagers in South Africa is known to be very poor and is currently estimated to be at a rate of 25% (DoH 2002). Teenagers who have unprotected sex are at a high risk of reproductive Health problems, such as Sexually Transmitted Infections (STIs) and HIV/AIDS, and unsafe abortion, amongst others (DoH 2002). Contraceptive use progressively declined between 2002 and 2004 among girls under 18 years in the Kwa-Zulu Natal Province as a whole (Health Statistical Bulletin, 2004).

### **Aim**

The aim was to determine knowledge, attitudes and perceptions of pregnant teenagers with regard to usage of contraceptives at the Pietersburg Hospital, Limpopo Province, South Africa.

### **Method of data collection and analysis**

A cross-sectional descriptive survey was used in this study. A self-administered questionnaire was used to collect data from pregnant clients aged 13-19 years of age. Data analysis was carried out by using the computer software called Statistical Program for Social Sciences (SPSS). The findings revealed that lack of knowledge, attitudes and perceptions of pregnant teenagers was a problem.

### **Findings**

The findings of this study indicated that culture and attitude of nursing personnel were not the barriers. Barriers were “not having enough time to choose the method and just not being serious about contraception”. Thirty-six

per cent (36%) of the participants said they had enough time to choose the method, but they did not choose. Sixty per cent (60%) said they were not serious about contraception, 40% said they were serious but did not use contraception. Married participants who did not hear about emergency contraception, the percentage was small, 6%, while the percentage of single women was higher (94%).

## **Conclusion**

The study revealed that the participants had knowledge of contraceptives, both single and married; however, married women seemed to have negative attitudes towards contraceptives, based on the culture and the believe that, once married, the usage of contraception was not necessary. Based on the findings of the study, it is recommended that there should be effective ways of information giving to the public regarding family planning.

## **Definition of terms**

### **1. Contraception**

Contraception is the prevention of conception resulting in unwanted pregnancies through the use of a variety of contraceptive methods. (Manual of Reproductive Health and HIV Research Unit, 2003).

### **2. Contraceptives**

The term Contraceptives refers to a variety of methods to prevent conception and is also referred to a family planning method. (Manual of Reproductive Health and HIV Research Unit, 2003).

### **3. Emergency contraception**

Emergency contraception is the use of the method in the first five days following an episode of unprotected sexual intercourse, without contraceptive cover or method failure - before pregnancy begins - in order to reduce the risk of an unwanted pregnancy. (Manual of Reproductive Health and HIV Research Unit, 2003).

#### **4. Teenage pregnancy**

Teenage pregnancy is an unplanned and/or unwanted pregnancy in a person of ages between 13 -19 years. (Manual of Reproductive Health and HIV Research Unit, 2003).

#### **5. Termination of pregnancy**

Choice of Termination of Pregnancy (CTOP) refers to voluntary interruption of pregnancy and evacuation of the contents of the uterus, either by medical or surgical means. (Manual of Reproductive Health and HIV Research Unit, 2003).

#### **6. Barrier**

Barrier refers to the stumbling block to the accessibility of the service.

#### **7. HIV/Aids**

Human Immune Virus/Acquired Immuno-Deficiency Syndrome (Manual of Reproductive Health and HIV Research Unit, 2003).

# CHAPTER 1

## INTRODUCTION

### 1.1 Background

Knowledge and attitudes of teenagers with regard to usage of contraceptives remains a major concern in South Africa, primarily because of high rate of teenage pregnancy in this country. According to Candice, Moodly & Tonya, (2004), a third of teenage girls in South Africa become pregnant before the age of 20, despite contraception being free and mostly accessible. Studies show that teenage pregnancy is more prevalent among rural black girls compared to girls from other settlements, with the highest occurrences among uneducated and semi- educated communities (Candice et al., 2004). This implies the likelihood to see more teenage pregnancy in Polokwane, Limpopo Province, which is surrounded by many rural villages and already, there is a high rate of pregnant teenagers attending antenatal care at Pietersburg Hospital, a provincial hospital servicing the surrounding areas in Polokwane.

The use of contraceptives remains a taboo in developing countries, as a result, it is a concept that is hardly discussed between spouses, leaving women vulnerable to being pregnant, even at a young age or as soon as they are sexually active. Studies in developed and developing countries report that communication between spouses on reproductive issues is still limited as most men disapprove contraceptive use, even though they are not necessarily ready for resultant pregnancy (Brückner, Martin & Bearman, 2004),. In most African countries men do not want to discuss issues of family planning, as cultural issues prevent women from using contraceptives. Issues such as: fear

that contraceptives would undermine the man's authority as head of the family; women's fear of harmful side effects, men's fear that contraceptives would encourage their wives to be unfaithful; opposition due to religious reasons and, desire to have a large family, are common in across all cultural diversities especially in Africa. These fears have been reported to influence behaviour of teenage boys and girls, as a result, some teenage girls would deliberately fall pregnant, just to prove their perceived womanhood, (Brückner, Martin & Bearman, 2004)

The high rate of teenage pregnancies has far reaching consequences, especially for the blacks who make up the poorest and most disadvantaged groups in the country, where the majority of the pregnancies are neither planned nor wanted. The father of the child (possibly a teenager or an older person) seldom acknowledges or takes responsibility for the financial, emotional and practical support of the child, forcing the mother of the child to leave school, thus ending her opportunities for personal development whilst the father of the child is likely to finish school and prosper in life without taking care of the child. According to Perez and Nelson, (2007), the consequences of not finishing school is that the young mother of the child becomes vulnerable to poverty, never finishes school, engage in exploitative sexual relationships and violence as well as low self-esteem.

The high level of teenage pregnancies in South Africa reflects a pattern of risky sexual activity that puts teenagers at a higher risk of contracting human immune virus (HIV).

Based on national estimates, a wide range of data including the household and antenatal studies, UNAIDS estimated that HIV prevalence was 17.3%

among 15-49 year olds at the end of 2011. According to their own estimate of total population, this implies that around 5.6 million South Africans were living with HIV at the end of 2011, including 460,000 children less than 15 years of age, (Department of Health, South Africa, 2012); The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2011).

Cultural beliefs within Black communities also prevent young people from gaining more information about sexuality, because culturally, parents could not discuss sexual information with their children. Concrete sexual education and related information were not made available to the youth until they were faced with the trauma of unwanted pregnancies, birth complications and Sexually Transmitted Infections (STIs) due to wrong decisions and misconceptions about contraceptives (Sapire 1988; Kau 1988). Ziyani and Ehlers (2006) also reported that adolescent girls see it as ideal to give birth by the age of 18 years, because of perceptions that contraceptives would delay childbearing and cause sub-fertility – an indication that within African culture families and childbearing are highly valued.

The South African Demographic Survey (1998) showed that sexual debut starts as early as at 13 years of age in boys and 15 years in girls; furthermore, teenage pregnancy is more prevalent amongst Coloured and rural girls (Berry & Hall 1998). According to Peltzer's (2001) mean age of sexual debut among teenagers in Limpopo is 15.4 years, and moreover knowledge and use of contraceptive methods seems to be poor in the province. Oyedeeji and Cassimjee (2006) also report that rural and Coloured girls experience some form of oppression when it comes to contraceptive use.

Despite government intentions to provide free contraceptive services, there is still a high proportion of adolescents being exposed to the risk of pregnancy. Teenagers in SA are exposed to the risks of unwanted and unintended pregnancies due to ineffective use of contraceptives and non-utilisation of contraceptive services. Mwaba (2000) reports that 17 000 babies were born to mothers of 16 years and younger in 2000. Furthermore, Ehlers *et al.* (2000) indicate that the rising incidence of adolescent mothers is expected to exceed 1 million by 2010, despite free supply of contraceptives in South Africa.

Among risks documented for teenage pregnancy, maternal mortality has been reported to be high in African countries, this despite the mandate by United Nations for all countries to reduce maternal mortality by half by 2015 (Millennium development goal, MDG, 5). Bisika *et al.* (2007) also indicated that in Africa more adolescent girls die due to pregnancy-related conditions due to unsafe abortions which account for a great deal of adolescent mortality. Though this maternal mortality has been significantly reduced in SA, according to interim report by the Minister of Health in South Africa, abortions continue to rise in this country and it is reported that over 60% of all unsafe abortions occur amongst women under the age of 25 years, meaning that the country is failing to reduce teenage pregnancy through promotion of contraceptive use. Furthermore, half of all new HIV infections occur in people of 15–24 years of age, most of them sexually active young girls – who are thus in even greater need of contraception and the dual protection it offers.

On the other hand, there is a high probability that within black cultures, parents, teachers and church leaders might be failing to communicate information about sexuality freely with their children as they feel embarrassed



and awkward thinking it is immoral. Some do not have adequate information about contraception. Various studies reported that adolescents in the Republic Of South Africa(RSA) had some knowledge of one or other method to prevent pregnancies, but never as much as tried to use these methods (Setiloane, 1990); (Ehlers & Khoza 2001). Furthermore, Ehlers (2003) reported in a study done in Tshwane, SA, that 60% of adolescent mothers knew about contraceptives but only 43% reported that they used injectables, condoms and the pill. In most studies teenagers gave many reasons for non-use of contraceptives, such as fear of parents and of infertility.

Emergency contraception (EC) is a type of modern contraception which is indicated after unprotected sexual intercourse when regular contraception is not in use. There are two types of ECs namely, emergency contraceptive pills and intrauterine devices (IUDs). The pills include combined oral contraceptive pills (COCs), and a progestin only pills (POPs); IUDs can be effective if it is inserted within 5 days of unprotected sexual intercourse. The importance of EC is evident in preventing unintended pregnancies and its ill consequences like unintended child delivery or unsafe abortion, which are the most common causes of maternal mortality. Therefore, EC need to be available and used appropriately as a backup in case regular contraception is not used, misused or failed. ( BMC Women's Health 2012).

## **In conclusion**

Programs designed to prevent pregnancy need to give young women information about pregnancy and opportunities to discuss the topic so that they form opinions. Furthermore, programs should emphasize positive attitudes toward contraception, because effective contraceptive use is shaped by such attitudes and is strongly associated with reduction of pregnancy risk.

### **1.2 Research problem**

The contraceptive uptake among sexually active teenagers in South Africa is known to be very low. Teenagers who have unprotected sex are at high risk of reproductive health problems, such as sexually transmitted infections (STI's) and HIV and AIDS, unwanted pregnancy resulting in unsafe abortion, amongst others. Despite the documented risks associated with risky sexual activity, teenagers still consult to the hospital for termination of pregnancy and also for antenatal care. This has prompted the researcher to ask the following question: what is the level of Knowledge, attitudes and practice of teenagers with regard to use of contraceptives? Are these contraceptives easily available to teenagers? Do teenagers have adequate knowledge on how contraceptives are used?

### **1.3 Research question**

Are there problems that are experienced by teenagers in accessing contraceptives?

What is the level of Knowledge, attitudes and practice of teenagers with regard to use of contraceptives?

Are these contraceptives easily available to teenagers?

#### **1.4 Aim of the study**

To determine knowledge, attitudes and practice of pregnant teenagers with regard to usage of contraceptives.

#### **1.5 Study objectives**

- To determine socio-demographic profile of pregnant teenagers attending ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital.
- To determine knowledge and use of emergency contraception, among pregnant teenagers attending ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital.
- To determine attitudes of pregnant teenagers attending ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital, towards contraception use;
- To determine the association between demographic profile and knowledge and attitude influence behaviour.

#### **1.6 Significance of the study**

**The study will benefit the following stakeholders:**

##### **1.6.1 Benefit to teenagers**

This study recommendations will be communicated to all teenagers and their families and information about benefits of contraceptive use and will serve as an opportunity for parents to discuss the sexuality and contraception so that teenagers make informed decisions about

whether to use contraceptives during sexual intercourse or not. These will empower them to be able to make decisions that will help them prevent unwanted pregnancies, STIs and HIV and AIDS, as well as high maternal and infant mortality.

### **1.6.2 Influence curriculum on sex education/life skills/orientation at schools**

The results of this study will be communicated to the dept of education, with more emphasis on strengthening sexual education in schools so that children can have access to information as early as primary schools. The study results can influence programs of sex education/life skills/orientation to be included when curricula is being prepared. These programs should emphasize positive attitudes toward contraception, because effective contraceptive use is shaped by such attitudes.

### **1.6.3 Influence policy at local and national level.**

Governments as policy makers around the world are focused on combating poverty and achieving a range of Millenium development goals, such as those outlined by the United Nations' (MDGs).

Policy makers will therefore ensure that Reproductive health care services are available, accessible and comprehensive, and also provide education, counselling and be adolescent-friendly, allowing the school girls to make informed decisions about reproductive health.

## **CHAPTER 2**

### **Literature Review**

#### **2.1 Introduction**

Chapter 2 provides a detailed discussion of literature relevant to the concepts; knowledge and attitude of pregnant teenagers with regard to usage of contraceptives. The researcher obtained information that contributed to writing of this dissertation from book chapters, report and journals. These chapters also include reproductive health services and health care provider as a barrier to contraceptive use by teenagers, health behaviour and attitude of the teenager and youth as a barrier to contraceptive use, cultural barriers to the use of contraception, barriers to emergency contraception in South Africa and elsewhere in the world and other barriers to contraceptive use.

#### **2.2 Reproductive health services and health care provider as a barrier to contraceptive use by teenagers**

Pregnant teenagers are often bullied and insulted by nursing staff and consequently are afraid to approach nurses regarding contraceptive advice as revealed by the findings of a qualitative study which was done in South Africa, (Wood & Jewkes 2006). A similar finding was observed in Senegal where teenagers felt uncomfortable in the clinics and felt that providers were reluctant to take care of them Katz & Nare, (2002). Health care providers are concerned that the use of emergency contraceptives could increase the problem of unprotected sexual intercourse and might encourage men to give

up the use of condoms (Uzuner,Unalan,Akman,Cifcili,Tuncer,Coban,Yikilkan & Akgun, 2005).

A quantitative survey was carried out in Gauteng after a financial grant was received from the World Health Organization (WHO). The aim was to establish whether adolescent mothers (aged 19 or younger at the birth of their babies) utilized contraceptives, emergency contraceptives and termination of pregnancy (TOP) services. The minority of the participants used contraceptives prior to conceptions; none used emergency contraceptives or termination of pregnancy (TOP) services. The findings indicated that the 111 adolescent mothers in Gauteng who participated in the survey did not make optimum use of the available reproductive health care services. (DOH,1999).

A recent article from an Obstetric-Gynaecology (OB-GYN) urgent care clinic in an American tertiary training hospital revealed that the need for fertility control and emergency contraception (EC) was not adequately assessed by health care providers. This was discovered from the retrospective charts reviews of pregnant teenagers who attended the clinic. Ongoing contraceptive needs and family planning issues were not discussed or documented adequately (Perez & Nelson 2007).

A qualitative study was conducted in a health care centre in the UK, in which thirty-two young males and females were interviewed. Many participants noted that in a five to ten minute consultation, there was no time to discuss personal issues that may affect their decision on the usage of contraceptives and effective use of available methods. Many described a feeling of being

rushed through the service and did not feel they had the opportunity to ask question (Schenk, 2003).

### **2.3 Health behaviour and attitude of the teenager and youth as a barrier to contraceptive use**

Teenagers continue to present a challenge to the health services due to the increase in their sexual risk taking behaviour: the earlier age at which sexual activity is started and the reluctance to utilise services available to them further put them to risk, (Wood & Jewkes 2006). Explorative study which was done in the Free State province of South Africa. The mean age of the participants was 18.6 years. The results indicated that the youth received insufficient reproductive health information to be able to prevent pregnancy and HIV and AIDS. The results also indicated the risk behaviours which indirectly act as a barrier to contraceptive use among youth (Seekoe, 2005).

### **2.4 Cultural barriers to the use of contraception**

Many of the teenage girls felt pressured from their male partners or even their family members to have babies as a way to prove their fertility, (Wood & Jewkes 2006). Another study was carried out in the Matemwe village in Tanzania, where the fertility level is high, to identify cultural barriers to the use of contraception. Interviews indicated that in order to lower fertility in Matemwe, cultural barriers to family planning would have to be confronted and modern ideas about contraception would need to be integrated. (Keele, Forste & Flake 2005).

## **2.5 Barriers to emergency contraception in South Africa and elsewhere in the world**

Emergency contraception is used to prevent pregnancy in the event of unprotected sexual intercourse. The most common methods of emergency contraception are oestrogen and progestin combinations and progestin-only oral contraceptive pills (Candice et al., 2004). They are effective, safe, and have few side effects. If teenagers are to benefit from EC they need to have prior knowledge and easy access to the method since its effectiveness has a time limit. The efficacy of EC is dependent on how soon after the unprotected intercourse treatment is administered (Candice et al., 2004).

A survey conducted in Durban, South Africa showed that most doctors and pharmacists had received requests for emergency contraceptive pills, but most of them (both doctors and pharmacists) were not sufficiently knowledgeable about emergency contraception (Harisparsad, 2001). Another survey was conducted in Durban among students in a tertiary educational institution to determine the knowledge, use of and attitude to the use of emergency contraception. Only a few of the participants knew the method of emergency contraception and the correct time limit in which it should be used. Even fewer students knew how effective emergency contraception was in preventing pregnancy (Candice et al., 2004).

A similar study was conducted among female undergraduates in Eastern Nigeria, where participants knew about emergency contraception, but their



knowledge was limited. Lack of awareness and a generally negative attitude towards the use of contraception contributed the most notable barriers identified in this study (Ikemme, Ezeqwei & Uzodima, 2005).

Conservative cultural or social norms in addition to lack of knowledge about EC were identified as the barriers in a study done among young women from various socio-cultural groups in British Columbia, Canada. (Shoveller, Chabot, Soon & Levine, 2007). Various studies have suggested barriers to emergency contraceptive use by teenagers and sexually active women; include the high price of EC Schenk, (2003).

## **2.6 Other barriers to contraceptive use**

A cross-sectional descriptive study was done among twenty-six schools in 22 rural districts of the Transkei region of the Eastern Cape. The findings indicated that early sexual maturation, early onset of dating, and poor knowledge of reproductive biology and contraception represent risk factors for unprotected sexual activity in this population, (Buga, Amoko & Ncayiyana 1996).

## **2.7 Conclusions**

The chapter focussed on the introduction, previous research on the subject, reproductive health services and health care provider as a barrier to contraceptive use by teenagers health behaviour and attitude of the teenager and youth as a barrier to contraceptive use, cultural barriers to the use of contraception, barriers to emergency contraception in South Africa and elsewhere in the world, other barriers to contraceptive use as well as the conclusion.

## **CHAPTER 3**

### **Research Methodology**

#### **3.1 Introduction**

This chapter is about research methodology and focuses on the introduction, study site, study design, sampling, data collection, reliability and validity, ethical consideration as well as conclusion.

#### **3.2 Study site**

The study was carried out in Pietersburg Hospital, Capricorn District in Limpopo Province, South Africa. Pietersburg Hospital is part of the Polokwane-Mankweng Hospital Complex which offers tertiary services in the Province. It is situated in the city of Polokwane. It has the capacity of 466 beds and amongst its clinics it also offers ante-natal care clinic, gynaecology clinic and Choice of Termination of Pregnancy Clinic (CTOP) services. This hospital services communities that are from the Central Business District, adjacent rural areas and all rural areas within the province.

#### **3.3 Study design**

This was quantitative cross sectional descriptive survey as it describes the relationship between one or more variables in a sample. Quantitative research involves the analysis and interpretation of numerical data. According to Given and Lisa (2008), quantitative research translates to systematic study of a social occurrence by way of statistical, mathematical or numerical data or computational method.

### **3.4 Study Population:**

The study population was all pregnant teenagers who visited ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital. According to statistics there are approximately 340 teenagers seen at these clinics per month.

### **3.5 Sampling Procedure and sample size**

Pietersburg Hospital was conveniently selected as the area of study because it services communities that are from the Polokwane Central Business District, adjacent rural areas and all rural areas within the province. The study sample was selected using random sampling technique where, every third pregnant teenager who visited the hospital for antenatal care (ANC) and CTOP services between February to April 2013. According to hospital statistics there are approximately 340 teenagers visiting Pietersburg Hospital for ANC and CTOP in a month. Using Morgan Krejcie table, the sample size of 171 for this study was derived and to cater for attrition and incomplete questionnaires, 10 teenagers were added in the study sample, making total sample size to be 181, (Krejcie & Morgan, 1997).

### **3.6 Data collection tool**

The data collection tool used in this study was a self-developed close-ended questionnaire which consisted of three parts: the demographics of the respondent, knowledge of contraceptive use which was measured by eight questions and attitudes to family planning which was measured by nine

questions. The scoring was such that each correct answer was given 1 point and incorrect answer was given 0 point. Data was collected at the above-mentioned clinics by the researcher.

### **3.7 Data collection Procedure**

The researcher distributed the questionnaire adapted from Social Science & Medicine 50, (2000) and the Obstetrics & Gynaecology Journal of India, 2005, to the participants and requested them to complete it. The researcher assisted participants who needed assistance in completing the questionnaire (those that could not read or write). The researcher took 20 minutes to complete the questionnaire, and they were required to hand the completed questionnaire to the researcher.

The data was collected for a period of three months (February-April 2013).

### **3.8 Data analysis**

The collected data were entered into Microsoft Excel Spreadsheet; then imported into SPSS for analysis. Frequency distribution and descriptive statistics was used to summarize the demographic profile of respondents. Some of these data were also categorized and percentages and proportions were calculated. Knowledge scores were added and percentages were calculated. Knowledge was categorized into the following: poor knowledge = < 50%; fair knowledge = 50 = 60%; good knowledge = 61 – 74% and excellent knowledge =  $\geq$  75%. For attitude: all correct responses were given 1 score and all incorrect responses were given 0 scores. All scores were added and percentages were calculated. Attitude was categorized into : negative attitude = < 50%; positive attitude =  $\geq$  50%. Possible associations between independent variables were determined using bivariate analysis like cross-

tabulation and Chi-square test. Logic regression was utilised to predict feasible association among the variable at 0.05 level of significance and P-values less than 0.05 considered as statistically significant.

### **3.9 VALIDITY AND REALIBITY:**

The content validity of the study was ensured by consulting with experts in the reproductive unit and also expertise of the supervisor. A pilot study was done on 10 nonparticipating teenagers who were consulting at the ANC. The aim of this piloting was to check whether teenagers understood the questions and how long it took for them to complete the questionnaire. For reliability, the data was analyzed using Cronbach's alpha value  $\geq 0.7$  and the results yielded  $\alpha = 0.72$ , and the items with value less than this were modified or deleted.

In addition, answering the questionnaire was voluntary with guaranteed anonymous status of each of the participants.

### **3.10 BIAS:**

Bias is likely to be introduced when the participants are given a questionnaire with language that they are not familiar with, to reduce this; the questionnaire was translated into Sepedi and back to English. Possible response bias was also minimized by assuring the participants that the information was confidential and that participation was anonymous.

Researcher bias was minimized by ensuring that the researcher remained neutral when respondents were filling the questionnaire, so that they are not influenced by her body expression and opinions.

### **3.11 INCLUSION CRITERIA**

These are the characteristics which the individuals in the study population should possess in order to be included in the study. These characteristics are also referred to as eligibility criteria and in this study, these were:

Participants were females,

They were of reproductive age (12 to 21),

Voluntarily participated in the study,

They were seeking antenatal care and termination of pregnant and

Informed consent was administered to.

### **3.12 EXCLUSION CRITERIA**

These are sets defined characteristics present in the identified population that will make them not to be eligible to participate in a research. These are guided by the objectives of the study as well as ethical considerations. In this study, these include:

Those women attending the women's clinic but for follow up post CTOP,

Those willing not to participate in the study.

### **3.13 Utilization and dissemination of results**

The results of the study will be available at the University Library for students and other researchers to use. An attempt will be made to publish results in a journal to make the findings available to the wider community. The researcher

will give participants feedback through community meetings, which will be held once the study is concluded and the findings documented. These results will be used for seminars, workshops and conferences.

#### **4. Ethical consideration**

The researcher observed relevant ethical and legal guidelines governing research with human participants. The researcher informed participants about procedures for data collection and analysis and for permission to use the procedure while ensuring confidentiality. For those under age, the researcher did not seek parental approval primarily because they were unaccompanied by any adult. The SA law for reproductive health states that the children from 12yrs of age can seek reproductive health services without parental approval. So, the nursing manager signed the consent on behalf of parents. The researcher submitted the proposal to the school of Health Sciences for review and guidance before submission to the ethics committee of the University of Limpopo for approval. The study commenced once approval of the Medunsa Research Ethics Committee was obtained. Names of participants were not included in the final report and confidentiality was upheld at all times.

#### **5. Conclusion**

This chapter focussed on the introduction study site, study design, sampling data collection, reliability and validity, ethical considerations as well as the conclusion.

## CHAPTER 4

### RESULTS

#### 4.1 Introduction

In the previous chapter, the study design, setting, study population, sampling methods, sample size, data collection and data analysis were outlined. In this chapter, the demographics, knowledge, attitude and barriers of contraception use were presented and interpreted.

#### 4.2 Demographic Characteristics of pregnant teenagers

**Table 4.1:** Demographic Information of the study participants, n=180

Variables		Frequency n= 180	%
<b>Age (years)</b> Mean=17.8 Median=18.00 Sd=1.49	13-14	6	3.3
	15-16	25	13.9
	17-18	72	40.0
	19-20	77	42.8
Residence	Rural	67	37.5
	Peri-urban	105	59.2
	Urban	6	3.3
<b>Ethnicity</b>	Blacks	164	91.1
	Whites	7	3.9
	Other	9	5.0
<b>Number of children</b>	No children	138	76.7
	1 child	40	22.2
	2 children	2	1.1

Table 4.1 shows that most of participants were between 19-20yrs (42.8) and least were 13-14yrs (3.3%) of age. Also, most of participants resided in peri-urban (59.2%), rural (37.5%) and 3.3% were from urban areas. Table 4.1 also show that the majority of participants were black (91.1%), 72% or respondents were at secondary school and 76.7% did not have children.



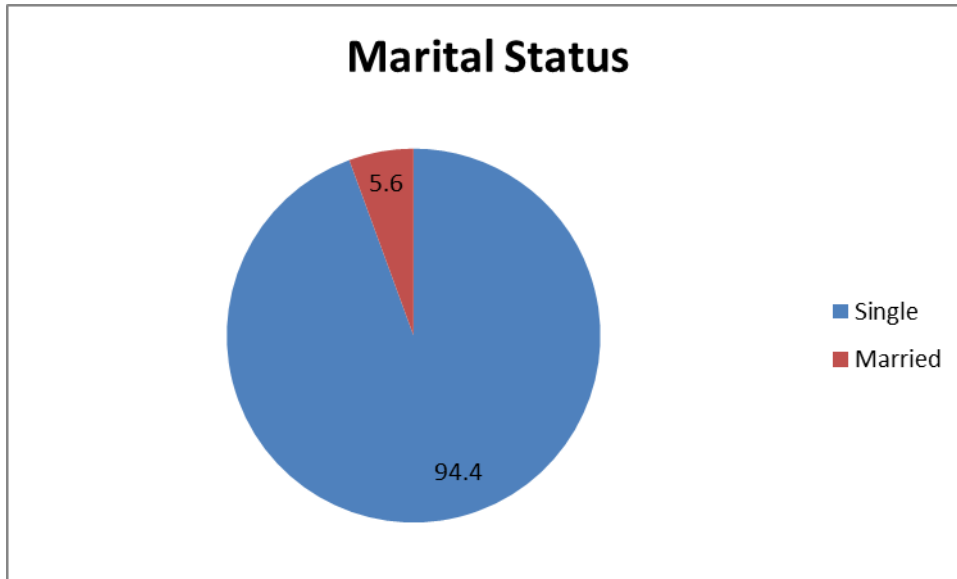


Fig 4.1 Marital Status of Respondents

Fig 4.1 shows that 94.4% of teenagers were single, with only 5.6% being married

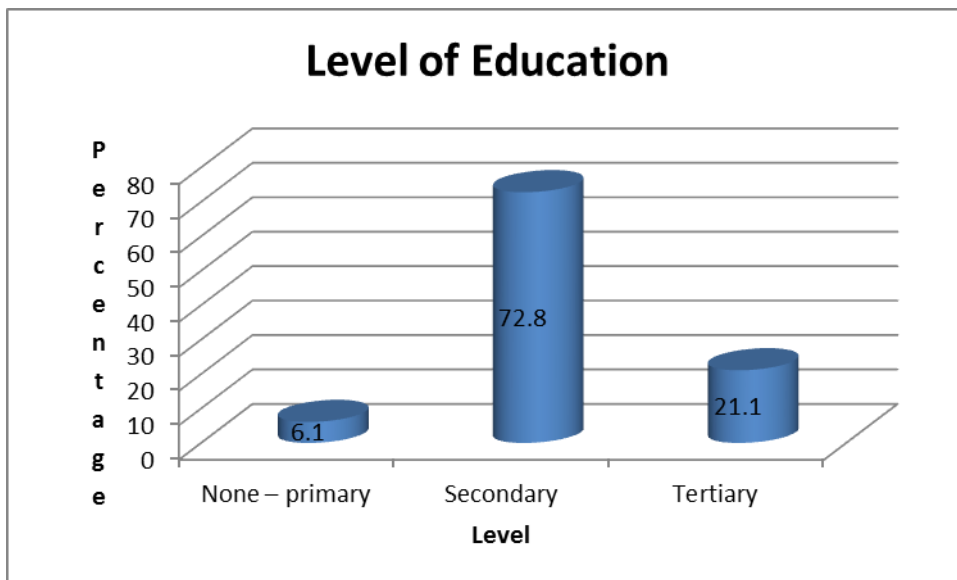


Fig 4.2 Level of Education

Fig 4.2 shows that 72.8% Of respondents were in secondary education, 21.1% were in tertiary and only 6.1% were in primary level.

**Table 4.2: Knowledge of emergency contraception among pregnant teenagers**

<b>Knowledge of Emergency Contraceptive Use</b>	<b>Yes</b>	<b>No</b>
Have you used contraceptives before?	48(26.7)	132(73.3)
Have you ever heard about emergency contraception?	62(43.4)	118(65.6)
If yes, have you used them?	43(23.9)	137(76.1)
Do you think you should use birth control each and every time you have sex?	96(53.3)	84(46.70)
Are you aware of side effects of EC?	31(17.2)	141(82.8)
Are you aware of contraindication of EC?	35(19.4)	145(80.6)
Are any of the following specific problems for you as a barrier to use contraception?		
a) Not enough time to choose method	100(55.6)	80(44.4)
b) Not serious about contraception	115(63.9)	65(36.1)

**Table 4.2** shows that 73.3% of respondents have used contraceptives before, but, overall 65.6% of respondents have never heard of emergency contraception and the majority have never used emergency contraceptives and were not aware of its side effects or contraindications.

Table 4.2 also reveals that 55.6% and 63.9% of respondents reported that they do not have time to choose contraceptives and are not serious about contraception respectively.

Table 4.3: Association between demographic variables and use of contraceptives

		Women who used contraceptive before	Women who did not used contraceptive before	X <sup>2</sup> p-value
Age	13-14yrs	0	7(100)	X <sup>2</sup> = 5.994 P= 0.019
	15-16yrs	5(20.0)	20(80.0)	
	17-18yrs	17(23.3)	56(76.7)	
	19-21yrs	26(34.7)	49(65.3)	
Marital Status	Single	45(26.4)	125(73.6)	X <sup>2</sup> = 0.60 P = .527
	Married	3(30.0)	7(70.0)	
Education level	Primary or less	6(46.2)	7(53.8)	X <sup>2</sup> = 3.543 P= .170
	Secondary	30(23.5)	98(76.5)	
	Tertiary	12(30.8)	27(69.2)	

Table 4.3 shows that there is a significant association between age and use of contraceptive., where the majority of women have not used contraceptives before falling pregnant.

**Table 4.4:** Association between demographics and knowledge of emergency contraceptives

		Teenagers who know emergency contraceptive	Teenagers who don't know emergency contraceptive	p-value
Age	13-14yrs	4(57.1)	3(42.9)	P=.401
	15-16yrs	10(40.0)	15(60.0)	
	17-18yrs	22(30.1)	51(69.9)	
	18-21yrs	26(34.7)	49(65.3)	
<hr/>				
Marital Status	Single	59(34.7)	111(65.3)	.429
	Married	3(30.0)	7(70.0)	
<hr/>				
Education level	Primary/less	6(46.1)	7(53.9)	.033
	secondary	34(26.6)	94(73.4)	
	Tertiary	22(56.4)	17(43.6)	
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Table 4.4 shows that there is no significant difference between teenagers who know emergency contraceptive according to age and marital status ( $p=.401$ ;  $.429$  respectively) and there is a significant correlation between knowledge of emergency contraceptive according to level of education ( $p=.033$ ), where 56.4% of teenagers at tertiary level knew about EC.

**Table 4.5: Attitudes of respondents towards Family Planning**

Items	Yes N(%)	No N(%)
Couple must decide on how many children to have	166(92.2)	14(7.8)
In favour of family planning	148(82.2)	32(17.8)
Partner in favour of family planning	114(63.3)	66(36.7)
Plans to use contraceptives in future	160(88.9)	20(11.1)

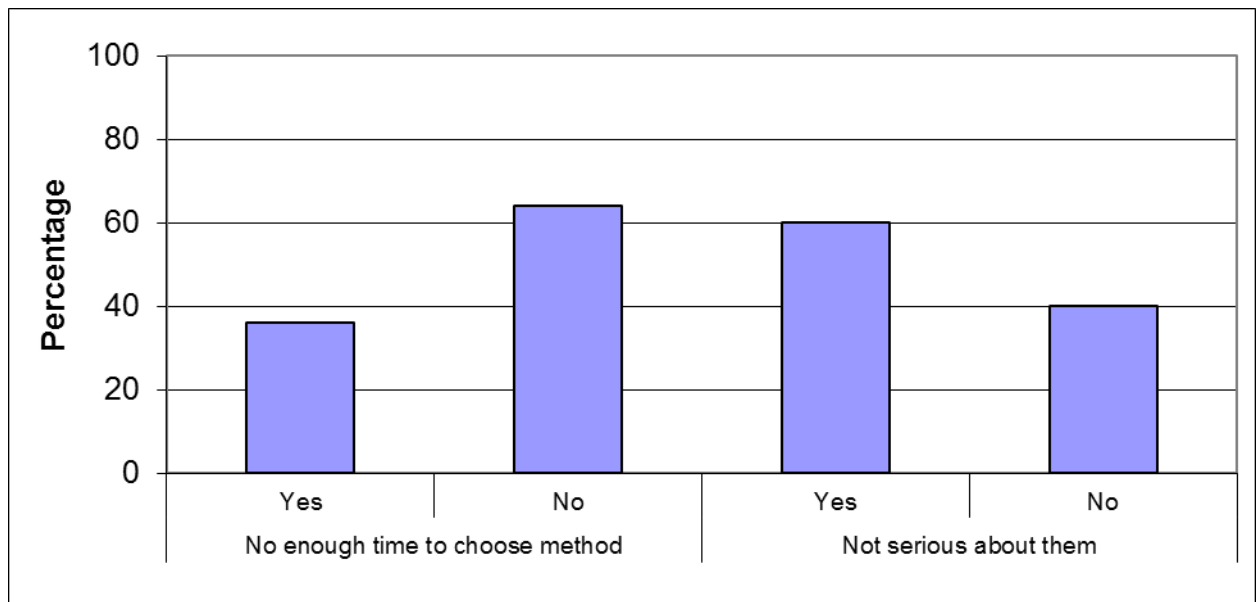
Discuss with partner on choice of contraceptive	108(60.0)	72(40.0)
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Table 4.5 above shows that the majority of respondents agreed that couples must decide on how many children to have (92.2%) and that couples must discuss choice of contraceptives to use (60.0). Also, the majority of respondents were in favour of family planning (82.2%) and 88.9% were planning to use contraceptives in future, however, only 36.7% of respondent indicated that their partners were not in favour of family planning.

**Table 4.6 Attitudes of respondents towards Sex Education**

Items	Yes	No
Need for more information on contraceptives	162(90.0)	18(10.0)
Need for sex education in schools	156(86.7)	24(13.3)
TV and Radio as means for providing information for family planning	162(90.0)	18(10.0)
Workshop about family planning including men	153(85.0)	27(15.0)

Table 4.6 shows that the majority of respondents agreed that there is a need for more information on contraceptives (90.0%) and at schools (86.7%). Eighty five percent (85.0%) agreed that a workshop on family planning must include men as well.



**Figure 4.3:** Barriers for use of contraceptives

Figure 4.3 illustrates the common barriers preventing women use contraception. Sixty per cent of women said the common barriers to use choose method (36%).

**Table 4.7: Association between Attitudes of respondents towards Family Planning according to level of education**

Items		Primary	Secondary	Tertiary	Pvalue
Couple must decide on how many children to have	Yes	11(84.6)	118(92.1)	37(94.8)	.489
	No	2(15.4)	10(7.9)	2(5.2)	
In favour of family planning	Yes	11(84.6)	105(82.0)	32(82.0)	.973
	No	2(15.4)	23(18.0)	7(18.0)	
Partner in favour of family planning	Yes	5(38.4)	86(67.1)	23(58.9)	.100
	No	8(61.6)	42(32.9)	16(41.1)	
Plans to use contraceptives in future	Yes	10(76.9)	114(89.0)	36(92.3)	.309
	No	3(23.1)	14(11.0)	3(7.7)	
Discuss with partner on choice of contraceptive	Yes	7(53.8)	81(63.2)	20(51.2)	.346
	No	6(42.2)	47(36.8)	19(48.8)	

Table 4.7 shows that the majority of respondents with tertiary education (94.8%) reported that couples must decide on how many children to have, whereas only 84.6% of respondents with primary education agreed. Also, 18% of those with tertiary and secondary education and 15% of those with primary education were not in favour of family planning. Also, the majority of respondents with primary education (61.6%) reported that their partners were not in favour of family planning compared to other levels of education however, the majority of respondents were planning to use contraceptives in future across different levels of education. There is however, no significant difference in attitudes and variables ( $p > .050$ ).

**Table 4.8 Association between Attitudes of respondents towards Sex Education according to level of education**

Items		Primary N(%)	Secondary N(%)	Tertiary N(%)	Pvalue
Need for more information on contraceptives	Yes	12(92.3)	117(91.4)	33(84.6)	.446
	No	1(7.7)	11(8.6)	6(15.4)	
Need for sex education in schools	Yes	11(84.6)	110(85.9)	35(89.7)	.808
	No	2(15.4)	18(14.1)	4(10.3)	
TV and Radio as means for providing information for family planning	Yes	11(84.6)	115(89.8)	36(92.3)	.721
	No	2(15.4)	13(10.2)	3(7.7)	
Workshop about family planning including men	Yes	11(84.6)	110(85.9)	32(82.0)	.837
	No	2(15.4)	18(14.1)	7 (8.0)	

Table 4.8 shows that Majority of respondents with primary (92.3%) and secondary (91.4%) education reported that they needed more information on contraceptives, compared to those with tertiary education (84.6%). Also, the majority of those with

tertiary education (89.7%) reported that there is a need for sex education in schools, compared to those with primary and secondary education. Also, the majority of those with primary and secondary education reported that there is a need to include men in sex education, however, there is no significant association between attitude and all the variables ( $p > .05$ ).



## **CHAPTER 5**

### **Discussions, Conclusion and Recommendations**

#### **5.1 Introduction**

The aim of the study was to determine knowledge, attitudes and practice of pregnant teenagers with regard to usage of contraceptives. This chapter discusses the findings of the research. The discussion will cover each objective individually. It will finally end with a conclusion, recommendations and limitations of the study.

#### **5.2 OBJECTIVE 1**

The results of this study show that the youngest teenager who was pregnant was 13 years of age, and the oldest was 21 years of age. These findings imply that the sexual debut may be lower than 13 years for the fact that they are already pregnant at 13 years. Similar studies done in Soweto by Mcleod & Tracy, (2010) also reported that the youngest teenage girl in Soweto to be pregnant was also 13 years. These findings indicate that teenagers start the sexual debut at an early age without understanding the consequences which results in unwanted pregnancy. This is a major concern because often these girls engage in sex with man that are not their age, which lead to this pregnancy which is often unwanted.

The findings in this study are not unique to this province especially where whites are more than blacks. Similar studies conducted in Soweto and Cape Town show that there is a high rate of pregnancy among teenagers in South Africa, Marteleto & Ranchhod (2008). According to Health System Trust (2014) the number of teenagers' pregnant school girls jumped from 1169 in 2005 to 2 336 in 2006 in Gauteng. The Chief Executive Officer of Love-life in South Africa indicated that in one school in Soweto 71% of teenage girls were pregnant, which is extremely high and an indicator that all the pregnant

teenagers were engaged in risky sexual behaviours in Soweto. These signify the high risk of the teenagers to contract diseases such HIV and STIs.

According to UNAIDS (2012) report, 6.1 million are living with HIV, and in South Africa the majority are between the ages of 15 years and 49 years.

South African Medical Council (SAMC) reported that 16% of pregnant mothers less than 20 years of age tested positive for HIV. Although this current study did not look at the HIV status of respondents, there are high chances that these teenagers could end up being infected with HIV in the long run, due to their risky behaviours. The fact that the teenagers in this current study were pregnant at the age of 13 years could indicate that they are exposed to HIV even earlier than 13 years. In their study Zuma et al (2010) found that the age of sexual debut of teenagers in South Africa was 16 years, however, more studies indicate even earlier sexual debut in most South African townships like Soweto and Limpopo.

The results of this study showed that the majority of pregnant teenagers were blacks, with only few whites and other races. Other studies in US and Jamaica predicted that black teenagers are likely to be active sexually before their 17<sup>th</sup> birthday and likely to be pregnant by their 19<sup>th</sup> birthday. Ziyani and Ehlers (2006) also reported that adolescent girls reported the ideal age to have a baby was 18 years of age. Seeing that this hospital is serving many teenagers from nearest villages, a third of participants are coming from rural areas surrounding Polokwane Central Business Center (CBD). It is a fact that women in rural areas are not empowered when it comes to sexual health and decisions involving family planning are normally taken by men. It is

therefore important for health professional to empower this women by educating them about reproductive health so that they can make informed decisions where there to have a child in a young age or not. School curriculum should be designed such that it empowers women to make their own decision about sexuality and reproduction.

The results of the study show that 95% of respondents were single and 5% being married. The fact that the majority of respondents were single indicate that participants are in relationship which could be unstable and could have been involved in a one night stand which could have led to a pregnancy, or pregnancy could be used as a way of pinning the partner down. In most cases when there is unstable relationship, some of these teenagers resort to TOP, in an effort to save the relationship which they loose anyway.

Teenage pregnancy has positively been linked to low level of education (UNAIDS, 2008). South Africa has been reported to be at 88% literacy level, meaning that South Africa is on track with MDG 2. It is therefore not expected that a Country with such high literacy level would have high teenage pregnancy, than a country which have low literacy level like Sudan and Mali where literacy level is 27% .It is also estimated that 1 in every 6 teenagers between 15-19 years gave birth annually . It is of concern that reports show that 1 in every 7 babies die before the ages of 1 year in those countries, (WHO, 2009). The National survey shows that South Africa has the highest prevalence of pregnancy at a rate of 71% per 1000 teenagers among blacks and 14% per 1000 teenagers among whites, (HSRC, 2009). The results of this study show that the majority of respondents had secondary or tertiary

education. Meaning that they would be having good knowledge on reproductive issues, but sadly that is not the case. This therefore means that there is an urgent need for schools to intensify health education and prioritise use of contraceptives by teenagers in order to prevent unwanted pregnancy.

### **5.3 OBJECTIVE 2**

To determine knowledge and use of emergency contraception, among pregnant teenagers attending ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital.

The results of this study showed that the majority of teenagers did not use contraception before falling pregnant. The fact that they fell pregnant is an indication that they were involved in risky sexual behaviours which leads to a risk of contracting HIV and STIs. The fact that they did not use contraception, indicates that teenagers may lack assertiveness when it comes to sexual matters between them and their partners, as result they may fear negotiating condom use during sexual activity. South African Health Systems Trust reported that women are sometimes willing to engage in high risk sexual behaviours in order to gain material benefits such as marriage and child social grant (Health System Trust 2014).

This study also found that there was a statistical significance association between use of contraception and age. However there was no statistical significance between use of contraception and the level of education,(Taiwo, 2012).The study found similar findings where younger adolescence did not use contraception on their first sexual debut, compared to older teenagers

who deliberately stopped using contraception and fell pregnant again, (Wood et al, 1996).

There is a significant association between education level uses of contraception with teenagers who are not educated lacked knowledge on the use of contraception that those who are better educated. Literature reveals that there is a number of reasons why women stops using contraception, such as psychological changes and perceived gynaecological changes in their bodies when they use contraception, Wood K (1996).

In this study it was found that half of the respondents reported that they did not have time to choose a contraceptive method and 2/3rd reported that they were not serious about contraception use. These reasons shows that teenagers would act irresponsibly and find themselves engaged in risky sexual behaviours that lead to unwanted pregnancies. The fact that these teenagers are still at school means that they at risk of dropping out of school, before finishing matric, further increasing the burden of unemployment and the vicious cycle of poverty in the province. Furthermore studies have found that the teenagers often drop out of school and the probability of them returning to school after delivery is low. According to the Minister of Basic Education in South Africa, South Africa is faced with challenges of learners who drop out of school before they finish matric, it is reported that 33.4% of learners between grade 11 and 12 dropped out of school in 2012, DOE, Education Statistics (2012).

The use of emergency contraception has prevented unwanted pregnancies for many years. Its success has been reported in many studies, Smith et al

(2009). Despite this reported successes of emergency contraception use there are reported cases of its failure, that could be attributed to time period the individual used it (i.e. it should be used within 72 hours of sexual activity), (Rodrigues, Grou & Joly, 2001). The results of this study showed that 2/3rd of respondents did not know and use about emergency contraception and 77% of teenagers in this study have not used emergency contraception. These results are similar to findings by Ramathuba, Khoza, & Netshikweta (2012). Knowledge who reported that the majority of teenagers did not know that such contraception exists and as a result they did not know the reported side effects of emergency contraception such as: falling pregnant when used, acne, irregular menstruations increased appetite etc.

The fact that two thirds (66%) majority of teenagers did not know emergency contraceptives and would imply that they did not use it. However the results show that both the once who knew about these contraceptives and those who did not know, did not use these contraceptives. The results of the study found no significant difference between those who did not have time or not serious about contraception according to age. These findings show that emergency contraception use or none use did not depend on maturity of teenagers. Kamau, Karanja, Sekadde-Kigonde, Ruminjo, Nichols, & Liku, (1996), found that some of the barriers to contraceptive use were mainly associated too spouse attitude, not serious and perceived undesirable side effects such as "no sex enjoyment". Wood & Jewkes, (2006), found that the behaviour of nurses in family planning and blood blockages when using contraceptives, were the major reasons why teenagers did not use contraceptives. Though this study did not focus on barriers to contraception use, it would be interested

to further studies to determine reasons for non-use of contraceptives by teenagers in Limpopo. These barriers signify an alarming reality that teenagers do not perceive themselves as being at risk of contracting serious illness such as HIV and STIs and consequences like pregnancy. One would expect that each teenager would find time and be serious about own health so that they do not find themselves being pregnant when they are not ready for a child.

#### **5.4 OBJECTIVE 3**

To determine attitudes of pregnant teenagers attending ante-natal care clinic, gynaecology clinic and CTOP clinic in Pietersburg Hospital. The results of the study show that the majority of respondents reported that they were in favour of family planning, despite the fact that most did not use contraceptives prior to becoming pregnant. There was also no significant difference in those who favoured contraceptive use, according to the age group, level of education and race ( $p > 0,05$ ). This indicates that good knowledge and positive attitude did not translate that to behaviour change among these teenagers. Saluja, Shama, Choudhary, Gaur & Pandey (2009) also found similar results, where rural teenagers with good knowledge and positive attitude about contraceptives did not use it. Onyensoh, Govender & Tumbo (2004), found that good knowledge and attitude towards contraceptives did not translate to uptake of contraceptives among teenagers in North-West Province in South Africa. Though this study did not find a significant association between use of contraceptive and level of education, similar studies reported an association existed between level of education and age, DeRose (2004) and Ibrahim (2013). What is of interest however was the fact that 37% of respondents said

that their partners were not in favour of family planning which could be a reason why these teenage girls did not use contraception prior to falling pregnant. Similar findings were reported by Oindo (2002) and DeRose (2004), who found that involvement of males in family planning education improved their attitude and therefore increase the chances of their partners using contraceptives.

Though the questionnaires was close-ended a 13 years old respondent scribbled that she did not know what contraceptives are, which indicates that she engaged in sexual activity without full knowing the consequences and prevention methods she could use to prevent pregnancy. There is therefore an urgent need to reinforce reproductive health in the school curriculum as early as primary schools; so that the learners that engage in sexual activities at a young age could make informed decisions about whether to use contraceptive or not. Similar results among teenagers in Nigeria, where it was reported that younger teenagers did not know what contraceptives were Taiwo (2012). Furthermore Sukati (2008) reported that in most instances females were scared to negotiate condom use during during sexual activity, because of fear that their partner will leave them, Sukati (1998).

The results also show that the majority of respondents (89%) reported that they were planning to use contraceptives in future, more blacks (70,05) reported this than other racial groups. The majority of teenagers' usually However the study by Berry & Hall (1998:7) found out that teenager starts sexual activities at 15 years of age. Repeated similar results among teenagers in Nigeria, Taiwo (2012) where it was found that younger teenagers do not know what contraceptives were in most instances females are scared to



negotiate condoms during sexual activity, because they fear that their partners will leave them, Sukati(1998).

The results also show that the majority of respondents (89%) reported that they were planning to use contraceptive in future, more blacks reported this than other racial groups (70,05).The majority of teenagers usually increase contraceptive use after they have had their first babies. Some of the reasons cited were that they were unable to support their children, and that they still want to go to school after they delivered. However in some cases teenagers find themselves falling pregnant the very same way that they fell pregnant previously, this instances they are likely to terminate the pregnancy.

The results of this study showed that the majority of respondents (87%) were in favour of sex education in schools. According to white paper on basic education in South Africa, the life orientation communication should indicate sex education as early as primary school .What is not clear however is what information is given to learners and to what extend, in terms of depth. It is therefore recommended that health professionals be involved in the design of school curriculum on sex education and also teaching learners on reproductive health at schools. Perhaps this would therefore have more depths and clarity such that learners could be persuaded to use protection and contraceptive which is dual protection, so at to curb those high rates of pregnancy.

The fact that a whopping 90% of teenagers reported that television and radio are good means of providing information regarding family planning .The problem with this media messages is that massages are brief and usually do not expand more on pertinent issues surrounding reproductive health. There is also lack of interaction with populations and communities such that if a

teenagers miss to understand that what is been said they do not have the opportunity to ask questions. These will lead to them using contraceptives incorrectly resulting in pregnancy. It would be of importance if television adverts were run by health care workers because they would entertain queries and questions on air ; but seeing that media is expensive that platform cannot be sustained. Media is also cited in Ramathuba et al (2012) as preferred means of information by teenagers.

The majority of teenagers reported that they would like to have a workshop on family planning for both men and women together. What is of concern is the fact that men are often excluded in these types of workshops, and yet they are the people being reported not to be in favour of contraceptives. It could be possible that men do not know the benefits to their partners using contraceptives, or they have misconceptions about perceived disadvantages of contraceptives. If men were included in family planning they would therefore be ready to face the challenges of parenting children, instead of them running away from responsibilities; and they would plan with their partners about when to start a family.

## **5.5 Recommendations**

From the results of this study, males seem to be the key reason for the teenage girls not to use contraceptives. It is therefore recommended that males be included in the reproductive health workshops, in order for them to understand the importance of being prepared to start a family.

Secondly, this study did not look at the barriers to contraceptives use except only 2; it is therefore recommended that further studies be done to get more information on barriers influencing contraceptive use in this province.

Thirdly, the questionnaire used did not adequately explore both attitude and knowledge, it concentrated on knowledge of emergency contraceptives. The researcher therefore recommends that a bigger study that explores both knowledge of and attitude of teenagers about the use of contraceptives in general should be done.

## **5.6 Conclusion**

The results of the study show that teenagers did not have enough knowledge about use of emergency contraception in Polokwane, as a result, they find themselves pregnant at a very early age (youngest being 13 years). More blacks than whites were reported to be pregnant in this town, meaning that there is a need to focus on health education on this group so that they upscale contraceptive use in order to prevent diseases and pregnancy. It is also clear from this study that the majority of teenagers have positive attitude towards contraceptives use and are planning to use contraceptives post-delivery. It is therefore recommended that healthcare workers should continue to educate and empower youth on contraceptive use, even at school level so that learners can receive accurate information and hopefully, they will use contraceptives, including dual contraceptives.

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## 7. LIST OF APPENDICES

### APPENDIX 1

#### QUESTIONNAIRE

#### Demographics of the client

#### Answer all questions

Variables	
Age	-----Years
Race:	<input type="checkbox"/> Black/ <input type="checkbox"/> White/ <input type="checkbox"/> Coloured/ <input type="checkbox"/> Indian/ <input type="checkbox"/> Other -----
Education:	<input type="checkbox"/> Primary/ <input type="checkbox"/> Secondary/ <input type="checkbox"/> Tertiary
Marital status	<input type="checkbox"/> Single/ <input type="checkbox"/> Married/ <input type="checkbox"/> Divorced
Where do you stay?	<input checked="" type="checkbox"/> Urban <input type="checkbox"/> Township or informal settlement <input type="checkbox"/> Rural
How many children do you have?	-----

<b>Knowledge of Contraceptive Use</b>	<b>Yes</b>	<b>No</b>
Have you used contraceptives before?		
Have you ever heard about emergency contraception?		
If yes, have you used them?		
Do you think you should use birth control each and every time you have sex?		
. Are you aware of side effects of EC?		
Are you aware of contraindication of EC?		
Are any of the following specific problems for you as a barrier to use contraception?		
a) Not enough time to choose method		
b) Not serious about contraception		

<b>Attitudes to family planning</b>	<b>Yes</b>	<b>No</b>
Do you think it is right for a married couple to decide how many children to have according to their wishes?		
Are you in favour of family planning?		

Is your sexual partner in favour of family planning?		
Do you think there is a need for more information on contraceptive methods?		
Are you in favour of sex education in school?		
Do you believe that TV and radio are good means to provide information regarding family planning to the population?		
Are you planning to use any contraceptive methods in the future?		
Do you discuss with your sexual partner the choice of a contraceptive?		
Are you in favour of a workshop about family planning for women and men together?		
Are you staying in rural area?		
Are you staying in peri-urban area?		
Are you staying in an urban area?		

## APPENDIX 2

### **PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT**

#### **Acknowledgement**

Thank you for participating in the study.

#### **Study Title**

Knowledge, attitudes and perceptions of pregnant teenagers with regard to usage of contraceptives at Pietersburg hospital, Limpopo Province, South Africa

#### **Introduction**

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you decide to take part in this study you should understand what it involves.

#### **Purpose of the study**

To determine knowledge, attitudes and perceptions of pregnant teenagers with regard to usage of contraceptives.

#### **Ethical approval**

This study protocol will be submitted for ethical approval by the University of Limpopo's research unit and committees

### **Your rights as participant in this study**

Your participation in this study is entirely voluntary and you can refuse to participate or stop at any time without reason. Your withdrawal will not affect you in any way.

### **Should the participation result in discomfort or inconvenience?**

This self-administered questionnaire will take approximately 5 minutes to complete. There will be no procedures or intervention that could be uncomfortable to you. Questions would be asked on issues related to barriers to contraception use. The questions will be asked in the language that you understand.

### **What are the risks involved in this study?**

None

### **Confidentiality**

All information will be gathered during the course of this study is strictly confidential. Data will not include any information that could identify you as a participant in this study.

## **Informed Consent**

I hereby confirm that the researcher has informed me, about the nature, conduct, benefits and the risks of the study. I have also received, read and understood the above written information.

I am aware that the results of the study, including personal details regarding my age, educational level and other socioeconomic characteristics will be anonymously processed into a study report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I declare myself prepared to participate in the study.

Participant's name:

Participant's signature:

Researcher's name:

APPENDIX 3

LETTER FROM THE ETHICS COMMITTEE