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THE UTILIZATION OF CONTRACEPTIVES AMONGST ADOLESCENTS AT
STUTTERHEIM IN THE EASTERN CAPE PROVINCE

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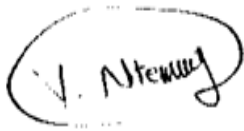
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DECLARATION

I, Visisa Ntengo-Kupula hereby declare that the mini-dissertation titled, “The utilization of contraceptives amongst adolescents at Stutterheim in Eastern Cape Province” is my original work. All the citations from other people’s work have been revealed and acknowledged with complete referencing.

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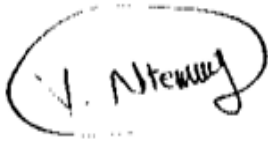


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DEDICATION

This mini-dissertation is dedicated to my family:

My parents: Mlindeli Ntengo (my father) and Ntomboxolo Ntengo (my mother) thank you so much for moulding me to become the woman I am today. Education has been always your emphasis growing up therefore; I intend to make you proud even more.

My siblings: Lusanda Ntengo (my brother) and Mhlali Ntengo (my little sister) you have always admired my progress in life; your lovely words of encouragement kept me going.

My husband: Bulelani Kupula, when I am weak you become strong. I am grateful for allowing me to stay at Stutterheim during data collection and the finances you settled at the university of Fort Hare so that I can finish my master's degree; you affirmed and reassured me, I cannot thank you enough. The way you value education is unexplainable,



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I would like to thank God for the strength he had given me throughout the process; now I can attest that he will never leave me nor forsake me. I cannot imagine my life without you Lord; thank you my Father.

My husband, Mr Bulelani Kupula, you are my number one supporter of all times; thank you so much for standing by my side when I needed you the most. I wouldn't have completed master's degree without you, you allowed me to pursue my studies without hesitation. I appreciate the sacrifices you had made, Enkosi ngondithanda myeni wam.

My earnest gratitude goes to my supervisor Dr Nkutu who keenly accepted me as her student when I was desperately in need of a supervisor. You were so patient with me. Thank you so much.



I would like to thank the adolescents (14-19 years) of the Amahlathi local municipality for giving me the opportunity to collect data in order to complete my research study at the University of Fort Hare. I further thank Mr. Merile, acting on behalf of the Eastern Cape Department of Health and to Mrs Gede, the Amatole district manager for providing me with the opportunity to proceed with the collection of data. The managers of the health facilities at Stutterheim, thank you so much, God bless you.

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I would like to show appreciation to the adolescent learners who assisted me in the data collection taking place at the nearby clinics: Isihoboti Public Combined School, Jongile Nompondo Secondary School, Sinethemba Public School and Mgwali Public School.

ABSTRACT

Introduction

Contraception has been identified as one way in which women can prevent unwanted pregnancies. Contraceptive utilization has been proved to minimize maternal mortality by lowering the risk of pregnancy and its associated life-threatening problems. Therefore, the researcher conducted a study at Stutterheim about the “utilization of contraceptives amongst adolescents at Stutterheim in Eastern Cape Province” with the intentions to explore perceptions of adolescents on utilization of contraceptives and to determine the factors that influence that contraceptive utilization.

Methods

This study adopted a quantitative, descriptive cross-sectional design which involved questionnaire tools completed by 436 adolescents between the ages of 14 and 19 years at Stutterheim health facilities and the surrounding schools, regardless of whether they were sexually active or not. After obtaining ethical clearance from the University ethics Committee and permission from the Department of Health the researcher visited the gatekeepers for obtaining informed consent and data collection procedures. The researcher administered the instruments herself to ensure validity and reliability of the instrument through a pilot study. The respondents of the pilot study did not participate in the major study. Any irregularities with the data instruments were corrected accordingly. Data collection took 3 weeks to complete all the sites. The raw data was captured onto an Excel spread sheet and analysed by the researcher with the assistance of a statistician.

Results

The data suggests that as much as the parents discuss about sex related issues and pregnancy, they are less likely to educate their adolescent girls about contraceptives probably due to the beliefs they have, lack of knowledge and the fear of introducing

them into premarital sex. The 34.4% of participants indicated that they were scared of contraceptive rumours spreading around the community as well as the stigmatization.

Conclusion

Due to the results of this study the Department of Health should work together with the department of education to put into effect the optimal utilization of contraceptives amongst adolescents by adding sexual, reproductive and contraceptives health education, as a subject in the school curriculum. Department of health must also make use of main media and social media since they are influential and can be the great sources of information for campaigns and more seminars on contraceptive utilization and its benefits to the adolescents, society and the State.

Keywords: *Utilization, contraceptives, adolescents, pregnancy*



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CHAPTER 1.

1.1 Introduction and Background

According to the World Health Organization (2018) adolescent pregnancies are a global issue that affects countries with high, middle, and poor incomes, the number of adolescent births has not decreased and West Africa and Eastern Asia have the highest rates of adolescent births and adolescent pregnancies, on the other hand are more likely to occur in marginalized groups where poverty, lack of education, and unemployment are prevalent as a result adolescents become prone to encounter variety of health and social challenges such as initiation of sexual activities even though they lack enough knowledge and skills to protect themselves from the risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections including HIV/AIDS.

Contraceptive utilization is supposed to be influenced by the knowledge people have up to the degree in which it is accepted by the community. An increase in an educational enrolment of older children in a household may lead into the increase of contraceptive use that may cause better spacing and/or lessening in the number of births. However, people need to understand the advantages and disadvantages contraceptive methods have in order to make knowledgeable choices for adolescents in particular (Mwanangombe, Mundende & Muzata 2020:514).

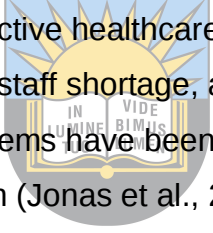
Contraception has been identified as one way in which women can prevent unwanted pregnancies. Contraceptive use has been proved to minimize maternal mortality by lowering the risk of pregnancy and its associated life-threatening problems (exposure reduction) and allowing teens to postpone their first pregnancies until they have reached the mature pelvic development stage (Islam, 2018:2).

Due to its ability to reduce maternal and child mortality and morbidity, family planning has been broadly accepted as an essential intervention for preventing unwanted pregnancies and unsafe abortions while promoting gender equality and educational and economic empowerment of women. Although family planning services come with huge benefits to women, the utilization of contraceptives in Sub-Saharan Africa remains low and several factors such as contextual, socio-economic, geographical, cultural and

religion were found to affect modern contraceptive utilization (Alemayehu, Fekadu & Yitayal, 2018:2).

Abate & Tareke (2019:2) stated that fear of side effects, health concerns, a lack of knowledge, low educational levels, spouse opposition, partner desire for children, and women's poor social decision-making capabilities are the hurdles to contraception use. In order to meet the goal of improving quality of care, it is crucial to ensure continuous service provision by following up women after family planning sessions (Nasr & Hassan, 2016:85).

In rural areas, culture, religion and traditional practices are important elements that shape the norms and values of the community, mainly when it comes to the adolescent girls' sexual activities (Jonas, Romand & Reddyd, 2019: 85). The attitudes and reactions of nurses to adolescents seeking family planning services compromise access and utilization of sexual and reproductive healthcare services in South Africa. Furthermore, clinic operating hours, staff shortage, age of the sexual and reproductive healthcare nurses and logistical systems have been identified as barriers to adolescent contraceptive use that need attention (Jonas et al., 2019:85).



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1.2 Problem statement

Adolescent pregnancies are a global public health concern in high-, middle-, and low-income nations, with marginalized families and communities being more prone to experience them. Adolescent pregnancies and births are caused by a variety of circumstances (WHO, 2018). According to Mouli & Akwara (2020:108) one key factor is a lack of access to and use of modern contraceptive methods; between 1995 and 2020 and the proportion of adolescent girls whose family planning needs were met by modern methods increased from 36% to 60%. Mouli & Akwara (2020:108) continue to say, one in every four adolescent girls aged 15 to 19 who want to avoid pregnancy is currently not using modern methods. While adolescent girls in South Asia, the Middle East, and sub-Saharan and North Africa have all seen steady increases in demand for modern family planning methods, less than half of adolescent girls in these regions received the services they required, compared to at least 75% of their counterparts in Latin America,

Europe, and Central Asia, and nearly 90% in North America (Mouli & Akwara, 2020:108).

Unwanted or unintended pregnancies or giving birth before the age of 20 had become a trend. As a result, adolescent reproductive health is one of the services that require attention in developing countries such as South Africa (Oluwole & Skaal, 2016:1).

World Health Organization (2017:4) stated that there is an underutilization of contraceptive methods amongst adolescents in general. Access to the contraceptive services is met with mixed feelings amongst the youth because of fear and stigmatization. World Health Organization (2017:4) explains further that 214 million women of reproductive age in developing regions have an unmet need for contraception. Reasons for this include limited access to contraception; a limited choice of methods; a fear or experience of side-effects; cultural or religious opposition; poor quality of available services and gender-based barriers (WHO, 2017:4). Researchers concur that lack of access, inability to insist on their use and make informed decisions and choices, result in adolescents being less likely to use condoms than adults (Ansha, Bosho & Jaleta, 2017:111).

Based on observations from some health care centers in Stutterheim, the majority of adolescents is not utilizing contraceptives or is defaulting. The researcher identified that it is necessary to conduct this study because Stutterheim is one of the rural places with adolescents who are failing to make use or adhere to contraceptives, which leads them falling pregnant at a very young age. According to the delivery register in the maternity section of the Stutterheim district hospital, there were 46 adolescent deliveries over an eight months period of 2019. Similar or related studies conducted in other provinces around South Africa and the world over (as reflecting on the literature review) found that the factors associated with contraceptive utilization are similar worldwide (Hlongwana, Thompson & Makhunga, 2020:7; Khoza, Zulu & Shungking, 2019:6). However, according to the researcher's knowledge, there are no studies conducted in Stutterheim regarding utilization of contraceptives by adolescents, and that has prompted the

researcher to investigate the perceptions and factors surrounding utilization of contraceptives amongst adolescents at Stutterheim in Eastern Cape Province.

1.3 Purpose of the study

The purpose of this study was to determine the extent of utilization of contraceptive services amongst adolescents at Stutterheim, in the Eastern Cape Province.

1.4 Objectives of the study

The objectives of the study were to:

1. Explore the perceptions of adolescents on utilization of contraceptives amongst adolescents at Stutterheim in the Eastern Cape Province.
2. Determine the perceived factors that influence contraceptive utilization among adolescents at Stutterheim in the Eastern Cape Province.

1.5 Research questions

- a) What are the perceptions of adolescents towards contraceptive utilization at Stutterheim in the Eastern Cape Province?
- b) What are the perceived factors that influence contraceptive utilization amongst adolescents at Stutterheim in the Eastern Cape?

1.6 Significance of the study

The results of this study would provide health service providers with valuable information on perceptions of adolescents and their knowledge of contraceptive services. Based on those results, it would be possible to design informed interventions to enhance the utilization of contraceptives by adolescents besides contributing to the updating and/or formulation of guidelines for adolescent sexual health. As a result of such development in the department of health, adolescents will be provided the access to a comprehensive range of sexual and reproductive health education and services to prevent unwanted sexual advances, unplanned pregnancies, unsafe abortions and sexually transmitted infections in a manner that will be responsive to the vulnerabilities of adolescents to promote their own empowerment.

1.7 Delimitations of the Study

The research was carried out in the Stutterheim district hospital only and all of the clinics that it serves. It was focusing on the perceptions and factors affecting the utilization of contraceptives amongst adolescents aged 14 to 19 years.

1.8 Limitations of the study

The study included only adolescents aged 14 to 19 years old from all of the health facilities in the area. Thus, making generalization impossible. However, the findings of this study, on the other hand may be applied in a comparable situation elsewhere.

1.9 Operational definitions

Utilization-is the action of making practical and effective use of something (Oxford English Dictionary, 2022). In this study it is the use of long- or short-term contraceptive method by adolescents.

Contraceptive- is a drug, device, or practice used to prevent a woman from becoming pregnant (Oxford English Dictionary, 2022). Contraceptive and family planning will sometimes be used interchangeably in this study.

Adolescent- in this study adolescent is a young person who is developing into an adult and for this study it means a girl in the 14 to 19 years age group.

Pregnancy-is the term used to describe the period in which a fetus develops inside a woman's womb or uterus. Pregnancy usually lasts about 40 weeks, or just over 9 months, as measured from the last menstrual period to delivery. Health care providers refer to three segments of pregnancy, called trimesters (Shriver, 2017). In this study a pregnancy is a state of carrying a baby in the uterus of an adolescent aged 14 to 19 years.



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1.10 CHAPTER OUTLINE

This mini-dissertation has five chapters which are outlined as follows:

Chapter 1: Introduction and background

It provides an introduction and background information. This chapter further outlines the research problem, study objectives, research questions, study significance and the study framework that guides the study were highlighted and key concepts were defined.

Chapter 2: A Literature review

This chapter contains literatures that were reviewed and discussed on factors affecting the utilization of contraceptives amongst adolescents globally, in South Africa and then Eastern Cape Province.

Chapter 3: Research methodology

This chapter outlines the methodology of the study which consists of a research process, research approach, research design, population and sampling, the research site and research methods. The quantitative method was included and discussed.

Chapter 4: Results- Data presentation and analysis

The outcomes of the data collection were evaluated and interpreted in this chapter. The data gathered from the participants was organized into topics and subthemes.

Chapter 5: Discussions, limitation, strengths and recommendations

In this chapter there is a summary of limitations, strengths and the findings of the study were discussed, compared with the literatures reviewed and summarized to make conclusion and recommendations.

oooOooo

CHAPTER 2. LITERATURE REVIEW

In this section a review of literature concerning the utilization of contraceptives amongst adolescents was conducted.

2.1 Introduction

Paul & Criado (2020:1) stated that the reviewing of articles carefully identifies and synthesizes relevant literature to compare and contrast the findings of prior studies in a domain. The purpose of literature review in this study was to unravel, discuss, argue and compare the views from different authors regarding the topic under study. Thus, reviewing of articles provided readers with a state-of-the-art understanding of the research topic, help identified research gaps and signaled future research areas. The literature review focused on adolescent utilization of contraceptives, globally, nationally and provincially as well as the challenges and/or barriers related to contraceptive utilization.



2.2 Utilization of contraceptives by adolescents globally

Approximately twelve million girls aged 15–19 years and at least seven hundred and seventy-seven thousand girls less than 15 years give birth each year in developing regions (World Health Organization, 2018). At least ten million unintended pregnancies occur each year among adolescent girls aged 15–19 years in the developing world. Complications during pregnancy and childbirth are the leading cause of death for 15–19-year-old girls globally. Of the estimated 5.6 million abortions that occur each year among adolescent girls; 3.9 million are unsafe, contributing to maternal mortality, morbidity and lasting health problems (World Health Organization, 2018).

2.3 Adolescent contraceptive utilization in South Africa

According to Seutlwadi, Peter and Mchunu (2012:44) there is a concern that although 34.5% of males and 79.1% of females reported having had unwanted pregnancies, they were not motivated to use contraceptives. The results of their study reveal that females and males who reported ever being pregnant or making someone pregnant were three times and twice less likely respectively, to be using contraceptives.

Hlongwa, Thompson and Makhunga (2020:7) study also confirms that although females reported having had unintended pregnancies, they had no desire to utilize contraception. Being HIV positive, having been diagnosed with Sexually Transmitted Infection in the past 12 months, having concurrent sexual partners and early sexual debut were strongly associated with less likelihood of using contraceptives, particularly among women. Even though participants had high knowledge of various methods of contraception, knowledge was not a strong determinant of contraception use.

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2.4 Adolescent contraceptive utilization in the Eastern Cape

According to the Study that was done at Mhlakulo region in Eastern Cape by Bana, Bhat and Godlwana (2010: 156) it is stated that only one-sixth of these young women wanted to be pregnant; hence most of the pregnancies were unwanted. However, two-thirds of the females who became pregnant eventually wanted to keep their babies. Most of the pregnant females' families (85%) showed strong disapproval of the pregnancy; and almost 30% of these girls ended up quitting school, although they returned subsequently. Regarding the participants' understanding of contraceptives, 80% associated contraceptives with the prevention of pregnancy and only 4% believed they could prevent STIs, including HIV. The remaining were uncertain about the purpose of contraceptives.

Research conducted at Mhlakulo region in Eastern Cape by Bana, Bhat and Godlwana (2010: 156) described types of contraceptive methods taken by participants to mostly include barrier methods such as condoms (54%) and pills (58%). There was a small number of girls using injectable (6%), and 16% reported not using any contraception and some of the girls were using combinations (for example, pills and condoms).

Makola, Mlangeni and Mabaso (2019:5) discussed that education exposes women to the information about reproductive health and empowers them to make knowledgeable decisions about contraceptive methods available for them. In line with the current findings, other studies also found that young women from rural informal and formal settlements were less likely to use contraception compared to those from urban formal settlements. This has been associated with the lack of awareness of contraceptive methods available to them and challenges with access to health care services.

2.5 Factors influencing adolescent contraceptive utilization

Morris and Rushwan (2015: S41) state that a series of multifaceted barriers currently prevents good sexual and reproductive health for adolescents. In the political level, adolescent Sexual Reproductive Health (ASRH) is a low priority and the restrictive laws and policies are always in place. Various societal, cultural and religious communities make it difficult to discuss about adolescent sexual reproductive health (ASRH) as many societies have a deep feeling of disapproval of adolescent sexual activities, which are usually reaffirmed through the stigmatization of sexual health concerns, including STIs and HIV. Judgmental attitudes about sexual activity are abundant, particularly for sexually active girls and women who are not married (Morris & Rushwan, 2015: S41). In some regions, accepted practices of early marriage and childbearing. Age differences between partners and societal pressure preventing the use of contraceptive methods may also occur. Poor adolescent sexual reproductive health can be further confounded by conflict, migration, urbanization and lack of schooling (Morris & Rushwan, 2015: S41)

Morris and Rushwan (2015: S41) continue to state that, with regard to service-related barriers, poor health systems for sexual health, family planning and maternal health are common, with unmarried adolescents ignored in some cases, married adolescents in others and an overall deficiency of youth-friendly services. Lack of integration is seen where services that might address counseling and family planning fail to include HIV/STIs etcetera. Services may also be hampered by corruption and lack /erratic availability of supplies and equipment. Economic and physical accessibility restrict adolescents' access to services where they do exist.

2.6 Cultural and religious factors

The subject of adolescent sexuality remains forbidden while parents are supposed to be the logical source of information; they often do not discuss sexuality issues with their children because culturally, sexual education is a private domain of aunts and uncles (Moyo and Rusinga, 2017:50). According to Subedi, Jahan and Baatsen (2018: 253) evidence indicates that deeply rooted socio-cultural norms and beliefs cross-cut different interlinked factors and influence contraceptive use among adolescents. With the restrictive cultural norms around sexuality and fear of promoting premarital sex, family members and other adults, like teachers rarely discuss issues related to puberty, changes in the body, sex, and contraceptives with adolescents especially those who are unmarried. These issues are often considered as matter of privacy and taboo.

2.7 Stigmatization

Negative attitudes towards family planning were based on several factors that hinder families from having contraceptives, including the belief that the use of contraceptives encourages prostitution. Even women who used contraceptives felt that the practice was considered unfavorable by their communities (Muanda, Ndongo & Messina, 2017:1016). In a study done in another issue was that confidentiality would be difficult to maintain and girls making use of the contraceptive service would be stigmatized (Khoza, Zulu and ShungKing, 2019:6).

The other major reason why adolescents were not accessing health facilities for Sexual Reproductive Health Services was fear of how the health workers would treat them. Some adolescents reported that they were dissatisfied with the care they received because of the judgmental attitude and unprofessional behavior of some health workers (Nmadu, Mohamed and Usman, 2020:251).

2.8 Accessibility of services

Among the collective obstacles that inhibit adolescents from getting clinical and counseling services in health institutions were primarily too far health institution (Kimo and Makuria, 2017: 422). A study conducted in Northern Nigeria showed that most adolescents have poor access to contraceptive information and services, especially long acting hormonal methods and intrauterine devices. This is a result of restrictive laws and policies, fear of confidentiality, judgmental health workers and the belief that some contraceptive methods are inappropriate for nulliparous women (Alayande, Garko & Umeh, 2019:3).



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2.9 Health care service delivery environment

Adolescents' capacity to get and utilize contraception is still hampered in certain regions by restrictive laws and practices. Even while there are no legislative limits on offering family planning services to adolescents, the attitude and opinion of health workers and community leaders has been found to limit contraceptive usage before marriage in many other cases (Coll, Ewerling & Hellwing, 2019:2).

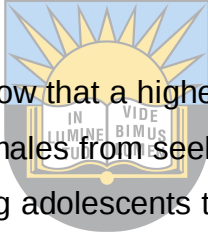
The judgmental attitude and reluctance of health service providers made it more difficult for adolescents to seek these services. Barriers to receiving and using these services was noted as the perceived embarrassment of seeking services from the opposite gender, as well as the difficulty of health care providers in addressing health issues with teenagers, particularly unmarried ones (Subedi, Jahan and Baatsen, 2018:254). Lack of

reproductive health club was also reason explained by teachers through qualitative response, so that the role and involvement of teachers in school-based health education was less (Ansha, Bosho and Jaleta, 2017:116).

2.10 Information availability

According to the study that was done by General Practitioners (GP) Duncan, Paterson & Anderson (2019:142) in New Zealand it was revealed that the lack of information is one of the barriers in contraceptive use among adolescents even in other countries by stating that the lack of knowledge was seen as challenging, but also as opening up an avenue for discussion.

2.11 Societal norms



Bukuluki et al. (2021:12) findings show that a higher percentage of respondents believe social norms prevent adolescent females from seeking contraception in the community. Negative attitudes regarding allowing adolescents to access and use adolescent sexual and reproductive health services, particularly contraception, worsen this. Those who believe in the efficacy of traditional contraception methods are more likely to accept societal norms that prevent girls from using contraception in their communities. Supporting social norms that deny adolescent females access to contraception is influenced by cultural context and location.

2.12 Level of Education

Kabagenyi, Habaasa and Rutaremwa (2017:6) stated that the females with secondary or higher education were more likely to use contraceptives than those without education. As expected the influence of education on reproductive health indicators is of great importance to monitor birth outcomes and health status of women. The influence of education on women could be explained in terms of empowerment as these women are likely to have knowledge about the existing family planning services. It is possible

that they could also be employed there have access to the required family planning commodities (Kabagenyi, Habaasa and Rutaremwa, 2017:6).

2.13 Sexual and Reproductive Health and Sustainable Development Goals

World Health Organization (2017: 4) had compiled sexual and reproductive goals for the purpose of reducing adolescent pregnancy rate and unintended pregnancies amongst women for better health and quality of life:

Goal 1: Enable all individuals to make informed decisions regarding their sexual and reproductive health, as well as to ensuring that their human rights are respected, protected, and implemented; this can be accomplished by enacting, protecting, and promoting Sexual and Reproductive Health related legislation; providing comprehensive sexuality education and information to all people at all stages of their lives; and preventing and responding to sexual violence by addressing gender inequality and cultural norms from a rights-based perspective.

Goal 2: Ensure that everyone has access to the best sexual and reproductive health and well-being possible. This necessitates the implementation of people-centered SRH care services capable of meeting the requirements of all and providing access to the most vulnerable, underprivileged, and hard-to-reach populations.

Goal 3: Ensure universal access to reproductive and sexual health care and minimize inequalities. Adolescents and population groups with unique needs should be included in the scope and reach of SRH services, and SRH should be integrated into public health strategies and programs. (World Health Organization 2017: 4)

2.13 Conceptual framework

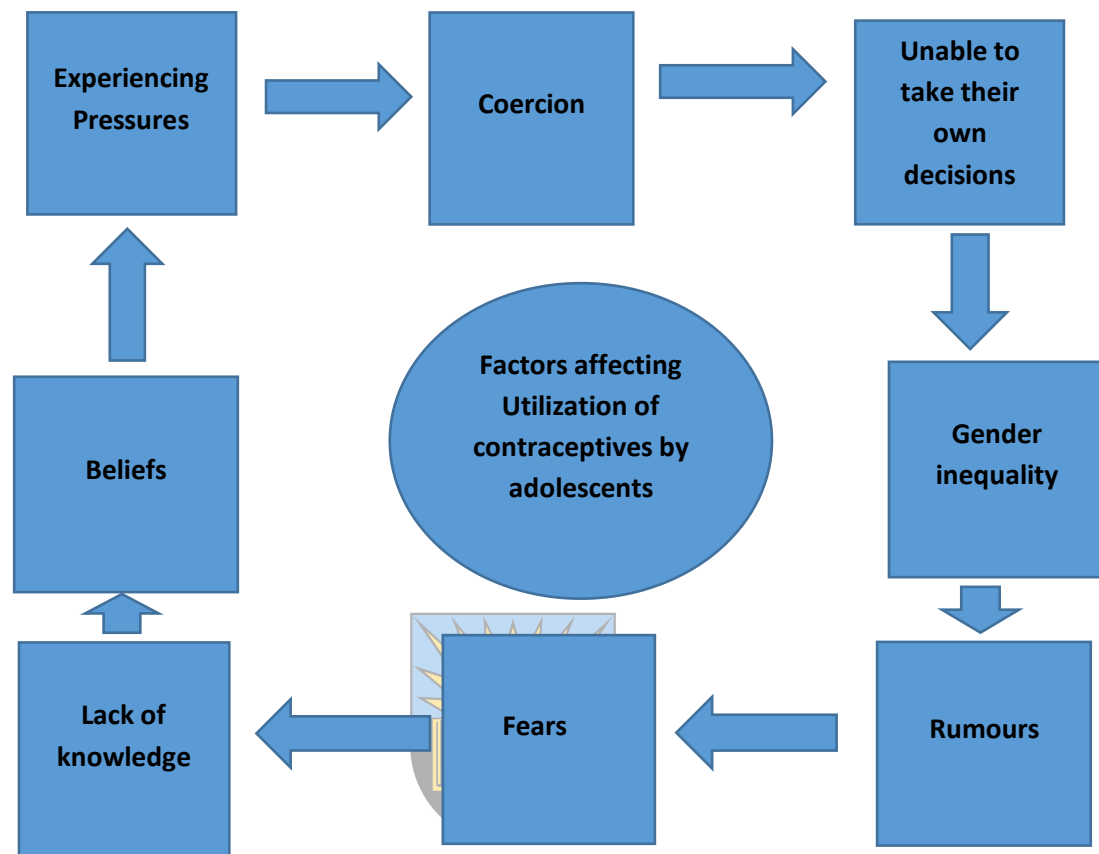


Figure 1. Conceptual framework: contraceptive chart (Wood & Jewkes, 2006: 111-113).

After reviewing the literatures conducted about the contraceptives, the researcher was able to gather the factors and developed a conceptual framework with the assistance of other researchers. In the following paragraph it is explained how these factors are connected:

Experiencing pressures and coercion from several sources affects decision making on contraceptive choice, use and pregnancy prevention as an independent individual. Gender inequality is also in line with the coercion factor for an example, some boyfriends can demand that contraception be stopped, enforcing this violently by threatening and tearing up a clinic card resulting in hearing and believing rumors that are roaming around the community instead of getting the information about contraception from the clinic. Some rumors/myths create fear of utilizing the

contraceptive methods which influences the lack of information and the development of beliefs (the religion and culture can be the source of these beliefs as well). The factors used on this conceptual framework were found in the study of Wood & Jewkes (2006: 111-113).

SUMMARY

Literature reviewed in this study revealed that females reported that in unintended pregnancies there were no desire to utilize contraception. In the political level, adolescent sexual reproductive health (ASRH) is a low priority and the restrictive laws and policies are always in place. The influence of education on women could be explained in terms of empowerment as these women are likely to have knowledge about the existing family planning services. Thus, World Health Organization (2017: 4) had compiled sexual and reproductive goals for the purpose of reducing adolescent pregnancy rate and unintended pregnancies amongst women for better health and quality of life. The next chapter will describe the research methodology and design.



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CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology applied in the execution of this study. The section describes the research approach, design and setting of the study, population and sampling, data collection and analysis, validity, reliability and ethical considerations

3.2 Study design

World Health Organization (2017: 4) had compiled sexual and reproductive goals for the purpose of reducing adolescent pregnancy rate and unintended pregnancies amongst women for better health and quality. A quantitative descriptive cross-sectional study design was adopted for this study. This was the most appropriate study design because, among other things, the study aimed to look at the prevalence of contraceptive use and such information is best collected across the population at the same point (short interval) in time. Since the intention was to describe the factors that influence the utilization of contraceptive as well as the perceptions about contraception, this study was a descriptive study. Descriptive cross-sectional observes the prevalence of a health outcome in a defined population at a specific period without drawing any causes for the prevalence.

3.3 Study setting

The study was conducted in the Stutterheim subdistrict. Stutterheim is a small town surrounded by farms and villages, together forming a health subdistrict. Stutterheim and other surrounding areas are catered by one hospital (Stutterheim hospital) and seven clinics.

3.4. Population

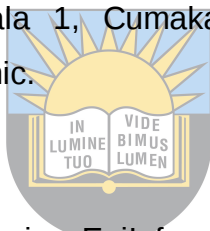
This study targeted those who were using the Stutterheim hospital and local clinics for antenatal and postnatal care (immunizations and 3-day visit), family planning services

or baby treatment in the month of January 2022. The population of interest was female adolescents (14-19 years) in the study area regardless whether sexually active or not.

3.5 Sampling

Participants were selected from female adolescents using healthcare facilities in Stutterheim and surrounding areas for antenatal, postnatal, family planning and child health care services. The participants were sampled as they presented themselves for health care services in the Stutterheim sub district healthcare facilities during the month of January 2022. The sampling was carried out in a way that all participating facilities were proportionally represented according to the expected monthly uptake of services by adolescents. The probability sampling was implemented where it involved a random selection of participants to the eight healthcare facilities in Stutterheim and surrounding areas participated in the study.

These health clinics are Cumakala 1, Cumakala 2, Kubusie, Amabele, Mgwali, Wartburg and Stutterheim Town Clinic.



3.5.1 Sample size estimation

The sample size was determined using EpiInfo version 7.10 sample size calculation software. Based on a 2018 estimated general population of 24 673 in Stutterheim, an acceptable error margin of 5%, two clusters and 95% confidence level, the estimated sample size was found to be 378. An additional 10% of the estimated sample size was included in order to cater for withdrawal from the study or spoiled questionnaires. This gave a final sample size estimation of 436. The output from the EpiInfo software, based on the above parameters, is shown in **Figure 2**. Showing sampling frame and sample size calculation

Population survey or descriptive study
For simple random sampling, leave design effect and clusters equal to 1.

Population size:	24673		Confidence Level	Cluster Size	Total Sample
Expected frequency:	50		80%	82	164
Acceptable Margin of error:	5		90%	134	268
Design effect:	1.0		95%	189	378
Clusters:	2		97%	231	462
			99%	323	646
			99.9%	519	1038
			99.99%	714	1428

Figure 2. Sample size estimation using EPINFO 7.2

3.5.2 Inclusion criteria

The only adolescents who were included in the study are only those who were 14 to 19 years of age, irrespective whether sexually active or not, parity and marital status. All those who fell out of this age group were excluded.

3.5.3 Exclusion criteria

Adolescents who did not understand Xhosa/ English and those who were not willing to participate.

3.6 Pilot testing

After the questionnaire was finalized, it was tested on a smaller but similar group of ten participants to check for relevance and clarity of questions. This pilot testing took the form with ten conveniently selected adolescents and a relevant healthcare worker from each facility.

3.7 Data collection

3.7.1 Data collection instruments

The main data collection instrument was a self-administered questionnaire. The questionnaire was divided into sections according to the different aspects namely:

section A which dealt with demographic characteristics, Section B which dealt with sources of information, Section C which dealt with the use of contraceptives, Section D which dealt with the perspectives regarding utilization of contraceptives and Section E which dealt with perceived factors influencing utilization of contraceptives. The questionnaire instrument consisted of closed-ended questions and it took twenty minutes to be completed by a participant and then in section E the participants were asked if the contraceptive education should be provided in schools as a strategy to fight adolescent pregnancy.

3.7.2 Recruitment of Participants

Participants who visit the facilities were recruited by word of mouth during their visits and requested to participate in the study after being given full information regarding the study. The researcher wrote and posted the notice on the notice board of where she would be collecting data from and asked the staff to share the news during consultation or history taking to make potential participants aware.

3.7.3 Data collection Process

Before the commencement of data collection, the researcher visited the health facilities to build rapport and request consent to conduct a study. Ethics committee and Department of Health granted the researcher a permission to conduct the study in the Amathole district health, at Stutterheim in particular; then the researcher began to collect data from adolescent girls' age 14 to 19 years using a questionnaire tool.

The data collection process started slowly because it was a holiday and even after the adolescents returned from their vacations, they came to the clinic one by one. The researcher went to the nearby schools and asked the principals for assistance in informing and preaching to the adolescent learners about the collection of data happening in the clinics; the adolescents willingly went to the clinics next door during lunch time or after school. There is a clinic next to every school at Stutterheim.

Jongile Nompondo Secondary and Sinethemba Public schools, Mgwali public school, Isihoboti Public Public Combined School. As a token of thanks, the principals including all the participants were given a snack.

3.7.4 Data collection Procedure

A separate room or location within the health care facility was used for the purposes of data collection and all COVID19 protocols were followed in order to minimize any chances of infection (wearing of mask, sanitizing hands before and after completing the questionnaire tool, 1, 5 meter distance from one another, etc.). In this designated room, the participants were given a briefing of the study objectives before being given the consent form. Those who consented to participation were given the questionnaire and asked to complete it in a designated room or location. The researcher was available during the completion of the questionnaire.

3.8 Data analysis

The variables of interest in this study were measured on a categorical scale. To analyze the data emanating from the questionnaire, frequency distribution tables and/or bar charts were used to summarize the data. Tests for associations among the categorical variables were carried out using the chi-squared test for independence and these tests were carried out at a 5% level of significance. Logistic regression analysis was used to determine the pattern of associations between contraceptive utilization and biographical characteristics, perceptions and knowledge. A statistician was consulted with respect to data capturing and ultimate statistical analysis once the data collection had been completed. These results are clearly distributed in Chapter 4.

3.9 Validity and reliability

Validity refers to how well an instrument measures. The degree to which the measuring tool accounts for random error is referred to as reliability, and it refers to the level of trust that can be placed in the data received via the use of an instrument (Mohajan, 2017:1).

To enhance validity and reliability of the data, the same information was collected for all participants. In developing the questionnaire, questionnaires on related studies were reviewed and colleagues and experts in the field were consulted.

3.10 Ethical considerations

Ethical clearance was obtained from the University of Fort Hare Human Research Ethics Committee. (Appendix 3)

Permission to conduct the research was obtained from research surveillance of Eastern Cape Department of Health Research Unit (Appendix 5) and from the district managers of the Amahlathi district as well as the Chief Executive Officer of Stutterheim hospital to access the patients (Appendix 4) .Permission was also sought from the leaders in the different healthcare facilities in the study area and the participants themselves (Appendix 4).

During the execution of the study, the following ethical issues were taken into consideration, respect for persons, principles of beneficence and justice, informed consent and COVID19 regulations adherence. These aspects are discussed individually below.

3.11 Respect for persons

Individuals are autonomous, which means they have the right to decide for themselves. This means that an individual had the freedom to choose whether or not to participate in a study without fear of punishment or discrimination. A participant had the right to withdraw from the study at any time, decline to provide information, and inquire about the study's aim Brink, Van der Walt & Van Rensburg (2018: 35). No coercion was applied to participants whatsoever. This was stressed during the briefing session with potential participants during the data collection phase and was upheld throughout the study.

3.12 Principle of beneficence

To adhere to this principle, the researcher needs to secure the well-being of the participant, who has a right to protection from discomfort and any form of harm. The questions in the questionnaire were structured in such a way that participants were not harmed and did not feel uncomfortable to participate. Besides, the data collection process was closely monitored by the research team leader.

3.13 Principle of justice

The participant's right to a fair selection and treatment was considered by the researcher. Participants were elected for reasons directly associated to the research problem, not because they were easily manipulated or readily available.

- **Privacy**

The researcher would not invade the privacy of the participants by observing through one-way mirrors and using hidden cameras.

- **Anonymity and confidentiality**

When a participant chooses to take part in research, she has the right to expect the information acquired from her would be kept anonymous and secret (Brinks, Van der Walt & Rensburg, 2018: 35). This study is for academic purposes only and no institution or personal identifying information was recorded.

3.14 Informed consent



The complete and clear information about the research was provided to the participants verbally and in writing, and were asked for consent (Brinks, Van der Walt & Van Rensburg, 2018: 35). In this study all the adolescent girls between the ages of 14 and 19 years did not need a parental consent in order to participate in this study because Department of Health made family planning accessible to all adolescent girls of different ages due to the stigma it carries in the households or families.

3.15 COVID-19 regulations

The COVID-19 regulations were considered because the corona virus pandemic is not yet over by keeping the room designated for the data collection well ventilated with windows slightly or widely opened depending on the weather; all participants were screened using a screening tool used in that particular health facility, and 1.5meter distance was maintained with their masks on and hands sanitized.

3.16 Research results dissemination

The dissertation will be kept in the school's library. The findings of the study will be presented and submitted to the Eastern Cape Department of Health, as well as the management of the selected health facilities in the research setting. Findings will be presented at national and international conferences and published in accredited peer reviewed national and international journals.

CONCLUSION

The study was conducted successfully at Amahlathi district at Stutterheim health facilities (Stutterheim hospital and local clinics and the neighboring schools). The targeted population were the adolescent girls aged 14 to 19 years regardless whether sexually active or not. The probability sampling was done to those who were in the inclusion criteria using a questionnaire instrument.



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CHAPTER 4. RESULTS

4.1 Introduction

The previous chapter described the research methodology which consisted of study setting, population and sampling, data collection and analysis, validity and reliability and ethical considerations. This chapter presents results based on the questionnaire instrument used during data collection. The instrument consisted of section A which dealt with demographic characteristics, Section B which dealt with sources of information, Section C which dealt with the use of contraceptives, Section D which dealt with the perspectives regarding utilization of contraceptives and Section E which dealt with perceived factors influencing utilization of contraceptives.



SECTION A: Demographic characteristics of the participants

Table 4.1: Distribution of participants by demographic characteristics n=436

Characteristic	Category	Frequency	Percentage
Clinic	Cumakala1	169	38.8
	Cumakala2	89	20.4
	Mgwali	68	15.6
	Town & Kubusi	29	6.6
	Wartburg & Amabele	81	18.6
Marital status	Single	426	97.7
	Married	1	0.2
	Other	9	2.1
Educational level	None	3	0.7
	Primary	22	5.1
	Secondary	406	93.1
	Tertiary	5	1.1
Day to day activity	Home	34	7.8

	School	391	89.7
	Work Full time	7	1.6
	Work Part time	4	0.9
Residential area	Rural	257	58.9
	Urban	179	41.1
Religion	None	64	14.7
	Christian	354	81.2
	Muslim	2	0.5
	Other	16	3.6
Living arrangement	Parents	377	86.5
	Husband	1	0.2
	Partner	4	0.9
	Sibling	22	5.1
	Relative	27	6.2
	Other	5	1.1

Based on these results, the participants came from Cumakala1 (38.8%), followed by Cumakala2 with 20.4% of the participants. Almost all of the participants were single (97.7%), in secondary school (93.1%), Christian (81.2%) and living with parents (86.5%).

SECTION B: Adolescents' sources of reproductive health information

Table 4.2: Distribution of participants by discussions about sex related issues n=436

Question	Response	Frequency	Percentage
Are there people you discussed sex related issues with?	Yes	284	65.1
	No	152	34.9
If yes, how are you related to these people?	None	10	3.5
	Friends	85	29.9
	Siblings	51	18.0
	Parents	98	34.5
	Relative	18	6.3
	School	22	7.8
Do you know how a pregnancy occurs?	Yes	289	66.3
	No	147	33.7



The results, in Table 4.2 show that many of the participants had discussed sex related issues with someone (65.1%) and the rest had never discussed with anyone (34.9%). Just over a third of them had discussed sex related issues with their parents (34.5%), followed by friends (29.9%) and siblings (18.0%). About two thirds of the participants knew how pregnancies occur (66.3%).

Table 4.3: Distribution of participants by source of sex and pregnancy information
n=436

Source of information	Yes (n (%))	No (n (%))
Home	151 (34.6)	285 (65.4)
School	259 (59.4)	177 (40.6)
Clinic	258 (59.2)	178 (40.8)
Main media	17 (3.9)	418 (96.1)
Social media	128 (29.4)	308 (70.6)
Other	9 (2.1)	427 (97.9)

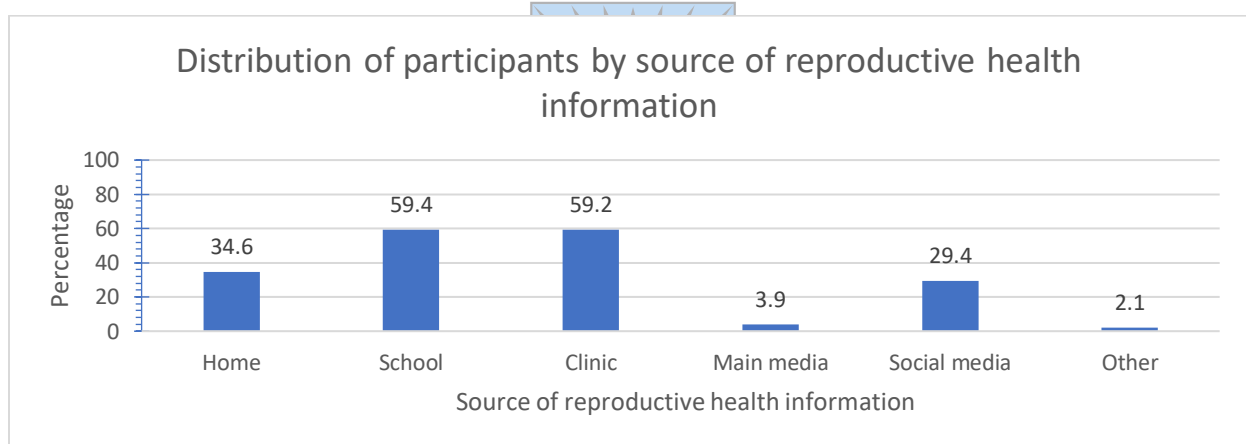


Figure 3: Reproductive health information

Table 4.3 shows that the adolescents' main sources of sex and pregnancy information are the clinic (59.2%) and the school (59.4%) followed by the home (34.6%). The least used source was the main media with 3.9% of adolescents getting information from that source.

Table 4.4: Distribution of participants by main source of information on contraceptives
n=436

Source of information	Frequency	Percentage
Home	77	17.7
School	84	19.3
Clinic	228	52.3
Main media	18	4.1
Social media	29	6.6
Total	436	100

The results, in Table 4.4 show that the main source of information about contraceptives is the clinic (52.3%) followed by the school (19.3%) then home (17.7%). From Table 2, 34.5% of adolescents discussed sex related issues with their parents and from Table 4.3, 34.6% get information about sex and pregnancy at home, and then in Table 4, only 17.7% get information about contraceptives from home.

SECTION C: The uptake of contraceptives use among adolescents?

In this section out of 436 participants only 225 responded to the questions. Other participants left this question blank because the questions were for the non-virgin and sexually active adolescents in Table 4.5.

Table 4.5: Distribution of participant responses to sex and pregnancy related issues n=225

Sex and pregnancy related issue	Response	Frequency	Percentage
Age at first sexual encounter (in completed years)	12	2	0.9
	13	11	4.9
	14	31	13.8
	15	60	26.7
	16	78	34.7
	17	35	15.5

	18	8	3.5
Was first sexual encounter planned	Planned	93	41.3
	Unplanned	132	58.7
Ever been pregnant?	Yes	34	15.1
	No	191	84.9
Was pregnancy planned?	Planned	2	5.9
	Unplanned	32	94.1
Contraceptive use at last sexual encounter	Yes	141	62.6
	No	84	37.4
Ever used contraceptives	Yes	175	77.8
	No	50	22.2

The 53.7% of the respondents had their first sexual experience at 16 years or older, 5.8% had their first experience at 12 or 13 years of age. Of those who had sexual intercourse, 58.7% had not planned to have sexual intercourse on that first occasion. While it is not clear whether it was this first sexual encounter that culminated in a pregnancy, 15.1% of those that had ever had sexual intercourse conceived and of those that fell pregnant, 94.1% had not planned to fall pregnant. With regard to contraceptive use, 77.8% had ever used contraceptives and 62.6% were on contraceptive the last time they had sexual intercourse; meaning that the adolescents had utilized the contraceptives.

Regarding the 225 participants in table 4.6, only 141 used contraceptives in their last sexual encounter whereas 84 participants were not on contraceptives for their own different reasons.

Table 4.6: Contraceptive use and reasons for not to use at last sexual encounter n=225

Contraceptive used	n	%	Reason for non-use	n	%
Condom	5	3.6	Condom	11	13.0
IUCD	1	0.7	Defaulted	9	10.7
Implanon	9	6.4	Disapproval	5	6.0
Abstaining	1	0.7	Inactive	9	10.7
Nur-isterate	54	38.2	No reason	14	16.7
Petogen	65	46.1	Not planned	7	8.3
Pill	5	3.6	Not ready	5	6.0
Different methods	1	0.7	Nur-isterate	1	1.2
			Pregnant	1	1.2
			Clinic staff attitude	2	2.4
			Rumors	20	23.8
Total	141	100	Total	84	100

The results in table 4.6 suggest that the 46.1% participants were on petogen, followed by nur-isterate (38.2%) then implanon (6.4%) and 0.7% decided to abstain and not to have a boyfriend and the 3.6% were on the contraceptive pills.

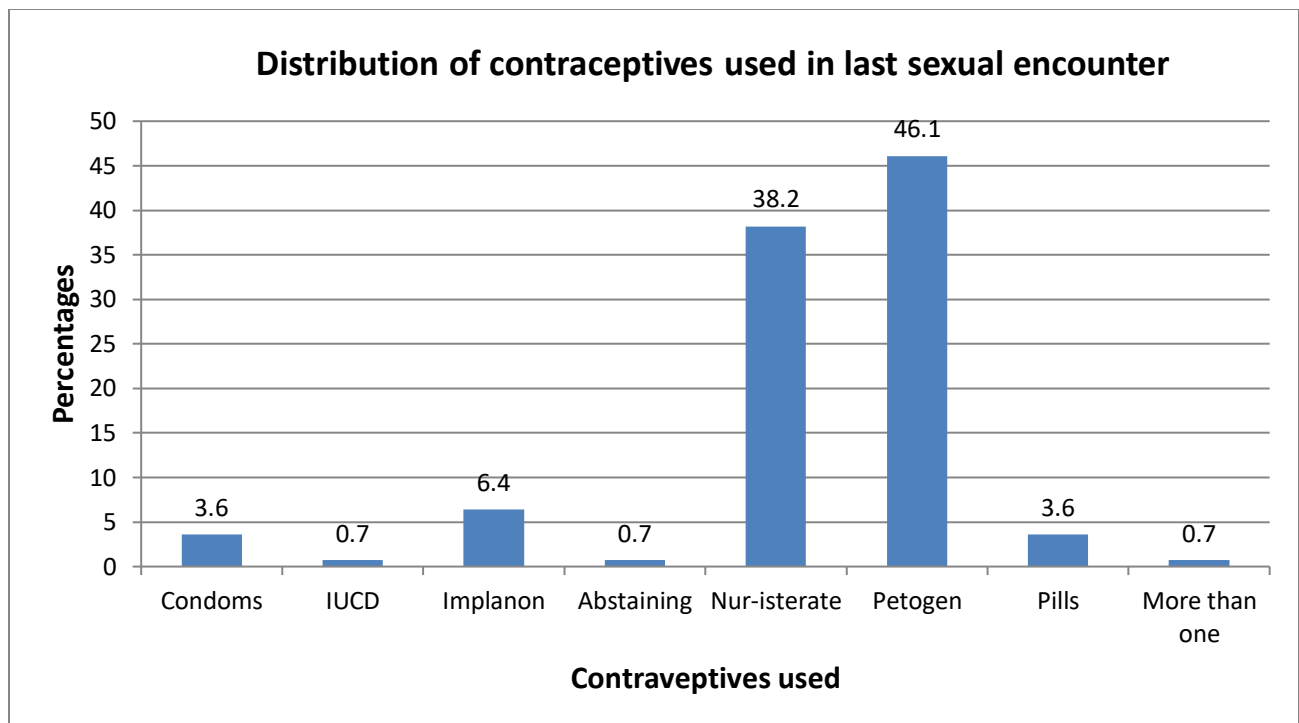
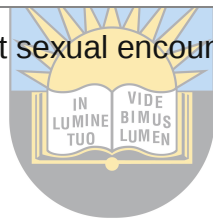


Figure 4: contraceptives used in last sexual encounter



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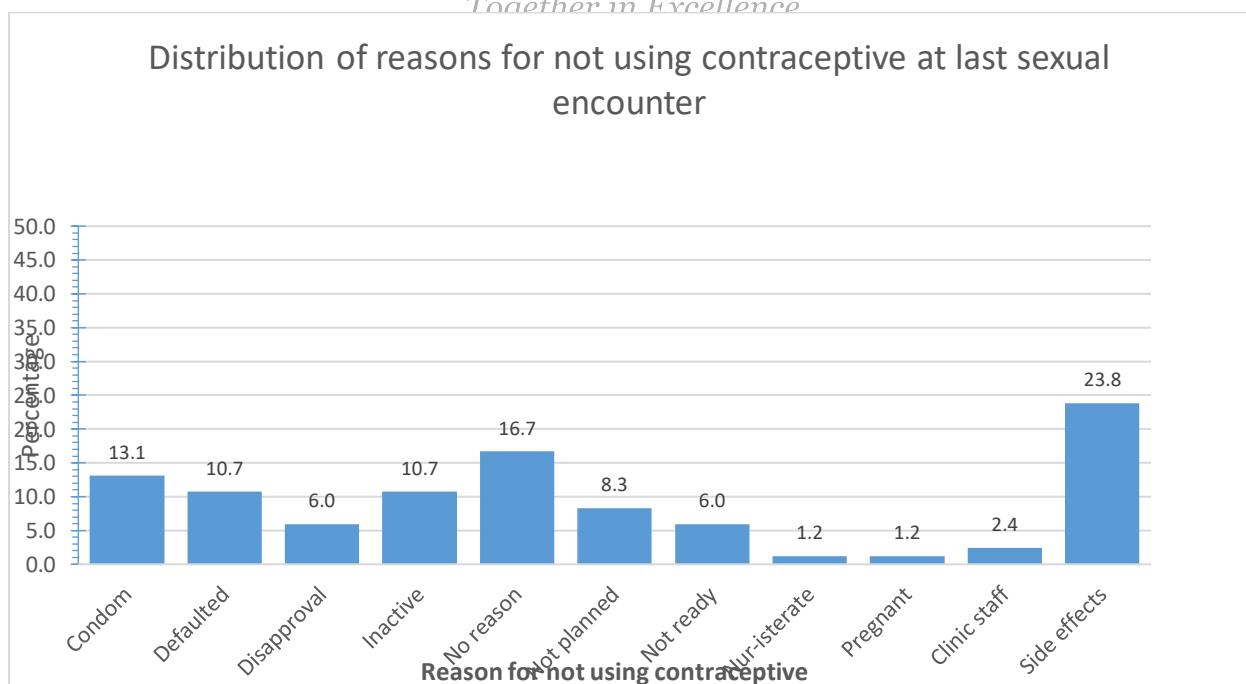


Figure 5: Reasons for not using contraceptive

Those who were not on contraceptives on their last sexual encounter gave reasons for the non-use. 23.8% of participants said their reason for non-use of contraceptives were the rumors or the side effects they heard from friends and other people, 16.7% had no reason, the 1.7% were pregnant during the data collection and 6.0% felt unready to initiate contraceptives. Interestingly, 13.1% of those that did not use a contraceptive actually used the condom. This seems to suggest that the respondents did not consider condoms to be a contraceptive.

Table 4.7: Distribution of participants by suggested contraceptive for the young women n=436

Contraceptive	Frequency	Percentage
Any	98	25.8
Condom	33	5.3
IUCD	18	1.3
Implanon	22	5.35
Morning After Pill	22	5.35
More than one	30	2.2
Nur-isterate	108	30.0
Petogen	72	18.9
Pill	33	5.8
Total	436	100%

The characteristics of participants shown on table 4.7 are for all the participants with the total number of 436. On being asked about the contraceptive that they feel is good for adolescents, 25.8% felt that any of the contraceptives available would be fine for the young women, 30.0% chose nur-isterate, 18.9% chose petogen, 5.35% chose implanon and the rest of the participants chose other contraceptive methods and their choices are shown in Table 4.7.

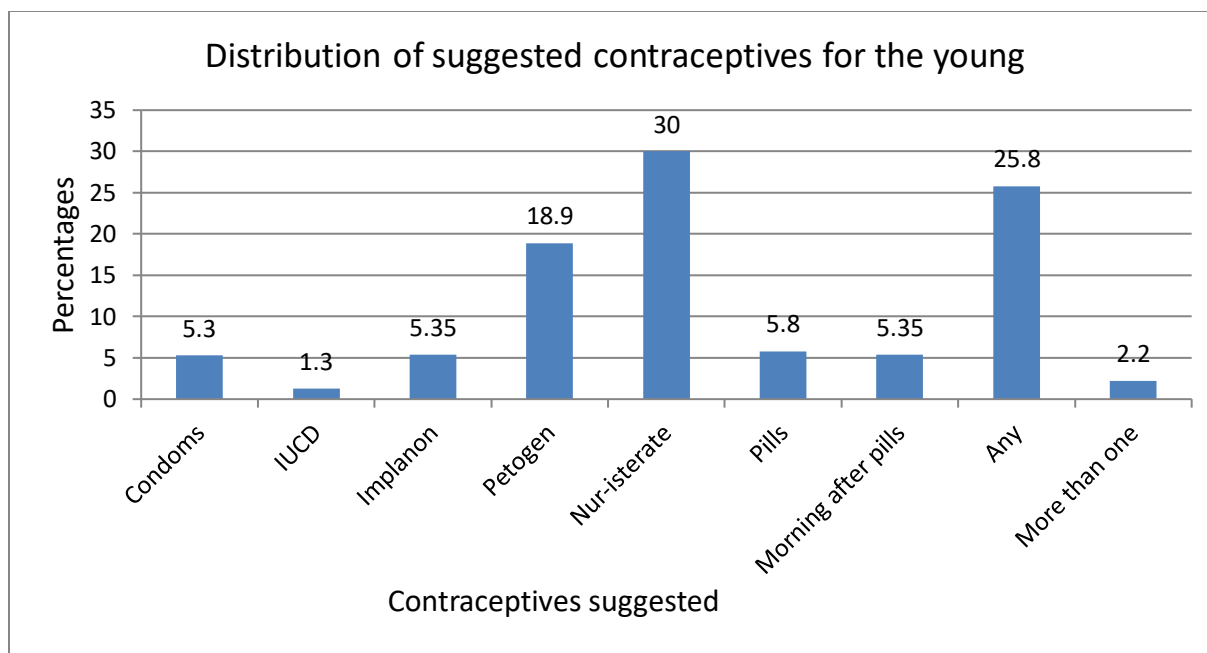


Figure 6: Contraceptives suggested for adolescents. This bar graph shows the results in table 4.7.



Table 4.8: Distribution of participants by preferred contraceptive n=436

Contraceptive	Frequency	Percentage
Any	74	22.2
IUCD	15	1.4
Implanon	21	6.3
Morning After Pill	44	2.4
More than one	50	0.9
Nur-isterate	94	29.3
Petogen	90	26.7
Pill	48	10.7
Total	436	100

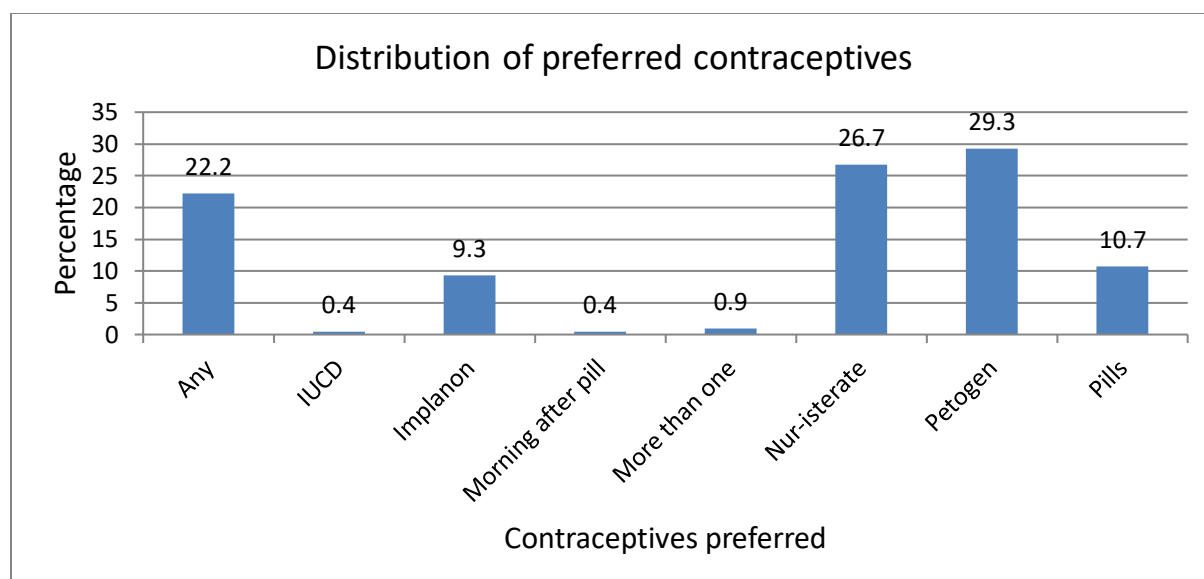
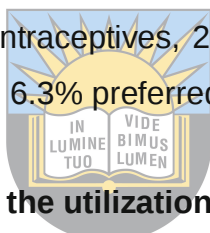


Figure 7: Preferred contraceptives by adolescents

With regard to their preferred contraceptive, 22.2% had no contraceptive preference. For those who preferred specific contraceptives, 26.7% preferred petogen, 29.3% nur-isterate, 10.7% preferred the pill and 6.3% preferred implanon.



SECTION D: Perceptive regarding the utilization of contraceptives?

Table 4.9: Distribution of participant responses to contraceptive perception questions
n=436

Statement	True	False	Don't Know
Daily use of the pill can prevent pregnancy	235 (53.9)	67 (15.4)	134 (30.7)
Women can use injection to prevent pregnancy	344 (78.9)	45 (10.2)	47 (10.8)
Women on injection will never have children	71 (16.3)	259 (59.4)	106 (24.3)
Condoms only prevent STIs	169 (38.8)	174 (39.9)	93 (21.3)
The morning after pill does not always work	94 (21.6)	18 (4.1)	324 (74.3)
Contraceptives do not have side effects	100 (22.9)	139 (31.9)	197 (45.2)
Contraceptives make unprotected sex safe	150 (34.4)	201 (46.1)	85 (19.5)
All contraceptives protect against STI	120 (27.5)	175 (40.1)	141 (32.3)
All contraceptives work the same way	171 (39.2)	139 (31.9)	126 (28.9)
Women do not conceive during their period	43 (9.9)	249 (57.1)	144 (33.0)

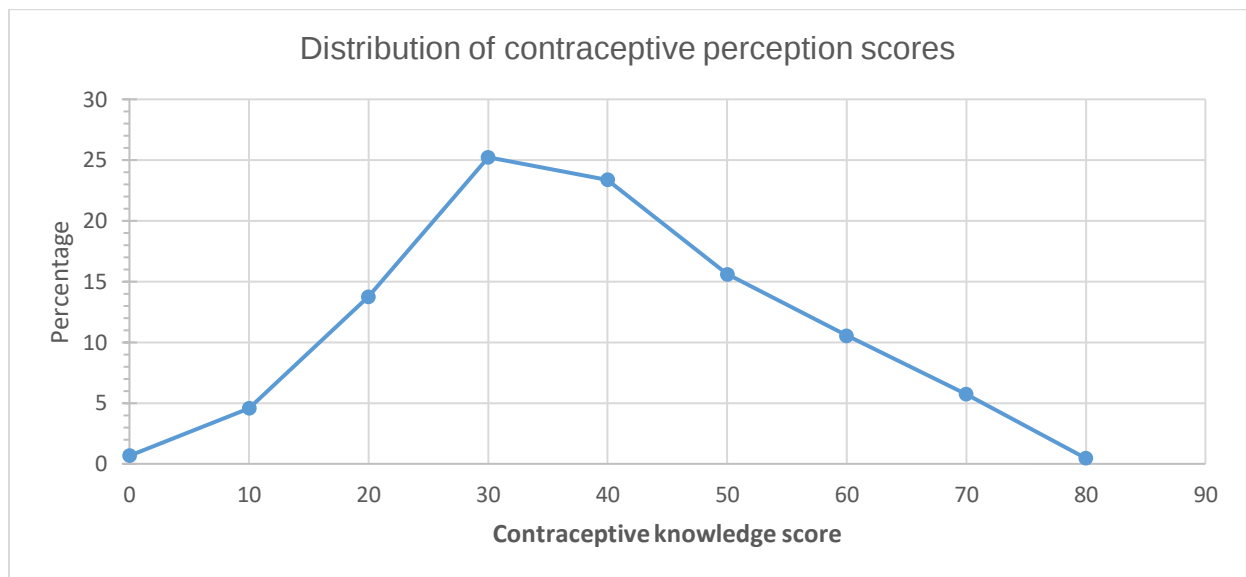
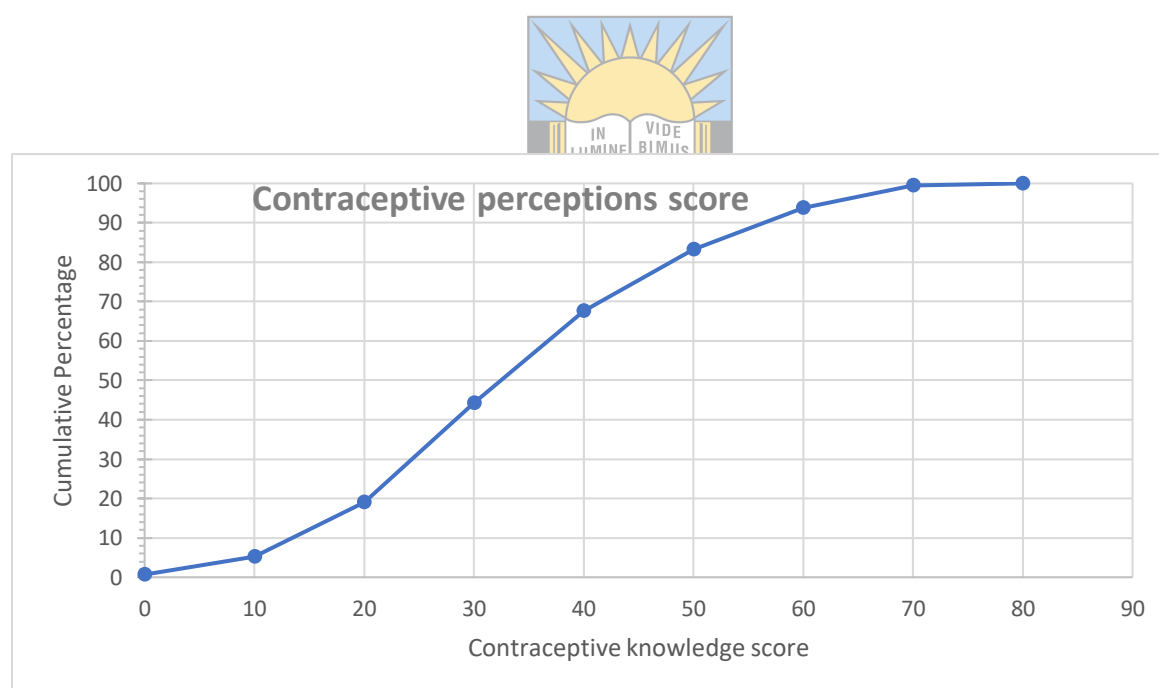


Figure 8: Contraceptive perception scores

Table 4.9 shows the distribution of responses to questions on perception about contraceptives. The numbers in **bold italics** show the response of many of the participants. The results show many of the participants know that daily use of the pill can prevent pregnancy (53.9%), that women can use an injection to prevent pregnancy (78.9%) and that it is not true women who use injection will never have children (59.4%). Although most of the participants know that condoms can do more than prevent STIs, it was only 39.9% of them who knew that.

Table 4.10: Distribution of contraceptive perceptions n=436

Score (%)	Frequency	Percentage
0	3	0.7
10	20	4.6
20	60	13.8
30	110	25.2
40	102	23.4
50	68	15.6
60	46	10.5
70	25	5.7
80	2	0.5

**Figure 9:** Contraceptive perceptions score

An overall perceptions score was derived from the responses shown in table 4.9. This score was derived as the proportion of correct responses to the 10 questions expressed as a percentage. The results show that 25.2% of participants got a score of 30%, and 23.4% of participants scored 40% on questions and then 15.6% participants got a score

of 50%. This means that few of the participants gave correct responses regarding the perceptions of contraceptives questions.

SECTION E: Perceived factors influencing utilization of contraceptives

Table 4.11: Labelling of perceptions items

Item	Label
1. People frown at young women using contraceptives	Stigma
2. I cannot discuss contraceptives with my friends	Peer discussions
3. Contraception is the responsibility of women	Responsibility
4. Members of my church are against contraceptives	Religion
5. Contraceptives are always available at my clinic	Availability
6. Clinic staff is friendly to young contraceptive seekers	Staff friendliness
7. Clinic staff provide education on contraceptives	Contraceptive education
8. Contraceptives are for educated women	Education effect
9. Contraceptive education should be done in schools	School curriculum
10. Side effects of contraceptives do not scare me	Side effects
11. People associate contraceptives with promiscuity	Promiscuity
12. Prolonged contraceptive use can cause infertility	Infertility
13. Information on contraceptives is difficult to find	Information access
14. Some cultures forbid women to use contraceptives	Culture

For ease of presentation and interpretation, the individual perception items were given labels. The labels were selected such that they closely represented the message contained in each item. Table 4.11 shows the items and their corresponding labels. These labels are the ones that are going to be used in the interpretation of perceptions about contraceptive use.

Table 4.12: Distribution of participants by beliefs and attitudes towards contraceptive use n=436

Statement	SD	D	NS	A	SA
1. Stigma	60 (13.8)	28 (6.4)	21 (4.8)	183 (42.0)	144 (33.0)
2. Peer discussions	76 (17.4)	153 (35.1)	48 (11.0)	112 (25.7)	47 (10.8)
3. Responsibility	39 (8.9)	51 (11.7)	57 (13.1)	184 (42.2)	105 (24.1)
4. Religion	81 (18.6)	194 (44.5)	87 (19.9)	46 (10.6)	28 (6.4)
5. Availability	47 (10.8)	25 (5.7)	35 (8.0)	176 (40.4)	153 (35.1)
6. Staff attitudes	92 (21.1)	89 (20.4)	40 (9.2)	123 (28.2)	92 (21.1)
7. Contraceptive education	51 (11.7)	56 (12.8)	47 (10.8)	198 (45.4)	84 (19.3)
8. Education effect	170 (39.0)	189 (43.4)	39 (8.9)	23 (5.3)	15 (3.4)
9. School curriculum	31 (7.1)	28 (6.4)	18 (4.1)	219 (50.2)	140 (32.1)
10. Side effects	78 (17.9)	150 (34.4)	84 (19.3)	99 (22.7)	25 (5.7)
11. Promiscuity	68 (15.6)	62 (14.2)	61 (14.0)	135 (31.0)	110 (25.2)
12. Infertility	39 (8.9)	78 (17.9)	149 (34.2)	123 (28.2)	47 (10.8)
13. Information access	57 (13.1)	156 (35.8)	71 (16.3)	117 (26.8)	35 (8.0)
14. Culture	45 (10.3)	55 (12.6)	103 (23.6)	165 (37.8)	68 (15.6)

Table 4.12 shows the distribution of participants' levels of agreement with different statements about their beliefs and attitudes towards contraceptive use. The numbers in the table represent the number of participants and, in brackets, the corresponding percentage.

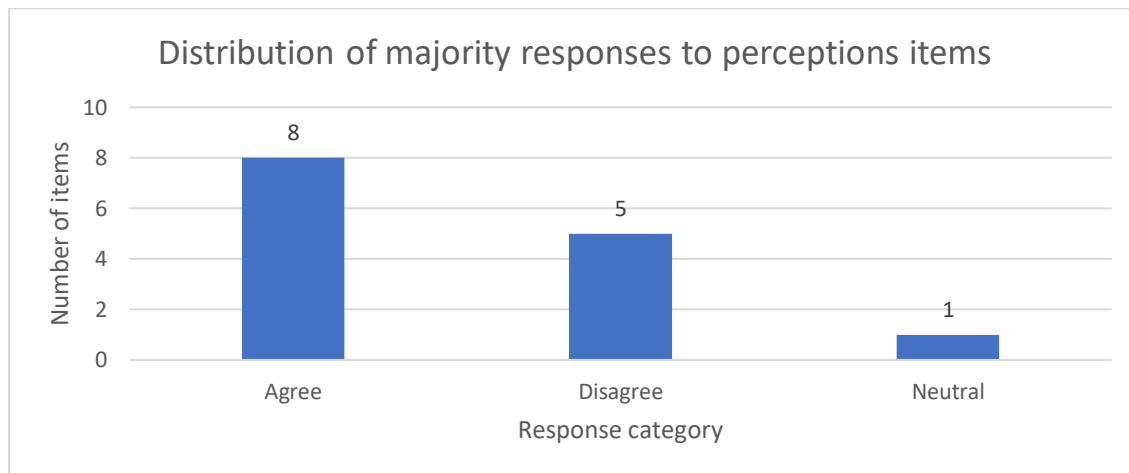


Figure 10: Perception of adolescents towards contraceptive use

The distribution of many responses on the 14 perceptions items is shown in the bar chart. The bar chart shows the response category with many of the responses and number of items in which that category has the highest percentage.

In the bar chart, there was one item in which a lot of participants were neutral (Not sure). For this item, the many (34.2%) were not sure. The graph also shows that the participants disagreed on 5 items. Based on the frequency distribution table, those items are peer discussions, religion, education effect, side effects and information access. That means, the most of the participants disagree that they cannot discuss contraceptives with friends; that church members discourage use of contraceptives; that contraceptives are for educated women; that they are not scared of contraceptive side effects; and that contraceptive information is difficult to access.

The graph also shows that the many participants agreed on 8 perceptions items. Looking at table 4.12, those are the items on stigma, responsibility, availability, staff friendliness, contraceptive education, school involvement, promiscuity and culture.

That means, participants agree that there is stigma associated with young contraceptive users, that contraception is the women's responsibility, that contraceptives are always available at local clinics, that clinic staff is friendly, that clinics provide contraceptive education that contraceptive education should be given at school, that contraceptive use is linked to promiscuity and that some cultures are against contraceptives.

CONCLUSION

The chapter presented results as displayed in tables and graphs (linear graphs and bar graphs). Section A, B about Adolescents' sources of reproductive health information C about, D about Contraceptive perceptions and E were outlined. The following chapter will discuss the results, make conclusions, limitations and recommendations.



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CHAPTER 5.

DISCUSSION, LIMITATIONS, STRENGTHS AND RECOMMENDATIONS

5.1 Demographic characteristics

- **Marital status**

In this study it was found that 97.7% of adolescents were single, 0.2% adolescents were married and only 2.1% were cohabiting with their boyfriends. Apparently, the married and cohabiting adolescents are utilizing contraceptives at their local clinics which indicate that they are responsible even though the practice of early marriage and cohabitation among adolescent girls might have a negative impact academically and health wise.

- **Educational level**

The results in table 4.1 show that there is a lot of adolescents at Stutterheim are all school goers. All the adolescents who were in tertiary were on contraceptives. Similarly, in the study conducted in Uganda by Kabagenyi, Habaasa and Rutaremwa (2017:6) the findings revealed that the females who had secondary or higher education had an increased likelihood of using contraception contrary to those with no education. The findings on this study showed that the 1.1% of adolescent girls were in tertiary; 93.1% were in secondary school; 5.1% in primary school and one of them (16-year-old) indicated that she is in grade 5, as a result, she had difficulty to write or read. Only 0.7% adolescents had stopped schooling.

- **Residential area**

There were 58.9% participants from the rural areas and 41.1% from the urban area which is expected because Stutterheim is surrounded by rural areas and farms. There are local clinics in each and every location and village therefore, there is access to the health facilities as against Kimo & Makuria (2017: 422) who indicated that obstacles

which inhibit adolescents from getting clinical and counseling services in health institutions were primarily due to distance travelled to get to the facilities.

5.2 PERCEPTIONS OF ADOLESCENTS

Many participants disagreed on 5 items and those items are peer discussions, religion, education effect, side effects and information access. That means, many of the participants disagree that they cannot discuss contraceptives with friends; that church members discourage use of contraceptives; that contraceptives are for educated women; that they are not scared of contraceptive side effects; and that contraceptive information is difficult to access.

The data also shows that many of participants agreed on 8 perceptions items; those are the items on stigma, responsibility, availability, staff friendliness, contraceptive education, school involvement, promiscuity and culture.

Data suggests contraceptives to be taught at school as a subject. Most of the participants agreed that contraceptive education should be done at schools particularly by the teachers (50.2%). It was whispered that parents might be against the idea because according to their understanding department of education will be introducing their children to promiscuity; little did they know adolescents discuss sex, pregnancy and contraceptives with friends, cousins and other people outside school and their homes as proven by the data of this study in table 4; eventually, they might get wrong information instead.

According to Subedi, Jahan and Baatsen (2018: 253) evidence indicates that deeply rooted socio-cultural norms and beliefs cross-cut different interlinked factors and influence contraceptive use among adolescents. With the restrictive cultural norms around sexuality and fear of promoting premarital sex, family members and other adults, like teachers rarely discuss issues related to puberty, changes in the body, sex, and contraceptives with adolescents especially those who are unmarried. These issues are often considered as matter of privacy and taboo.

5.3 FACTORS THAT INFLUENCE THE UTILIZATION OF CONTRACEPTIVES

- **Sex related issues**

According to the results in table 4.2 the data suggests that 65.1% adolescents discuss sex related issues with someone and 35.9% adolescent who do not discuss with anyone. Apparently, over a third of them had discussed sex related issues with their parents (34.5%), followed by friends (29.9%) and siblings (18.0%). About two thirds of the participants knew how pregnancies occur (66.3%). Therefore, the data opposes the theory discussed by Moyo & Rusinga (2017:50) that the subject of adolescent sexuality remains prohibited. While parents are supposed to be the source of information, they often do not discuss sexuality issues with their children because culturally, sexual education is a private domain of aunts and uncles.

- **Sources of information about sex and pregnancy**

The adolescents' main sources of sex and pregnancy information are the clinics (59.2%) and the school (59.4%) followed by the home (34.6%). The least used source was the main media with 3.9% of adolescents getting information from that source. According to this study, the sources of information at school are particularly friends, life orientation teachers, nurses and health educators who usually come and go to do health education at school in particular. The sexual and reproductive health information is supposed to begin at home but instead, the homes take a third place. Nevertheless, Subedi, Jahan and Baatsen. (2018: 253) put forward that with the preventive cultural norms around sexuality and fear of promoting premarital sex, family members and teachers hardly educate about matters like puberty, body changes, sex, and contraceptives with adolescents. The sex education is considered as a matter of privacy.

According to the results of this study it is evident that, even though the adolescents are more likely to discuss sex related issues with their parents than other people (friends and siblings) it is evident that there are sources of information about sex and pregnancy outside the home in which the adolescents mostly learn from; which indicates that the adolescents will always receive that information even if the parents are fearful to educate them or not.

- **Source of information about the contraceptives**

The results show that the main source of information about contraceptives is the clinic (52.3%) followed by the school (19.3%) then home (17.7%). From Table 4.2, 34.5% of adolescents discussed sex related issues with their parents and from Table 4.3, 34.6% get information about sex and pregnancy at home, and then in Table 4.4, only 17.7% get information about contraceptives from home. This data insinuates that as much as the parents discuss about sex related issues and pregnancy, they are less likely to educate their adolescent girls about contraceptives probably due to the myths and beliefs they have, lack of knowledge and the fear of introducing them into premarital sex. The data supports Hlongwa, Thompson & Makhunga (2020:7) study which confirmed that although females reported having had unintended pregnancies, they were not motivated to use contraceptives.



- **The uptake of contraceptives among adolescents**

The results in Table 4.5 show that 51.6% of the adolescents have had sexual intercourse and, in most cases, that first sexual encounter was not planned (58.7%). While many had their first sexual experience at 16 years or older (53.7%), 5.8% had their first experience at 12 or 13 years of age. Of those who have had sexual intercourse, 58.7% had not planned to have sexual intercourse on that first occasion. While it is not clear whether it was this first sexual encounter that culminated in a pregnancy, 15.1% of those that have ever had sexual intercourse conceived and of those that fell pregnant, 94.1% had not planned to fall pregnant. With regard to contraceptive use, 77.8% had ever used contraceptives and 62.6% were on contraceptive the last time they had sexual intercourse. The data suggests that it is advisable to use contraceptives before the adolescent girl get into an intimate relationship because the majority of the first encounters and pregnancies were not planned. Growing up with the knowledge and encouragement of using contraceptives/

dual protection from both school and parents can play a big role in reducing adolescent pregnancy.

- **The utilization of contraceptives**

The majority of the participants were on the petogen (46.1%) at their last sexual encounter, followed by nur-isterate (38.2%) then implanon (6.4%) and the rest of the other contraceptive methods. The results show that the contraceptive services are being utilized at Stutterheim which is a positive outcome for the health promotion that has been an ongoing intervention done by the health professionals.

- **Suggested contraceptives for young women**

On being asked about the contraceptive that they feel is good for adolescents, 25.8% felt that any of the contraceptives available would be fine for the young women, 30.0% chose nur-isterate, 18.9% chose petogen, 5.35% chose implanon and the rest of the participants chose other contraceptive methods and their choices. The response was good when it comes to this question because the majority of adolescents believe that any of the contraceptive methods are good for young women. There is a rumor going around Stutterheim that petogen is for people who have children and nur-isterate is for those who do not have children that is why most of the adolescents chose to use nur-isterate instead and also because they are afraid of the side effects long term methods can have.

- **Preferred contraceptives**

With regard to their preferred contraceptive, 22.2% had no contraceptive preference. For those who preferred specific contraceptives, 28.4% preferred petogen, 25.8% nur-isterate, 10.7% preferred the pill and 9.3% preferred implanon. The participants are more likely to prefer between petogen and nur-isterate because they are the most trusted and preached contraceptive methods in the community as compared to other

methods; similar to the findings of Alayande, Garko & Meh (2019:3) there was a belief that some contraceptive methods are inappropriate for nulliparous women.

- **Stigmatization**

Most of participants agree that there is a stigma associated with young contraceptive users similarly to the findings of the study conducted in Nigeria by Muanda, Ndongo & Messina (2017:1016) who concluded to say, negative attitudes towards family planning were based on several factors that hinders families from having contraceptives, including the belief that the use of contraceptives encourages prostitution. Even women who used contraceptives themselves felt that the practice was considered unfavorable by their communities. Another study done in South Africa by Khoza, Zulu and Shung King (2019:6) agrees to say another issue was that confidentiality would be difficult to maintain and girls making use of the contraceptive service would be stigmatized.



- **Availability of contraceptives**

Data indicates that the adolescents agreed that contraceptives are always available at local clinics (40.4%) followed by 35.1% strongly agree, meaning that Stutterheim clinics do stock up the contraceptives for these girls in fighting pregnancy amongst adolescents. The questionnaire did not specify if all the methods (short and long term) were available, it generalized.

- **Staff attitude**

The minority of adolescents agreed that clinic staff is friendly (28.2%) and that they do provide contraceptive education (45.4%) in contrary with the findings of Nmadu, Mohamed and Usman (2020:251) which stated that the major reason why adolescents were not accessing health facilities for Sexual Reproductive Health Services was fear of how the health workers would treat them. Some adolescents reported that they were dissatisfied with the care they received because of the judgmental attitude and unprofessional behavior of some health workers.

- **Cultures and norms**

About 37.8% of adolescents agreed that some cultures are against contraceptives followed by 15.6% strongly agreed. According to Subedi, Jahan and Baatsen. (2018: 253) evidence indicates that deeply rooted socio-cultural norms and beliefs cross-cut different interlinked factors and influence contraceptive use among adolescents.0

- **Linking contraceptives to promiscuity**

According to the data collected for this study, the participated adolescents agreed that contraception is the women's responsibility (42.2%) even though the majority of participants (31%) agreed that the use of contraceptives is associated with promiscuity in the communities of Stutterheim in general; similarly, to what Muanda, Ndongo & Messina (2017:1016) stated in their research results, that contraceptive use encourages prostitution even women who used contraceptives they felt that the practice was considered unfavorable by their communities.



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- **Rumors**

Many of participants (34.4%) indicated that they were scared of contraceptive rumors spreading around the community, which could be one of the possible factors affecting contraceptive utilization. The data also indicated that some mothers or parents were disapproving the contraceptives services use (6%) in table 4.6 specifically because they believed that the body of adolescent girls will be damaged and/or they might be infertile in the future. The data in table 4.6 also suggests that side effects or rumors are the common factor of the non-use of contraceptives amongst adolescents at Stutterheim (23.8%). Thus, Kabagenyi, Habaasa and Rutaremwa. (2017:6) said as expected, the influence of education on reproductive health indicators is of great importance to monitor birth outcomes and health status of women.

- **Contraceptive knowledge**

The data suggests that many of the participants know that daily use of the pill can prevent pregnancy (53.9%), that women can use an injection to prevent pregnancy (78.9%) and that it is not true that women who use injection will never have children (59.4%). Although most of the participants know that condoms can do more than prevent STIs, it was only 39.9% of them who knew that.

5.3. LIMITATIONS OF THE STUDY

The study was intended for the utilization of contraceptives amongst adolescents aged 14 to 19 years of age in Stutterheim at Eastern Cape Province. Therefore, the findings of this study cannot be implied to the women older than 20 years of age or the entire population. In December 2021 and at the beginning of January 2022 the data collection process was moving very slowly since the majority of adolescents were on holidays and they barely went to the clinics for health services. Some of the pregnant adolescents refused to participate because they felt embarrassed and uncomfortable. The study was quantitative therefore, it did not get deeper to the bottom of other factors and/or it was not specific as it would have been if it was a qualitative study.

5.4 STRENGTHS OF THE STUDY

Findings from this study revealed the sources at school are particularly friends, cousins, and other people; the home takes the third place when it comes to sexual and reproductive health although, it is supposed to start at home. This study managed to expose the factors affecting the utilization of contraceptives amongst adolescents at Stutterheim which are the stigma, fear of rumors, lack of contraceptive education at home, culture and norms and how much they wish the contraceptives can be officially taught at school.

5.4 RECOMMENDATIONS

Department of health should work together with department of education to put into effect the utilization of contraceptives amongst adolescents by adding sexual and reproductive health education, with contraceptives included (types of contraceptive methods, advantages and side effects) as a subject in the school curriculum.

Department of health must also make use of main media and social media since they are influential and can be the great sources of information.

Due to the lack of information and negative perceptions the community upholds as the contraceptives are concerned it is recommended the health professionals to include contraceptive utilization amongst adolescents during their health promotion events. The researcher also recommends contraceptives to be displayed on the television flat screens in waiting areas of the health facilities whereby the patients or clients of all ages would learn meanwhile waiting for consultation.

5.5. CONCLUSION

The home takes the third place when it comes to sexual and reproductive health, although; it is supposed to start at home. Even though the adolescents are more likely to discuss sex related issues with their parents than other people (friends and siblings) it is evident that there are sources of information about sex and pregnancy outside the home in which the adolescents mostly learn from; which indicates that the adolescents will always receive that information even if the parents are fearful to educate them or not.

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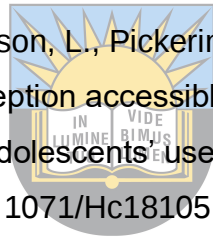
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APPENDIX 1

QUESTIONNAIRE TOOL FOR ADOLESCENTS (14-19YEARS)

The objectives of the study are to:

1. Explore the perceptions of adolescents on utilization of contraceptive services at Stutterheim in the Eastern Cape Province
2. Determine the factors that influence contraceptive utilization among adolescents at Stutterheim in the Eastern Cape Province.

Section A: Biographical characteristics

1. What is your date of birth?		Day/Month/Year

2. How old were you on your last birthday?		years
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3. What is your marital status?	Single	
	Married	
	Other (specify)	

4. What is your highest level of education?	No education	
	Primary	
	Secondary	
	Tertiary	

5. How would you best describe your main daily activities?	Stay at home	
	Go to school	

	Work full time	
	Work part time	
	Self employed	

6. Where do you stay?	Village	
	Location	
	Town	

7. What is your religion? 	None	
	Christian	
	Muslim	
	Other (specify)	

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8. Who do you stay with?	Parent	
	Husband	
	Partner	
	Sibling	
	Relative	
	Other (specify)	

Section B: Sources of information

1. Are there people that you have discussed sex related issues with?	Yes	
	No	

2. What is your relationship with that person/people?	
---	--

3. Do you know how a pregnancy occurs?	Yes	
	No	

4. What were/are your main sources of information about sex and pregnancy? (You can choose more than one source)	Home	
	School	
	Clinic	
	Main media	
	Social media	
	Other (specify)	



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5. What was/is your main source of information about contraceptives?	Home	
	School	
	Clinic	
	Main media	
	Social media	
	Other (specify)	
	No information	

6. Have you ever had sex?	Yes	
	No	

7. How old were you when you had sex for the first time?		years
--	--	-------

8. How did that first time to have sex happen?	Planned	
	Not planned	

9. Have you ever fallen pregnant?	Yes	
	No	

10. How did the first pregnancy happen?	Planned	
	Unplanned	



Section C: Contraceptive use

1. The last time you had sexual intercourse, were you on any contraceptive	Yes	
	No	

2. The last time you had sexual intercourse, were you on any contraceptive	Yes	
	No	
<i>If yes, which contraceptive method were you on?</i>		
<i>If no, why were you not on contraceptive?</i>		

3. Have you ever used contraceptive methods?	Yes	
	No	
<i>If yes, which contraceptive methods have you ever</i>		

used? List all	
If no, why have you never used contraceptives?	

4. Which contraceptive do you think is good for young people?	
---	--

5. Which contraceptive is good for young people?	
--	--

6. Which is your preferred contraceptive? Tick	• Petogen • Nur-isterate • Pills • Implanon • IUCD • Morning after pill • Abstainance
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Section D: Perspectives regarding utilization of Contraceptives

Mark the following statements as **TRUE** or **FALSE**. If you are not sure then put your mark on **Don't Know**.

Statement	TRUE	FALS E	Don't Know
1. Women can prevent pregnancy by taking a pill everyday			
2. Women can prevent pregnancy by taking an injection			
3. Women who take the injection will never have children			
4. Condom can only prevent sexually transmitted diseases			

5. The morning after pill does not always work for everyone			
6. Contraceptives do not have side effects on women's health			
7. Unprotected sex is safe if the woman is on contraceptive			
8. Contraceptives protect against sexually transmitted diseases			
9. All contraceptives are good for all women			
10. Sex during a woman's period never results in pregnancy			

Section E: Perceived factors influencing utilization of contraceptives



Indicate your level of agreement with the following statements. In the table below, **SA**-Strongly Agree, **A**-Agree, **N**- Neutral, **D**-Disagree and **SD**-Strongly Agree.

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Statement	S D	D	N	A	S A
1. People frown at young women using contraceptives					
2. I cannot discuss contraceptives with my friends					
3. Contraception is the responsibility of women					
4. Members of my church are against contraceptives					
5. Contraceptives are always available at my nearest clinic					
6. Clinic staff is friendly to young women seeking contraceptives					
7. Clinic staff always provide education on contraceptives					
8. Contraceptives are for educated women					
9. Contraceptive education should be provided in schools					

10. Side effects of contraceptives do not scare me					
11. People associate contraceptives with promiscuity					
12. Prolonged contraceptive use can cause infertility					
13. Information on contraceptives is difficult to find					
14. Some cultures do not allow women to take contraceptives					

APPENDIX 2

INFORMATION SHEET AND CONSENT FORM FOR ADOLESCENTS

This study has been approved by the University of Fort Hare Faculty of Health Sciences Research Ethics Committee (UFH HREC) (Ref No: 100118-054) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.



What is this research study all about?

The study is all about exploring the perceptions and factors affecting the utilization of contraceptives amongst adolescents aged 14-19 years of age at Stutterheim in Eastern Cape

What were The Objectives for This Study?

- The objectives of this research were:
 - To explore the perceptions on utilization of contraceptives amongst adolescents at Stutterheim in the Eastern Cape Province
 - To determine the factors affecting the utilization of contraceptives amongst adolescents at Stutterheim in Eastern Cape Province.

Why have you been invited to participate?

Because the participant is a suitable candidate to take part in the research according to the inclusion criteria

What will your responsibilities be?

- The responsibility of the participant is to be honest and transparent as possible in the questionnaire, and all the information provided by the participant will be confidential.

Will you benefit from taking part in this research?

- There are no direct benefits for participant but the results will help Department of Health in Eastern Cape to use the finding in an effort to reduce adolescent pregnancy rate. This study will also help in assessing and possible renewing the current policies concerning the use of contraceptives.

Are there risks involved in your taking part in this research?

- The researcher will obtain informed consent from participants,
- to protect the anonymity and confidentiality of participants,
- to avoiding deceptive practices when designing your research and
- providing the participant with the right to withdraw from the research at any time.

Who will have access to the data?

- Confidentiality and privacy of patients' information will be ensured by collecting a data in a lockable and safe boardroom or environment, where only the researcher and participant will be there.
- Data will be collected using a checklist and will be locked away in a cabinet at the researcher's place until the research study is finalized.

What will happen with the data/samples?

- This is a once off collection of data, it will be analyzed and communicated to Head: EC Health and UFH through reports and articles will be published in peer-reviewed journals.

Will I be paid to take part in this study and are there any costs involved?

Participants will not get paid for taking part in this study and there are no costs involved but the researcher will give away the freebies (snack) as a sign of appreciation.

Who can you contact for additional information regarding the study?

The primary investigator Visisa Ntengo can be contacted during working hours at (0437331289), or on her cellular phone at (0634953590). Should you have any questions regarding the ethical aspects of the study, you can contact the Acting Chairperson of the UFH HREC, Prof Leon van Niekerk, during office hours at leonvn@ufh.ac.za or tel. no: +27 (0) 40 602 2435.

How will you know about the findings?

- The findings of the research will be shared with the Head: EC Health through a report and workshops

Declaration by participant

By signing below, I agree to take part in a research study titled: (The utilization of contraceptives at Stutterheim in Eastern Cape Province)

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.

Signed at (place) on (date) 20....

APPENDIX 3

ETHICAL CLEARANCE

ETHICAL CLEARANCE CERTIFICATE REC-100118-054

Certificate Reference Number: Ref #2021=11=09=NtengoV

Project title: The utilization of contraceptives amongst adolescents at Stutterheim in the Eastern Cape Province

Nature of Project: Masters of Public Health

Principal Researcher: V Ntengo

Student Number: 200900572

Supervisor: Dr N Nkutu

HEALTH RESEARCH ETHICS COMMITTEE

P.O. Box 1054
East London 5200
Tel: +27 (0) 43 704 7368
Email: dgon@ufh.ac.za



University of Fort Hare
Together in Excellence

On behalf of the University of Fort Hare Health Research Ethics Committee (HREC), I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instruments(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the HREC must be informed immediately of

- **Any material change in the conditions or undertakings mentioned in the document**
- **Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research**

The Principal Researcher must report to the HREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

The HREC retains the right to

- 
- **Withdraw or amend this Ethical Clearance Certificate if**
 - o **Any unethical principles or practices are revealed or suspected**
 - o **relevant information has been withheld or misrepresented**
 - o **regulatory changes of whatsoever nature so require**
 - o **the conditions contained in the Certificate have not been adhered to**
 - **Request access to any information or data at any time during the course or after completion of the project.**

APPENDIX 4

1. LETTER FOR DISTRICT MANAGER



Fort Hare University
Public Health Department 50 Church Street
East London



5200

03 December 2021

The District Manager Amathole
University of Fort Hare
Together in Excellence

District Medical Centre

5200

Dear Sir/Madam

RE: Request for permission to conduct a research project at Stutterheim Hospital: Ms. Ntengo V.

I, Visisa Ntengo, a student studying for a master's degree in Public Health at University of Fort Hare, hereby request permission to conduct a quantitative research project at Stutterheim District Hospital as part of the requirements for the

completion of the degree. The title of the research study is: 'the utilization of contraceptive services amongst adolescents at Stutterheim in Eastern Cape Province'.

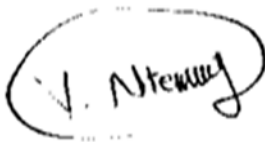
The purpose is to determine the extent of utilization of contraceptives and factors affecting that utilization amongst adolescents at Stutterheim, in the Eastern Cape Province.

Participants will be selected from female adolescents aged 14 to 19 years using healthcare facilities in Stutterheim for antenatal, postnatal, family planning and child health care services. These health clinics are Cumakala 1, Cumakala 2, Kubusie, Amabele, Mgwali, Wartburg, Stutterheim Town Clinic and Stutterheim hospital will only be used for piloting. This study will be conducted under the supervision of Dr. Nkutu. The results of this study will provide health service providers with valuable information on perceptions of adolescents and their knowledge of contraceptives. Ethics clearance from the UFH REC and approval letter from NHRD are both attached.

I hope my request will receive your favorable consideration

Yours faithfully

University of Fort Hare
Together in Excellence



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Province of the
EASTERN CAPE
HEALTH

Enquiries: Yvonne Gixela

Tel no: 079 074 0859

Email: Yvonne.Gixela@ehealth.gov.za / [ygixela@gmail.com](mailto:yvonne.gixela@gmail.com)

Date: 01 December 2021

The utilization of contraceptives amongst adolescents at Stutterheim in the Eastern Cape Province. (EC_202111_024)

Dear Mrs V. Ntengo

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

