

**Adolescent sex and contraceptive experiences:  
perspectives of teenagers and clinic nurses in the Northern Province**

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## **Acknowledgements**

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## **Executive summary**

Prevention of unwanted adolescent pregnancy through effective contraceptive use is a national health priority. The aim of this research was to contribute towards such improvements in services in the Northern Province through developing in-depth understandings, from the perspectives of teenage women and clinic nurses, of: barriers to effective contraceptive use and how to overcome these; teenagers' contraceptive-seeking practices; teenagers' perceptions of methods and side-effects; and perceptions of adolescent sexual activity and pregnancy. Qualitative methods were used and the research was conducted around Pietersburg (mainly in semi-rural areas). Thirty-five in-depth, semi-structured interviews and 5 group discussions were held with adolescent women, recruited from clinic waiting-rooms and schools, and nursing staff in 14 clinics were also interviewed.

The researchers found that the teenagers had been provided with virtually no useful information about menstruation or sexual matters by older relatives or teachers. Some discussed contraception with their friends, but others did not, perceiving sexual matters to be 'secret'. First contraceptive use was commonly initiated by mothers, once daughters started to menstruate. Some adolescents decided to start contraception themselves because they perceived that sexual initiation was imminent and often because their peers used contraception. Others only began after they had their first baby, which was often conceived in response to pressure from their families, as well as boyfriends. Teenage pregnancy was largely socially sanctioned and regarded as infinitely preferable to the threat of contraceptive-induced infertility.

Nuristerate was the preferred method for most teenagers and all the nurses as Depo was perceived sometimes to cause permanent infertility. Oral contraceptives were regarded as inconvenient and 'easily forgettable'. Most teenagers, in response to information from nurses, said that forgetting to take one pill would probably result in pregnancy. Nurses were generally unfamiliar with emergency contraception. Condoms were rarely perceived to be a contraceptive and were often not offered to girls in clinics. Teenagers expressed fears of using them in case they were 'left inside', and would have to be removed either with the tongue, by a doctor, or in hospital where they had the right 'equipment'. Several said they had just never thought of using them.

Menstrual irregularities were the most severe and common side-effects of the injection. Amenorrhoea was often interpreted as blood having 'accumulated' or 'clotted', usually in the womb or abdomen. This state of 'blockage' was described as a dangerous condition, identified by 'dark clots' or by 'waist pains', and construed as an indication or cause of illness. Prolonged absence of menstruation was also seen to be problematic as teenagers did not know whether they were pregnant, feared that blocked blood might eventually 'come out too fast' with adverse effects, and were anxious that 'dirt' would accumulate in the womb and cause STDs. Several other side-effects of contraceptives were mentioned, including some experienced by the male partners of contraceptive users.

Nurses' management of side-effects was a source of dissatisfaction. Change of method was usually reserved for cases where they identified a pathological condition, and so teenagers often did not feel that they were taken seriously when they reported side-effects. This often led to them stopping contraceptive use, either for a short break or altogether. Although teenagers reported sharing a waiting area with elders to be problematic, by far the most important concerns when seeking contraception from public clinics were the attitudes of nursing staff towards them. Many teenagers reported verbal 'harassment' by nurses, who were commonly described as rude, short-tempered and arrogant. Teenagers said that nurses would not provide the method until they had asked 'funny questions' about whether they had boyfriends, why they had sex so young and whether they had told their mothers, and had lectured them that they were far too young to be sexually active and must 'stop going around with men'. Teenagers who refused to answer these questions were reportedly scolded. 'Scolding' provoked emotions of shame, unhappiness and fear in the teenagers and many reportedly stopped using contraception and had unwanted pregnancies as a result of it. Some teenagers also reported instances in which they had been refused contraception if they had previously attended a GP or did not have parental permission, as well as situations where nurses had given a method but refused to explain about it because the teenager had not gone to her nearest clinic. Some teenage informants clearly perceived that nurses at times transgressed their professional role to an unacceptable degree, and were out of touch with adolescents in their advice about sexual abstinence.

Nurses perceived that the effects of their comments were usually to make a teenager shy and 'look down' silently, and acknowledged that at times they would prevent further contraceptive seeking. Nonetheless, they perceived that giving moral guidance to teenagers and discouraging sexual activity formed part of their roles. Most nurses said that giving contraception to young teenagers did not make them 'feel very good', although they were somewhat consoled by the thought that they were helping to prevent adolescent pregnancy and early educational drop-out. Nurses described several other sources of stress in working with teenagers. Some mentioned overwork and tiredness, but mostly they related to small acts of insubordination, including not taking heed of health lessons, 'forging' clinic cards to mask contraceptive breaks, lying in an attempt to procure abortion and being rude in out-of-clinic settings.

Several recommendations are made for improving the services. These concern improving supervision, introducing continuing education of staff, values clarification workshops, curricular changes and providing information leaflets and pregnancy testing in clinics.

## Contents

<b>1.0</b>	<b>Background, aim and objectives</b>	<b>6</b>
<b>2.0</b>	<b>Research methods and context</b>	<b>6</b>
<b>3.0</b>	<b>Findings</b>	<b>7</b>
<b>3.1</b>	<b>Teenage informants: profile</b>	<b>7</b>
<b>3.2</b>	<b>Sexual knowledge and circumstances of first contraceptive use</b>	<b>7</b>
<b>3.2.1</b>	<b>Sources of reproductive knowledge</b>	<b>7</b>
<b>3.2.2</b>	<b>Information requested by teenagers</b>	<b>9</b>
<b>3.2.3</b>	<b>Circumstances of first contraceptive use</b>	<b>9</b>
<b>3.3</b>	<b>Perceptions of teenage sex and pregnancy</b>	<b>10</b>
<b>3.3.1</b>	<b>Perceptions of teenage sex</b>	<b>10</b>
<b>3.3.2</b>	<b>Teenage pregnancy</b>	<b>12</b>
<b>3.3.3</b>	<b>Knowledge of conception</b>	<b>14</b>
<b>3.4</b>	<b>Contraceptive methods</b>	<b>14</b>
<b>3.4.1</b>	<b>Contraceptive methods for teenagers: teenagers' and nurses' and perceptions</b>	<b>14</b>
<b>3.4.2</b>	<b>Condoms: perceptions and experiences</b>	<b>16</b>
<b>3.4.3</b>	<b>Emergency contraception</b>	<b>17</b>
<b>3.4.4</b>	<b>Contraceptive side-effects</b>	<b>18</b>
<b>3.4.5</b>	<b>Views of male partners about contraception</b>	<b>20</b>
<b>3.4.6</b>	<b>Management of side-effects: teenagers' and nurses' perceptions</b>	<b>21</b>
<b>3.4.7</b>	<b>Contraceptive mis-use</b>	<b>22</b>
<b>3.4.8</b>	<b>Contraceptive non-use or dis-continuation</b>	<b>22</b>
<b>3.4.9</b>	<b>Nurse training</b>	<b>24</b>
<b>3.5</b>	<b>Contraceptive services</b>	<b>24</b>
<b>3.5.1</b>	<b>Choice of contraceptive service: clinic versus general practitioner</b>	<b>24</b>
<b>3.5.2</b>	<b>Experiences of first contraceptive visit and choice of method</b>	<b>26</b>
<b>3.5.3</b>	<b>Problems with clinics: waiting with elder women</b>	<b>26</b>
<b>3.5.4</b>	<b>Teenagers' perceptions of encounters with nurses</b>	<b>27</b>
<b>3.5.5</b>	<b>Nurses' perceptions of encounters with adolescents</b>	<b>30</b>
<b>3.5.6</b>	<b>Perceptions of nurses' roles</b>	<b>32</b>
<b>4.0</b>	<b>Discussion</b>	<b>33</b>
<b>4.1</b>	<b>Nurse-adolescent relationships</b>	<b>33</b>
<b>4.2</b>	<b>Management of side-effects</b>	<b>35</b>
<b>4.3</b>	<b>Contraceptive methods</b>	<b>35</b>
<b>4.4</b>	<b>Provision of information</b>	<b>36</b>
<b>4.5</b>	<b>Pregnancy testing in clinics</b>	<b>36</b>
<b>5.0</b>	<b>Recommendations</b>	<b>38</b>

## **1.0 Background, aim and objectives**

Adolescent pregnancy ranks among the most important health and development problems in South Africa (ANC 1994). Although no reliable data disaggregated by province or ethnicity are available, the national teenage pregnancy rate is estimated to be 330/1000 women under 19 years (RSA 1995). Contraceptive prevalence among sexually active teenage women in South Africa is known to be very low, with an estimated rate of 25% (e.g Buga *et al* 1996). These figures are of concern because they are both indicative and determinants of poor sexual and reproductive health, since teenagers who have unprotected sex are at increased risk of a broad range of reproductive health problems, such as sexually transmitted diseases (STDs) and HIV/AIDS, unsafe abortion and pelvic inflammatory disease (Rees *et al* 1996, Klugman & Weiner 1992, Zabin & Kiragu 1992). Another recent indicator of problems amongst this age-group was the most recently published national HIV/AIDS survey which found the overall HIV-positivity rate among pregnant teenagers to be 9.5% (Swanawelder 1996).

Prevention of unwanted adolescent pregnancy through effective and appropriate contraceptive services for teenagers is essential. Previous research and anecdotal evidence indicates that several serious barriers to teenage access to contraceptive services exist, including clinic nurses' obstructive attitudes, teenagers' fear of social retribution for their early sexual activity, and lack of confidentiality, especially in rural clinics (Abdool-Karim *et al* 1992, Mathai & Jewkes 1996, NPPHCN 1995).

The *aim* of this research was to contribute to the accessibility and quality of contraceptive provision for teenage women in the Northern Province;

The *objectives* were to develop in-depth understandings, from the perspectives of teenage women and clinic nurses, of: barriers to effective, appropriate and sensitive contraceptive provision, and how to overcome these barriers; teenage women's contraceptive-seeking practices, decision-making, and patterns of and reasons for contraceptive (non)-use; perceptions of available contraceptive methods, side-effects and information provided; and perceptions of the circumstances of and reasons for adolescent sexual activity and pregnancy.

## **2.0 Research methods and context**

Qualitative methods were used. The research was conducted around Pietersburg in the Northern Province, mostly in the semi-rural areas around Mankweng Hospital. A total of 35 individual semi-structured interviews and 5 focus groups each containing 3-6 informants (used to validate the individual interview data) were conducted with Pedi adolescent women who were recruited

from clinic waiting-rooms and schools. In addition, individual or group interviews with nurses from 14 clinics were conducted: 10 in clinics in the semi-rural Mankweng area, 3 in clinics in Seshego township, and one in a clinic in Pietersburg. Interviews were conducted in Pedi during three weeks in March 1997 mostly by the principal researcher (KW) (a medical anthropologist by training) and a local nurse acting as interpreter and co-interviewer (JM), although nurses in 4 clinics were also interviewed by the second author (RJ). Interviews were tape-recorded after consent was obtained, and the data was fully transcribed, translated into English and analysed using standard ethnographic techniques.

### **3.0 Findings**

#### ***3.1 Teenage informants: profile***

A total of 35 teenage women (age range 14 to 20 years) were interviewed individually. Of these, 25 had used contraception at some time. Twenty-two had used injectable contraceptives (mostly Nuristerate) and 3 oral contraceptives (two of these because of experiences with side-effects on Nuristerate). Of the 35, 14 already had a child, and 6 of these had never used contraception. Two informants were not yet sexually active.

#### ***3.2 Sexual knowledge and circumstances of first contraceptive use***

##### *3.2.1 Sources of reproductive knowledge*

###### *Elder women*

Teenagers reported that during early adolescence they had been provided with virtually no useful information about menstruation or sexual matters by elders, whether female relatives or teachers. Communication about such matters with mothers was decidedly limited (despite the fact that mothers were often key figures in contraceptive initiation: see below), and this was frequently ascribed to their 'culture', 'living in the old secretive ways', and notions of 'respect' of elders, although some informants suggested that mothers were also 'afraid' that such information might encourage sexual activity. Many teenagers expressed regret that their mothers had failed to provide them with information, in particular about contraception and 'how it works'. One informant, for example, who became pregnant at the age of 16, blamed her parents for not 'advising' her or taking her to the clinic after her first menstrual period, whereas another explained that a mother would not guide her daughter but 'only says something once you are pregnant, whereas she shouldn't have waited, and then she scolds you, saying there are too many in the family'. Those teenagers who reported that they had discussed contraception with their mothers said this had not occurred in a 'straight' way but rather that they had often been the ones to initiate the conversation, asking abstract questions about whether it was 'right' for girls to use

it or 'what prevented people from conceiving', or asking permission to go to the clinic for their second dose once they had started to use contraception.

In most cases, informants reported that their mothers had not even told them about menstruation, or had simply informed them that it was 'grown-up', 'normal' and would continue, that 'you must not be surprised when you see the blood coming out' or that the blood signified that 'at any time you can have a baby'. Consequently many teenagers reported that they had been secretive about their first menstruation, hiding it out of fear. Similarly, information provided at home to teenagers about sex and its link to pregnancy appeared to have been limited to highly mystifying warnings: 'stay away from boys', 'run away if you see a boy', 'don't go around with boys', 'don't sleep with boys', 'look after yourself well' (which one informant said she had interpreted to mean that she should *not* use contraception in case it made her 'naughty'). Many admitted that they had not understood what these statements (or even what 'in love') referred to, especially because even sexually active peers were reluctant to provide details about 'how sex happens'. Several teenagers stated that they had not even known during their first few months of sexual activity that sex could lead to pregnancy, and one informant explained that she became pregnant at the age of 16 because she thought that she couldn't get pregnant as she had not yet started menstruating. As one informant explained, the consequences of parental silence were that 'a girl just finds herself in love and then the mistake happens'.

Although elder sisters were often reported to have played key roles in first contraceptive use, this was not often the case in information dissemination. One informant, for example, said that she had always been excluded from conversations which her elder sister had with friends about contraception, and was 'scolded for listening and wanting to know about what was for adults to know'(she was 16 at the time).

### *Role of peers*

Peers played ambivalent roles in these processes of information dissemination. Some teenagers described friends as important sources of information about the relative advantages and disadvantages of different contraceptive methods and reported that they regularly exchanged stories about clinic encounters, occasionally visited the clinic in small groups and gave each other advice (for example that 'if you are a girl you must make a point of using the injection' since boys will 'run away' once they make you pregnant, or conversely that the method should be stopped if the side-effects were bad).

Other teenagers said that sexual and contraceptive matters were supposed to be 'secret'. A lack of a specific vocabulary of sex was suggested by assertions that explicit sexual information was 'too difficult to discuss' or refer to, even among peers. This contributed to a mystification of sexuality, which was further reinforced by processes of exclusion of the uninitiated. As one informant explained: *'sometimes you go around with your friends at school and you hear them talking about weekend issues, that they went somewhere with some boys, in such a way that you admire them and you want to go too. It'll even come to a stage where they'll start talking about you because you're not in love and they'll say you're afraid of boys, you're stupid. Sometimes you try to keep yourself to yourself, and when they talk about men, you console yourself that at least you can't get diseases. Sometimes you find that you are forced to do things which you are not prepared to do'*. As a consequence of peer exclusion, many teenagers reported that their first knowledge about sex derived from sexual initiation by men, a pattern reported among teenagers elsewhere (Wood *et al* 1997).

### *3.2.2 Information requested by teenagers*

Most informants had questions about contraception which they wanted the researchers to answer, mostly to do with the availability of methods and how to choose between them, and with concerns about what the injection 'does in your body' when side-effects are experienced. The most common questions were: which methods are available and what are the differences between them; does the injection make you infertile, and if so how; what happens in your body if you don't menstruate or menstruate excessively on the injection, and won't I be sick if I don't menstruate; is the injection good for you or not; what alternatives are there to the injection; women can get pregnant while using contraception, so what can you do to avoid this; does contraception make my boyfriend sick; can I use the injection if my baby is still young (breast-feeding); is there a limit to how many doses of injection you can have; and if a condom has holes in it or bursts, what happens. Other common queries concerned STDs: different types and their symptoms, how to prevent them and whether they are curable.

### *3.2.3 Circumstances of first contraceptive use*

Both nurses and teenagers suggested that the decision to use contraception was often the mother's. Several teenagers reported that when they started to menstruate around the age of 14 their mother (or less commonly, older sister) had taken them to the clinic, and 'forced' them to use contraception. This first clinic visit was reportedly often made on some pretence, such as treatment of illness or 'pimples', regulation of menstrual periods or prevention of pregnancy in case of rape. One informant described how her elder sister had asked her whether she had 'seen blood', and when the answer was affirmative, had told her with no

further explanation that ‘it means you are sick and must go to the doctor’. Another narrated how her mother had ‘forced’ her to use contraception at the age of 13 because her cousin had become pregnant at that age, and that she had only agreed because she had been afraid that her father would beat her if she disobeyed. Many of the teenagers said that the first visit had occurred before they were sexually active, although the nurses indicated (and some teenagers confirmed) that mothers would also bring daughters when they were ‘defeated’ and no longer able to ‘control’ their behaviour. Often girls would admit that they were sexually active when the mother was out of the room, but even if they did not, the nurses stated that they would reassure them and explain why their mother wanted them to use contraception, and then give them the injection.

Some informants had themselves started to use contraception because they perceived that sexual initiation was imminent, or at least a possibility, often because their peers used contraception. Similarly, one nurse explained that girls wanted ‘to be prepared’ in case they met a boy with whom they would want to have sex immediately in order to ‘please’ him. Several teenagers indicated that they had not wanted to become pregnant as they wanted to finish their schooling and ‘not be a burden’ to their parents. Other informants, however, reported that they had only started contraceptive use after the birth of their first baby, some explaining that their mothers had told them to have a baby before starting contraception in case it caused permanent infertility (see below), others that they had lacked basic information.

The nursing staff explained that the procedure for first use was that the client had to be menstruating to be given the injection (because pregnancy tests are not available in clinics), and if not she was told to come back when she was bleeding or start the method at the hospital where she would get a pregnancy test. Mobile services appeared to be the exception to this rule; due to the distance from the hospital, clients were often given oral contraceptives and told to begin using them when they started menstruating. Interestingly, several adolescent informants had known to time their first visit with their menstrual period, information which had been acquired from peers. One teenager who had not known to do this reported that the nurses had given her a lecture on the dangers of early sex and had told her to ‘think about it’ and then, if she still wanted to use contraception, to return to the clinic when she was menstruating.

### ***3.3 Perceptions of teenage sex and pregnancy***

#### ***3.3.1 Perceptions of teenage sex***

Many of the adolescents described sex as 'playing'. One girl explained that some teenagers (particularly those from poor families) had sex frequently because there were no other activities available to them: 'it starts with the girls because we are lost. You just do a thing, not thinking about the after-effects; it's nice to go with boys'.

For a minority of informants a considerable amount of coercion was associated with sex. Many said that forced sex or assaults were common occurrences, particularly when men's sexual advances were rejected. One teenager suggested a degree of sympathy towards her partner who assaulted her whenever she refused sex, saying 'maybe at the time he feels hot and is in pain'. In one focus group, participants were in agreement that 'most of the time boys force girls to have sex', and when asked about their own experiences of this, rather poignantly said 'we are on good terms with these boys because we give in', explaining that they submitted to demands (occasionally against their will) because they feared that they would be raped if they didn't. Two other situations mentioned by informants in which their boyfriends threatened assault were when they wanted to use contraception, and when they challenged male requests to get pregnant. Two teenagers also reported that their partners were usually older married men who gave them money or presents in return for sex. The power dynamics operating within this type of exchange are likely to put teenage women in compromised positions where their capacity for sexual negotiation is constrained. These indications that teenage women often find themselves in sexual circumstances where their potential for control over sexual events and contraceptive use is limited are very similar to the findings among urban Xhosa adolescents of Wood *et al* (1997).

Without exception, nurses perceived that teenagers' attitudes towards sex as a 'game' were problematic, and symptomatic of 'ignorance' and a lack of care about the consequences (especially STDs and HIV). They perceived that sexual initiation was occurring at a much younger age now than in previous generations, and blamed television ('they see pictures of people making love, fighting, they want to experiment'), the easy availability of contraception which made teenagers think they could just 'fool around' without getting pregnant, and loss of parental control. One nurse ascribed the shift to living in a 'democratic and civilised' world where people 'choose what they want'. Related to this, it was interesting that teenagers reportedly appropriated the new human rights discourse as a way of challenging nurses; one nurse for example explained that *'it changed with the new South Africa. Some of them will tell you I've got a right to do what I want as long as I don't hurt anybody. So if you say, do you want a baby, they say yes, it's my right; are you sexually active, yes, why so early, that's my right and I don't think I'm hurting anybody because I'm satisfying myself and my partner'*.

Nurses attributed much of the early teenage sex to peer pressure, explaining that adolescents had to succumb to it if they wanted to be included in group discussions and activities (otherwise peers would perceive them to be still ‘children’). They also identified the desire to ‘please’ boys and prove love through sexual availability to be a strong motivating force; as one nurse said, ‘I don’t think girls are forced to have sex, but misled, they’re just in the issue (*sic*) of proving love’. Many nurses also mentioned that poverty led some adolescents to exchange money and presents for sex with older married men (teachers, taxi men and so on), and one health worker perceived that these teenagers were being victimised and exploited. Relatedly, a couple of nurses said that sexual abuse by uncles or bored, unemployed and alcoholic neighbours was very common, especially in the rural areas, and this was sometimes a reason why very young teenagers came to the clinic secretly for contraception. Generally, nurses perceived boys and men to be highly unreliable (especially those who were unemployed and used mandrax or dagga), often violent and to ‘just want sex’. Male tendencies to have many sexual partners were also mentioned; ‘this HIV is a problem for the whole world because today a boy is in love with this one, tomorrow with another one’.

In general, nurses perceived teenagers to be ‘children’. The words of one nurse echoed those of others; ‘I’m concerned because it worries me a lot to see such small children getting involved at an early age exposing themselves to diseases, it touches me a lot’. Besides teenagers’ exposure to debilitating STDs, nurses were also very concerned about the consequences of adolescent pregnancy, especially educational drop-out and the increase in cases of malnourished (particularly kwashiorkor-affected) children as a result of ‘overcrowding’ and poverty in families. Nurses at an urban clinic also mentioned that teenage pregnancy put an extra burden on the health services, particularly because of requests from very poor clients for powdered milk which were described as ‘a drain on the government’. A couple of other nurses said that in many cases the male partner would not be forced to pay for the pregnancy or support the child and would abandon the woman, and consequently children from teenage relationships would often be brought up in poverty and end up as ‘criminals’ or street children.

### *3.3.2 Teenage pregnancy*

In contrast to the characterisation of teenage pregnancy in the nurses’ discourse and in biomedical literatures as being universally problematic, many health workers and teenagers indicated that it was often viewed positively by adolescents and their families. Many teenagers were subject to pressures from their families and male partners to prove their fertility, and some nurses confirmed this, saying that a woman could not get married until she had at least one

child. Nurses at one clinic added that many mothers apparently encouraged their teenage daughters to get pregnant, as they did not pressurise them to go for contraception and often accompanied them with some pride to ante-natal clinic. Some informants explained that in many homes grandmothers put pressure on teenagers to get pregnant so that they could have a baby to 'play with' and so ease their loneliness. Nurses in a township clinic also mentioned that teenagers would be proud to be pregnant because it would be interpreted as an indication of having a 'strong snake' in the womb, referring to a lay model of female reproductive organs which describes conception in terms of a snake (according to the nurses, an image of the Fallopian tubes) 'catching' the sperm and forming the embryo.

Most teenage girls were clearly under pressure from their male partners to have a child, an event which was often reported as characterised by men as 'proof' of the girls' love. The girls, however, expressed some cynicism about this, stating that men's enthusiasm for a baby often evaporated once it was born. A common narrative was that 'some boys tell lies and say you must make him a baby and then he'll come and support you, but then when you have the baby he runs away and goes around with other girls'. Several teenagers who had a child had themselves experienced such neglect. Some however were evidently unimpressed with peers who fell for this; 'the girls agree to have babies because they are fools, then the boys run away, and it doesn't mean the boys pressurise them, but they make them fools and the girls agree to be fools'. Conversely, many teenage women reportedly used pregnancy as a strategy for 'forcing the boys to love' them and support them economically when they thought their partners would abandon them if pregnancy did not materialise from the relationship. One teenager whose baby had been fathered by an older man who had given her money for sex explained 'most of us girls are after money, and if I realise that my boyfriend is giving me money, I'd think that if I had a baby with him he would support me'.

Several informants who had a child described how their mothers had not allowed them to use contraception, the perception being that it could cause permanent infertility (especially in young women) and that they would be unmarriageable. One teenager narrated how her parents and partner had told her that she should get pregnant to prove that she was fertile, and she had thought she was too young to conceive but was 'so happy' when she did because she was given a great deal of affirmation at home for it. Prophets at local churches also prohibited contraceptive use due to their understanding that it caused infertility and was 'bad for teenagers'. For a couple of informants this was the primary reason why they had never used contraception and had become pregnant.

Further evidence of the social sanctioning of teenage pregnancy is found in the observations of nurses that attendance at the male (*koma*) and female (*kgopa*) initiation schools was a factor. Although there was considerable secrecy surrounding what was taught in these schools, boys tended to return from the bush wanting to prove their masculinity (boys at a school reportedly told a nurse that ‘it’s a pride thing that we are able to impregnate a woman, now that we are men’) and nurses at one clinic said that girls would sometimes complain that boys changed after initiation school, becoming argumentative and demanding a child. Although she didn’t actually know what happened in the girls’ initiation school another nurse said she thought ‘they are told to bear a child, because when the girls come out, they get pregnant very quickly, within six months’.

Teenage pregnancy was very much a norm in the area (as elsewhere) and peer pressure based around exclusion of those not participating was reported with respect to pregnancy, as it was with sex. One teenager who reported being left out of group discussions because she had never been pregnant explained that ‘they boast, they say we are having babies, today we’re going to see our boyfriends’ (one exception to this was an informant who said that her friends with babies envied the fact that she could still ‘have a nice time without responsibility’ and wished they could be like her’). Nurses also reported a desire to ‘identify with the group’ as a factor in pregnancy, saying ‘if their friends have a normal baby and are breast-feeding, they all want that experience’.

### *3.3.3 Knowledge of conception*

Beliefs about the conditions necessary for conception to occur evidently caused some teenagers to think they were not at risk of pregnancy, in particular the notion that the blood of each sexual partner has to ‘get used to’ that of the other through multiple sexual encounters before conception can occur, and relatedly, the belief that if a woman has multiple partners and alternates them regularly, conception cannot take place because ‘the blood is different’. One informant, for example, who was sexually active for a few months before using contraception, explained that she had initially thought that ‘his blood and my blood were not yet used to each other’ and had therefore ruled out the possibility of pregnancy. The opposite of this was expressed in another focus group, where the participants explained that they had thought that they were ‘just playing’ and that only girls who were ‘running around’ with many partners could get pregnant.

## **3.4 Contraceptive methods**

### *3.4.1 Contraceptive methods for teenagers: teenagers’ and nurses’ and perceptions*

Despite its reported problematic bodily effects, the injection was the preferred method for 22 of the 25 teenagers who had ever used contraception. All the nurses, similarly, perceived Nuristerate to be the most appropriate method for the ‘child-bearing age’, especially ‘school children’. Nuristerate was characterised by staff and teenagers as a ‘short-acting’ injection which was less strong and ‘usually reversible’, as opposed to Depo (called the ‘old woman’s injection’), which was perceived to cause permanent infertility in many women. Approximations of figures cited on drug company leaflets were often quoted in the interviews by nurses, for example that return to fertility after use of Nuristerate was 6-8 months and Depo a year or longer. Several nurses said that they informed teenage clients that they could take time returning to fertility after injectable use, and clearly the teenagers’ fears of permanent infertility were in some cases supported by information given by nurses. One nurse explained: “‘we tell them, ‘you might get pregnant, you might not get pregnant’ (after injectable use), and say that ‘sometimes it may be because of the development of your reproductive system, sometimes because you used the injection’”. Other clinical information given to clients was the necessity of coming on set return dates, the possibility of bleeding irregularities and the instruction to wait for 14 days before sex so the injection ‘can get used to the body’.

Oral contraceptives were regarded by both teenagers and nurses as inconvenient and problematic because they were ‘easily forgettable’; as one nurse put it, ‘with the injection you just come here and get injected and it’s a guarantee (of contraceptive protection)’. Two other nurses mentioned other advantages of the injection: that teenagers could use it secretly and that they enjoyed the absence of menstruation. Most teenagers were under the impression that forgetting to take one pill would in most cases result in pregnancy, which (with weight gain) was stated to be the main disadvantage of the method. This belief was apparently supported by advice given by nurses, as one explained that she would try and discourage the clients from using the pill because ‘if they miss one then it’s over’. Teenagers were frequently perceived by nurses to lack responsibility or be too busy with school or games to be trusted with using oral contraceptives, although some said they did not discourage them if they were keen to use them. One lay belief about the pill which was mentioned a few times by teenagers (but not entirely taken seriously) was that if a woman uses the pill and has twins, they may be delivered with their heads locked together. Advantages of the pill were rarely mentioned, but included the ease with which it could be stopped and its short-term use to control bleeding irregularities experienced on the injection. Among the brands available in the clinics, nurses recommended Microval for breast-feeders and Triphasal or Nordette for other teenagers. Nurses at one clinic mentioned that adolescent clients tended to be familiar with certain brand names which were

fashionable to take (such as Ovral) and that they ‘often change what they ask for because they have a lot of group influence’.

Some informants had also heard of the loop (not available in the clinics), which as one teenager said, ‘the doctor puts in your abdomen’. Lay beliefs about it included that a baby could be delivered with the loop in its hand, that a ‘strong’ man could ‘take it out’ during sex, or that if you have many sexual partners the loop could move and ‘kill you’.

Several teenagers had knowledge about local ‘traditional’ methods of contraception. They perceived that they were effective in some women (explaining that pregnancy would only occur if the medicine had lost its strength) but explained that they themselves had never used these methods because they weren’t ‘used’ to traditional healers. The methods involved either tying a rope containing traditional medicines around the waist, or mixing a cloth covered in the woman’s menstrual blood with medicines from a traditional healer and burying it until conception was desired. Religious methods used by followers of the Zion Christian Church (which disallows the use of biomedical contraceptive methods) were also mentioned, including drinking tea or medicines which church leaders had prayed over.

Another method mentioned by some teenagers was ‘prevention by menstruation’, which they explained consisted of abstaining from sex in the second half of the cycle. However as one teenager pointed out, it was not always effective as some women were forced to have sex during the ‘dangerous’ (fertile) time.

#### *3.4.2 Condoms: perceptions and experiences*

All informants mentioned that condoms could be used to prevent STDs, particularly *drop* (gonorrhoea) and HIV. Only a minority added that they could be used to prevent pregnancy. Multiple concerns about using condoms were mentioned, the most common of which was that they could be ‘left inside’ the vagina or womb, and would then have to be removed either with the tongue (fingers were said to make them go ‘deeper and deeper’), by a doctor, or in hospital where they had the right ‘equipment’. Informants in one focus group explained that a condom would probably stay inside if used more than once, as ‘it has a limited time and needs to be destroyed after first use’ while participants in another perceived that condoms would ‘burst inside’ if their expiry date had passed. Teenagers said that another major disadvantage of condoms was that boys wanted ‘flesh-to-flesh’ intercourse in order to be sexually satisfied, and to illustrate this they frequently used the analogy of the impossibility of eating oranges or bananas without removing the peel. Another disadvantage was said to be that boys were known

to 'puncture' condoms if they wanted to make a woman pregnant, and then as one informant said, 'you'll get a disease or fall pregnant even if you were using a condom'.

Only six informants said that they had ever used a condom. One explained that she sometimes used condoms with her partner whenever she suspected that he had another partner, adding that they openly did not always trust each other (although she said she had always been sexually faithful), and that this situation was acceptable to both of them. Two informants had used condoms when the clinic had run out of Nuristerate, but one of these reported that 'we didn't feel any desire' and stopped, and the other said that on one occasion they had sex without a condom because her partner told her he hadn't brought one and she became pregnant. Many informants who had never used condoms reported that they and their partners 'trusted each other', and had no (or few) other sexual partners and so perceived themselves to be safe. Some said that they were reluctant to use them because of the potential problems, while others merely thought them to be 'horrible'. A few admitted that they had never thought of using or that nurses had never offered them or explained what they were for.

Some teenagers were evidently too disempowered within their sexual relationships to request or enforce condom use, despite general awareness that 'diseases' could 'spoil your reproductive organs', 'affect' your womb and cause infertility if not treated early. One teenager for example described how her partner had refused to use condoms saying that 'plastic' made him 'sweat', and she hadn't challenged him because she feared that he would beat her. Another teenager reported that her partner had aggressively rejected her request that they use condoms, had demanded to know whether she had sex with other men, threatened to beat her and shouted at her that he would never 'throw his blood away while looking at it'. In her words: 'I told him about their importance, that there are many diseases and that he has many affairs but never tells me so he'll infect me'. Another informant made the point that women who wanted to prevent pregnancy had to use methods which they themselves could control as 'boys force us to sleep with them without a condom even if we're not using contraception, and then obviously you can get pregnant'.

Nurses reported that although they informed teenagers who had defaulted from a method to use condoms while waiting for their next menstruation, most teenage clients refused to take them because their partners would never agree to using them or because they were afraid to ask in case it would be misconstrued as an admission of sexual infidelity or mistrust. At most clinics however, nurses reported that some boys did come to request condoms (usually in small groups) and that there had been a visible increase in the numbers doing this since the campaigns

held in National Condom Week. One nurse said she believed that some teenagers did use condoms because she saw used ones discarded on the streets or in the bush. Another suggested that boys took condoms to use when their partners were menstruating, due to the belief that STDs could be caused through direct contact with the ‘dirty’ blood. Nurses were familiar with people’s reasons for disliking condoms; as one summarised, *‘they say it’s tight, messy, they don’t feel anything, all these stories, and there’s no time to reach for the condom because sex deals with emotions, and by the time they are emotionally charged they even forget where they put the condom’*. Some nurses mentioned that boys were embarrassed to go to the clinic in front of elders and wanted nurses to put boxes of condoms outside so that they could take them discreetly, however nurses perceived this to be an impossible arrangement because they needed precise figures for their ‘statistics’ and because they perceived that younger teenagers would take the condoms and inflate them or sell them in the shebeens. Adolescent informants complained about having to give their names when taking condoms, in case ‘maybe one day a relative of ours would come and see our names written there [in the book]’.

#### *3.4.3 Emergency contraception*

The majority of nurses were unfamiliar with the concept of emergency contraception, and were apparently unaware of what it consists (a two-tablet dosage of a high oestrogen oral contraceptive such as Ovral, taken twice, with a 12 hourly interval, within 72 hours of intercourse) as many said they did not stock it in the clinics. Interestingly however, at one township clinic there were some reports of lay knowledge of it: nurses mentioned that occasionally teenagers would visit the clinic very upset because they had had unprotected sex and would cry until the nurses had given them two tablets (*sic*).

#### *3.4.4 Contraceptive side-effects*

##### *Menstrual irregularities*

Menstrual irregularities were reported to be the most severe and common side-effect experienced while using the injection. Many teenagers said that they had not menstruated for weeks or months while using Nuristerate, and interpreted this phenomenon in terms of blood having ‘accumulated’ or ‘clotted’, usually in the womb or abdomen but also in the head and feet, which explained why the blood would not ‘come out easily’. One informant explained irregular menstruation as follows: ‘a woman has two tubes which they say release the menstruation, but sometimes only one tube releases it, and if this is the case it can’t release it every month’.

The majority of informants described this state of ‘blockage’ to be a dangerous condition, identified by ‘dark clots’ or by ‘waist pains’, and construed it either as an indication or cause of illness. Some said that not menstruating was itself the sickness, and explained that it meant the injection was not ‘good for the blood’. Remaining in such a blocked state was perceived to cause other symptoms, including a large or painful abdomen, swollen body, headaches (if the blood was seen to be blocked in the head region), tiredness, ‘sores on the body’, weight gain and skin changes, in particular a ‘bluish’ tinge which demonstrated that ‘the blood wasn’t circulating properly’ or had been ‘withdrawn’ somewhere. Bodily swelling was interpreted by one teenager to be caused by blood which would ‘normally stay in the abdomen to make a baby’ descending to the legs or other parts of the body.

In addition to these side-effects, prolonged absence of menstruation was seen to be problematic for three reasons. Firstly, this was because monthly bleeding indicated that pregnancy had not occurred (which was particularly significant knowledge given the general complaint that clinic nurses failed to ‘check’ for pregnancy on return visits), and secondly because of fears that blood blocked somewhere in the body might eventually ‘come out too fast’ with adverse effects. Two stories were narrated of cases where women were said to have literally collapsed and bled to death because the blood had come out too fast. The final reason was related to the belief (particularly reported to be held by men) that if menstruation, which is widely constructed as a cleaning process ridding the womb of accumulated ‘dirt’, did not occur, there would be a build-up of ‘dirt’, which is the notion widely used to express STDs. Relatedly, waist pains, a common complaint among injectable users, were said to indicate the presence of ‘dirt’ in the womb.

Anxieties about missing menstrual periods led to specific patterns of lay contraceptive use. In particular, some informants mentioned that if they failed to menstruate over an extended period, they would not return for the next dose but would ‘wait for the blood to come out’: in the words of one teenager, ‘then you can see that pregnancy hasn’t happened’. In some cases this was probably based on clinical advice. It was also common knowledge that nurses could give ‘pills’ to bring on menstruation (referring to oral contraceptives).

Menstruating excessively was another commonly reported side-effect of Nuristerate. There were also worries about this process, as indicated by the words of an informant who explained that she feared that her blood would eventually be ‘finished’.

### *Infertility*

Infertility, often expressed in terms of being ‘condemned’, was a fear almost everybody expressed about injectables (particularly Depo), and was reported to be an important barrier to contraceptive use among adolescents. Several teenagers who already had a child had been told by their mothers to get pregnant before starting contraception because of the stories about infertility. In addition, many churches were said to disallow contraceptive use, the underlying explanation being that it ‘spoils our bodies’, or ‘punctures and spoils the eggs’. If a woman in the community was known not to have ever been pregnant, it would reportedly be speculated that this was due to prolonged contraceptive use. Although many using the injection said that they didn’t entirely believe these tales, infertility was a very visible concern among informants, constituting the primary question which was asked of the researchers at the end of interviews.

Some teenagers related this phenomenon to the blood blockages described above. One explanation given was that blood accumulated in the abdomen and caused the womb ‘to get tired’, potentially preventing pregnancy, sometimes permanently. Another informant explained the process as follows: *‘if you’re not on the injection, the blood stays somewhere next to the womb, and if you don’t conceive that month, the blood can get out; but if you use Nuristerate, this blood doesn’t pass easily to the place next to the womb, and it means your body will never be as it was before, and this blood prevents you from ever falling pregnant’*. Informants who thought of this infertility as a temporary state (the majority), explained that after two or three years the injection could be ‘still in your body’, or alternatively that it would take the same length of time to conceive after stopping the injection as that spent on it. One informant who hadn’t menstruated since she had stopped Nuristerate two months previously explained that the injection was ‘still in the bloodstream’.

#### *Other side-effects*

Weight gain was often mentioned by informants to be a problem with contraception because they were ‘used to a thin body’; one teenager explained that her friends complained because ‘they say they have changed from a teenage weight to an adult weight and that their body is full of fluid’. Another side-effect which was mentioned was unintentional pregnancy, several teenagers reporting that some of their peers had become pregnant while using contraception; one informant even said that ‘most people get pregnant while preventing, and this troubles me the most’. Other miscellaneous side-effects which were mentioned included general body pains, rash, ‘too much fluid’ in the body, lumps, increased breast size, headaches, dizziness, vaginal discharge, and even ‘an affected mind’.

#### *3.4.5 Views of male partners about contraception*

Informants were divided fairly equally between those who reported that they were able to discuss contraceptive matters with their partners and those who used the method secretly, often out of fear that they would prohibit its use. Although many men opposed contraception because they wanted to prove their fertility, it was common for them to express their opposition in terms of their bodily sensitivity to contraception. It was said to make them 'sick', in particular causing 'waist pains' after sex, and 'condemned' them (made them infertile). Some men would accuse their partners of using contraception if they experienced such symptoms and in some cases demand that it be stopped. One teenager reported that her boyfriend 'started complaining of waist pains from the first month I had my injection, saying there were changed things about his body, and that he was experiencing some pains below the belly button area'. Other complaints reportedly made by male partners included weight loss and diminishment of sexual feeling because of vaginal 'wetness'. In one case, church leaders were said to have warned men that sex with a contraceptive-user affected boys' 'singing and dancing' performances at church.

Several informants spoke of the use of coercion to prevent girls using contraception, in particular threats of or actual beatings. One partner reportedly tore up the clinic card and threw away the pills when the informant told him she had been to the clinic, the consequence being that she became pregnant. Another woman said that some girls stopped using contraception when the partner told them to, because they took it to be an indication that the boys loved them and wanted to have a baby to prove it. Several teenagers described how they had only informed their partners when they had returned from their first visit to the clinic. One explained this as follows: 'if he hadn't wanted me to come to the clinic, he could have raped me on my way to the clinic or taken my card and torn it up'. Some reported that their partners reacted supportively, once they had explained their motivations for wanting to use contraception (usually in terms of delaying child-bearing until they had completed education or because the couple already had a child together), and four informants had been told by their partners to go to the clinic to prevent pregnancy.

#### *3.4.6 Management of side-effects: teenagers' and nurses' perceptions*

Nurses' approach to dealing with side-effects was a source of dissatisfaction, largely because they did not share the teenagers' perceptions of what was a 'problem'. They suggested that most of the problems experienced by teenagers were 'psychological' or 'minor ailments', which they contrasted with conditions interfering with 'health', such as raised blood pressure. For example one nurse explained that 'if you try to interview them, most of their problems are psychological, not really physical'. Change of method was reserved for cases where there was clearly a specific pathological condition. Other nurses reported that they told clients that these

side-effects were 'not a problem' and warned them not to default from the method; "they come for more explanation, we give them a sort of lecture, we say 'yes, it does cause this, but you must still come on time'". One township nurse explained that she simply told clients who said that their sexual partners were complaining about waist pains, that 'if you want to satisfy your boyfriend then leave it and get pregnant'.

The teenagers, on the other hand, perceived the side-effects they experienced as 'real' and problematic for them and did not feel that they were taken seriously. For example one informant who was worried about the blood 'staying inside' said that the nurses simply told her that it would 'come out' at some point and then immediately gave her another dose. Teenagers reported that the failure of nurses to respond to their concerns often led to them stopping contraceptive use. One informant described how she had asked the mobile clinic staff (who were reportedly 'always in a hurry and short-tempered and would not explain what was happening') to change her to the pill when she experienced excessive bleeding on Nuristerate, and when they refused she defaulted from the injection. In another case, a teenager described how after a year of not menstruating on Depo, she had finally told the nurses at her local clinic who scolded her, saying 'you must just feel like that, that's how it works'. As a result of this encounter, she went to a GP who advised a change to Nuristerate; however, when she returned to the clinic to convey this information to the nurses, they reportedly refused to give it. She never returned to the clinic, stopped using contraception, became pregnant and attempted an unsuccessful backstreet abortion.

Most nurses interviewed indicated that they would assist women with long-standing menstrual problems (whether amenorrhoea or menorrhagia) by prescribing Ovral for a month to regulate the bleeding. Nurses at one clinic however stated they would often not give the pill to teenagers as they would forget to take it, but would refer severe cases to hospital. Generally nurses reported that they would not encourage a change of method for teenagers, because they perceived the body to take some time 'adjusting', 'absorbing' or 'getting used to' the hormonal content of the injection. Several nurses explained that they had to 'convince' and 'encourage' clients that they may experience normal menses once the process of adjustment had happened. A further consideration expressed by nurses at one clinic was the limited range of methods available in clinics.

#### *3.4.7 Contraceptive mis-use*

Several examples were found in the interviews with nurses and teenagers of ineffective use or mis-use of contraception. This often occurred in efforts to manage side-effects because of a lack

of knowledge about modes of action or in the course of an attempt to bring on menstruation. For example one teenager explained that she had adopted a pattern whereby she used the injection for three months at a time and then had a three month break so that she would menstruate. Nurses reported patterns of lay use of the pill among adolescents, especially taking it only when their partner came to visit or only on half the required days (one nurse explained, to reduce the chances of gaining weight) and taking all the missed pills at once.

Nurses at several clinics reported that some teenagers would request the injection because they suspected they were pregnant, perceiving that it would make them abort. One nurse also mentioned that some would ask for 'the red pills' (Ovral) for the same purpose. Because of the clinic rule that a woman could only be given the injection when menstruating, nurses reported that teenagers would borrow the soiled sanitary towels of friends, or put beetroot juice or blood from a pricked finger onto a pad, to try and convince the nurses that they were actually menstruating. Nurses explained that they could often detect such cases from the teenager's behaviour, 'these ones will be aggressive, she just forces you to inject her or she may cry', or that such clients would ask specifically for the injection and claim to have forgotten the date of their last menstrual period. Another nurse claimed to be able to detect such 'cheats' by whether their manner was confident or not.

Sometimes, however, nurses failed to detect them. One nurse, for example, described the case of a teenage client who told her that her parents prohibited her from using contraception and begged her to inject her, and as soon as she had, the teenager told her the truth, saying that she thought she was pregnant and wanted to bring on her period. Another explained that nurses would sometimes only find out when they saw these clients at ante-natal clinic where they would admit that they had wanted to be injected in order to abort. Nurses said this kind of event made them feel 'like fools' and 'stupid to be taken for a ride like that'.

#### *3.4.8 Contraceptive non-use or dis-continuation*

Multiple explanations were provided for why teenagers failed to use contraception or discontinued use. Non-use was said to be motivated by a fear of side-effects, which were well-known and discussed in peer networks. Some informants, who clearly had not had the confidence to use contraception secretly, reported that they had become pregnant because they had stopped using contraception after their partners' protests. Other informants said contraception made them 'sick' and so had stopped altogether because nurses had not allowed them to change method.

Nurses' attitudes were clearly an obstacle to contraceptive use for some teenagers who had heard anecdotes about how nurses scolded adolescent clients and asked personal questions (see below). Relatedly, some informants reported that women became pregnant because they had missed their return date and feared the nurses' anger. Structural problems with services were also mentioned, in particular the fact that mobile clinics in rural areas were sometimes unreliable (especially in the December holidays) and did not always come on the appointed day, causing some clients to miss their next injection.

Some informants who had become pregnant said they had not known what contraceptives were, how they worked or where they could be obtained. However, many had not made an active effort to find out, and evidently this was influenced by a host of other pressures which acted to construct pregnancy as a positive event and thus caused many teenagers, who perceived that pregnancy would 'not be too much of a problem', to risk it (particularly as they were aware that there were support structures at home which would enable them to finish school if they were to have a child). This passive approach is illustrated by the words of one teenager (pregnant at the age of 15) who described how she had gone to the clinic for contraception but had been told to return when she was menstruating and had never done so, for 'no particular reason'. Another informant was unlucky and had become pregnant after her first sexual encounter.

Nurses at all the clinics reported that many teenage clients defaulted from contraceptives. Some teenagers were reported to be late for the return date because they were busy, forgot or were away, or because they had lost or 'bent' their clinic card. In the words of one nurse, 'they say they were held up, but there are no valid reasons why they don't come, it's just because of ignorance'. When asked how nurses spoke to defaulters, one nurse said 'we don't scold them as such, but we tell them the facts and warn them'. There were some differences in the way clinics managed such cases. Generally nurses explained that if the client had defaulted by a few days (usually by about two, but as many as ten), they would send her away and tell her to return when she had her menstrual period or go to the hospital for a pregnancy test (most clients reportedly chose the first option). The town clinic and mobile services appeared to be more flexible in dealing with defaulters, as they reported that they usually gave the repeat dose anyway unless a client had defaulted for a 'long' (unspecified) time.

Nurses recognised that an important cause of defaulting were disruptive side-effects, especially amenorrhoea, which as one nurse explained caused some teenagers to stop the method 'without notifying us, because they want to see their menstruation'. Another nurse explained that clients often stopped the method without complaining first to the nurses about the side-effects because

*‘they say we always try to convince them, this thing of convincing them, but I can’t just say to her, then stop using the method, because I know the results so I try to sympathise and maybe convince her’.*

Nurses mentioned other reasons for defaulting, including the occasional unreliability of mobile services, teenagers’ perception that clinic queues were too long, the distance of the clinic from their home (and no money to pay for transport), use of contraception without parental consent and then subsequent discovery by the parents, male complaints that the method made them sick, and general ‘carelessness’ combined with the attitude that ‘tomorrow comes with its own problems’. Another common reason mentioned by nurses was that some teenagers actively wanted to become pregnant. Nurses at two clinics mentioned that teenagers who were not successful at school or who didn’t have ‘that zeal to be educated’ would get pregnant as a way out.

#### *3.4.9 Nurse training*

Several nurses felt that their contraceptive training was inadequate to deal with client needs. Particular queries which were mentioned included what the protocol was for changing methods in cases where clients were experiencing disruptive side-effects, whether they were ‘supposed’ to give oral contraceptives to teenagers, and what the differences were between the progesterone-only and combined pills (and their respective merits). Nurses at one clinic asked for guidance on the correct intervals between doses of Nuristerate, pointing out that contrary to standard practice (where dosage was every 8 weeks), the manufacturer’s leaflet stated that after the first four doses, contraceptive protection would be acquired for 13 weeks and so repeat doses should be given at intervals of 13 weeks. At one clinic a nurse commented that nurses in the ex-Lebowa rural clinics frequently did not have the confidence to deal with clients who had defaulted by a few days and so referred them. She perceived this to be a problem because it resulted in clients thinking that they couldn’t get the help they wanted in those areas because the nurses were incompetent.

### **3.5 Contraceptive services**

#### *3.5.1 Choice of contraceptive service: clinic versus general practitioner*

Many informants reported that they had first acquired contraception from their local general practitioner. Although one reason for this was clinic procedure not to provide contraceptives to first-time clients unless they are menstruating but to refer them to the hospital for pregnancy testing, in many cases it was because their mothers had simply taken them (or told them to go) to the GP or because an elder sister used the doctor rather than the clinic. Several teenagers

explicitly said they had chosen to go to the GP because of the widespread ‘stories’ about nurses in the clinics, while others had changed to the doctor after experiencing harassment themselves in the clinic. One teenager, for example, who had to travel far from her home to get to a clinic, explained that clinic nurses had said to her ‘we don’t want you here’, ordering her to go to the local clinic in her area (when in fact there wasn’t one), and that this experience had made her go to her GP instead. A couple of informants mentioned that the nearest clinic was too far away from their home and so used the GP for convenience.

Although many teenagers were obliged to go to the clinic because they could not afford doctors’ fees, there was consensus that GPs were far preferable to clinics as a source of contraception, the most important reason (cited by nearly everybody) being that doctors (unlike clinic nurses) ‘check you’ for pregnancy, and ‘to see if the injection is good for you’. Confirmation of absence of pregnancy was perceived to be particularly important given that amenorrhoea was frequently experienced on Nuristerate, and that as one teenager said, ‘some of us don’t even know what changes we would experience if we were pregnant’. One teenager said that the doctor checked her temperature and examined her for vaginal discharge, and gave her ‘health education about how to prevent it’, while another asserted that the doctor even checked ‘your eyes and your breathing’. Teenagers who only had experience of the clinics also indicated that they wanted nurses to check them because of the menstrual irregularities and weight changes caused by the methods; another explained that she wanted to be checked for ‘sickness in the womb, dirty discharge which means you are sick’. One informant explained that the benefit of a check-up was that ‘you can go home and feel free that you’re not ill’. Some teenagers who normally used the clinic would consult GPs with contraceptive side-effects because they were concerned that nurses would assert that the side-effects were not a problem without doing a ‘check-up’ to confirm this.

Apart from the check-ups, teenagers said that GPs’ attitudes were far better than nurses’. A clear hierarchy of ‘niceness’ was established in informants’ narratives, with doctors coming first place, followed by mobile nurses who, one informant explained, ‘when talking, they laugh with you, whereas at the clinic when you enter their attitude changes immediately’, though mobile nurses were also described as being in a permanent rush with no time for explanation. Clinic nurses were undoubtedly perceived to be the most unkind. Teenagers reported variously that doctors ‘speak to you nicely’, don’t ask awkward questions about why they are sexually active so young, and get a chance to ‘sit with you’ and provide health education about STDs. In addition a couple of informants mentioned that there were no queues at doctors’ surgeries, and

one said that some people used GPs because three or more clients were injected with the same needle in the clinics and this could spread ‘diseases’.

### *3.5.2 Experiences of first contraceptive visit and choice of method*

Many teenagers reported that on their first visit to the clinic or GP they had directly asked to be given the injection, while others were simply given ‘the two month injection’ by nurses who told them that it was the most appropriate method for teenagers. Only two teenagers were concerned about not having been given a choice in the matter: one who was only told about the injection and was too afraid to ask about alternative methods, and another who said she hadn’t gone to the clinic out of fear that the nurses would simply inject her with Depo (which she perceived to cause permanent infertility). Others trusted the authority of the nurses, such as one teenager who explained that ‘I thought maybe it was the way they checked me that they knew it was the correct method for me’. Mostly, health workers had only told informants that they had to wait for 14 days and return on the due date. A minority reported that they had been told by nurses that they could expect to experience side-effects (including headaches and not ‘seeing’ their menstruation).

### *3.5.3 Problems with clinics: waiting with elder women*

From the teenagers’ side, one of the most important problems with clinic use was their anxiety about elder clients’ perceptions of them. Since older women were said to ‘joke and gossip’ about adolescents and speculate publicly that they were sexually active, several informants reported that being ‘seen’ at the clinic made them unhappy and ashamed. As one teenager put it, ‘we think they’ll judge us that we are so young, and they just gossip, they don’t tell us straight’. One informant explained that ‘you get ashamed because you may find a person there whom you didn’t think would ever come to the clinic, maybe a neighbour, and you become afraid that she will say bad things about you, that you’re in love with many boys’. Lack of anonymity in clinics was a particular obstacle for adolescents who wanted to keep contraceptive use a secret from their sexual partners, female relatives and neighbours (because they were church members or had partners or mothers who disallowed contraceptive use). Several teenagers mentioned that if they saw their mother or a neighbour in the clinic waiting-room they would leave immediately.

A common solution proposed by teenagers was to have a separate time and room for adolescent clients coming for contraception so that they could wait with their peers and be educated by nurses about their own needs: ‘then we’ll know what we’re coming for, there’ll be nobody who’ll laugh at the other person, we’ll all be there with one aim’. Secondly, many informants

said they wanted nurses who would work with them ‘hand in hand’, understand their problems and speak to them kindly. A few informants said that they wanted younger or at least ‘middle-aged’ (rather than ‘old’) nurses to give them contraception, and nurses who were not known to them but who came from a different area. They also said they wanted to be ‘checked’ regularly by nurses, especially for pregnancy. It was also suggested that there ought to be ‘health programmes taught through radios because some of us are afraid to come to the clinics’, and that boys ought to be encouraged to visit the clinics more.

Nurses expressed mixed views on the benefits of separate rooms or times for teenagers. Although they recognising that mixed generation queuing was problematic both for teenagers and older women (who did not want to encounter their daughters in the clinic), there was a perception that separate rooms or times would only act to expose individual adolescents seeking contraception. One nurse said that this would ‘draw the attention of the elders in the area’, and similarly another argued that ‘most’ teenagers were in love with married men and that the gossip about this would increase. Other nurses however, like the adolescents, considered that separate times or rooms for adolescents would enable nurses to provide relevant information and advice to teenagers in groups.

#### *3.5.4 Teenagers’ perceptions of encounters with nurses*

Although these problems with the clinics were significant, by far the most important and commonly reported problems encountered by teenagers were the attitudes of nursing staff towards them. Experiences of ‘harassment’ by nurses emerged as a strong theme in the interviews despite the fact that teenagers participating in the research were usually recruited and interviewed in a clinic and so potentially could have been inhibited about discussing their perceptions of nurses. Many teenagers reported their own experiences of verbal ‘harassment’ by clinic nurses, while others relayed their friends’ descriptions of it. Nurses were commonly described as rude, short-tempered and arrogant, and liable to harass clients without any provocation. Teenagers said that one of the most problematic aspects of clinic encounters was that nurses would not provide the method until they had asked ‘funny questions’ about whether they had boyfriends, why they had sex so young and whether they had told their mothers, in addition to lecturing them that they were far too young to be sexually active and must ‘stop going around with men’. Teenagers who refused to answer these questions were reportedly scolded. One teenager who had even tried to explain to the nurses that she had come for contraception because her mother told her to reported that ‘they only injected me after making a lot of noise to me’. One teenager said that ‘it’s not at all the clinics that they can help you, they’ll say you are too young, whereas at other clinics you’ll be lucky and they’ll help you’; and

this perception among teenagers that nurses (in the words of one informant) ‘think you are too young to do adult things which aren’t good for you’ was supported by the fact that nurses were also known to scold pregnant teenagers attending for ante-natal care.

Several specific sources of conflict between nurses and teenage clients were reported. Some teenagers reported that when they had produced GP’ cards at their local clinic, the nurses had objected to the fact that they had obtained contraception from the GP and refused to give the required dose. One informant said that she was very confused when this happened because she had been told by nurses on her initial visit to get her first dose of Nuristerate from the GP or hospital. Another described how a nurse refused to give her more of the pill because the first packets had been acquired from the GP. Other teenagers were reportedly scolded for not using local mobiles and ‘wasting money on taxis’ to travel to the clinic (even though the clients’ main motivation, that mobile services were frequently unreliable, was apparently rational). One informant who reported this experience said that the nurses had told her that they would help her ‘for the first and last time’ but would not explain about the methods because her local mobile nurses were ‘supposed’ to do that. Several teenagers reported that nurses scolded teenagers who did not arrive at the clinic early in the morning, despite the fact that, for most, visiting the clinic was only feasible after school hours. The nurses for their part complained that by not asking for permission from teachers to leave school early, the adolescents put pressure on them when they were already exhausted.

Teenagers seeking contraception without parental permission was frequently a source of conflict between staff and clients. One teenager, reporting that she had been told to come back with her mother, explained that ‘even if you want to go to the clinic, you end up not going because of this’. At two clinics in the more rural areas, nurses reported that they asked teenagers whether their mothers knew that they wanted contraception, explaining that this was because the clients were ‘minors’, and because ‘some cultures don’t like contraceptives so we can’t just give them to a child without their parents’ permission’. By ‘cultures’ these nurses explained that they were referring to the Roman Catholic and Zion Christian Churches, whose leaders believed that contraception could ‘completely block the tubes’. It was also clearly motivated in part by the distinct possibility that the mother would find out and be angry with the nurses for giving contraceptives, and relatedly the perception that most parents would not agree to their daughters using a method because ‘the child will be loose, free’. One nurse explained that usually the teenager would say that her mother knew and would be willing to disclose her mother’s name, so that the nurse could write it on her card as ‘proof’ of parental knowledge. However nurses reported that they would provide the method to a teenage client

whose mother disagreed, because as one put it, 'she has the right to choose, it's her choice' though she added that 'according to our tradition we must respect our parents'.

Another source of conflict was over the clinic cards. Most nurses reported that some teenage clients tampered with their clinic cards and, in particular, changed the dates and forged the nurses' signatures 'for their own convenience' if they were late for their return date and feared that they would be scolded, as one nurse put it 'not knowing that they are cheating themselves'. Another nurse explained that some teenagers used forgery as a strategy for resisting mothers who forced them to use contraceptives against their will. Nurses perceived such forgery to be 'truanting' (in the words of one, it was 'criminal' behaviour) which made them feel 'fed up' and 'offended'. They said that their response was to ask the client why she had changed the dates on the card and whether she was aware that it was wrong. Nurses at one clinic however reported that they did not experience this problem because they explained 'carefully' the first time they saw a teenage client that she must never write on her card because they would see that she had done so and the consequences would be 'strenuous' for her.

The impression given by some informants' comments was that nurses were at times perceived to transgress their professional role to an unacceptable degree. One teenager for example described how she once went to the clinic after school with some peers and they had met a boy in the street and started conversing with him; *'the nurses were just looking at us, and when we arrived they started scolding us and saying what were you doing talking to that guy; they scolded us as if we knew one another whereas it wasn't like that. From then onwards I started hesitating to go to the clinic whenever I was due to go there'*. Relatedly, another informant suggested that teenagers were scolded because they refused to answer nurses' questions, perceiving them to be so personal that only their mothers were supposed to ask them (questions such as: why did you get pregnant). Parallel to this, there was a suggestion that nurses were out of touch with teenagers' perspectives in the advice they frequently gave about sexual abstinence; in the words of one teenager, *'nurses say this generation doesn't wait to be given keys, they give themselves keys by having babies, but you find that this (advice) is not practical because it's not possible that our boyfriends simply talk to us and that it ends there- he wants to have sex with you first'*.

The main emotions which 'scolding' provoked in teenagers were said to be shame, unhappiness and fear. Informants unanimously reported that nurses were unchallengeable, because they were older and so expected to be granted respect (demonstrated by silence), and because they needed their services. As one teenager put it, *'we just feel ashamed but we don't challenge them [because] sometimes you may challenge them and find that you use words which may hurt*

*them, then next time you go there you find they refuse to help you*'. Those clients who did resist were said to have already decided to change clinics.

An important consequence of nurses' 'scolding' was reported to be that teenagers stopped using contraception and had unwanted pregnancies. In particular, fear of nurse retribution was said to cause many adolescents who had missed their return date to 'stay at home' and a few informants reported considering just not going back because of the nurses' behaviour. One teenager for example described how *'they continued scolding us (for arriving at the clinic after school), and said 'bring those buttocks of yours and let us give you the injection', then we exposed our buttocks and they gave us the injection very deeply. After that I told myself that I would stop having the injection but I didn't*'. Another consequence reported by nurses at two clinics was that some teenagers would share their packets of oral contraceptives with their friends who were afraid to visit the clinic themselves. The nurses detected this as they wrote down the exact number of packets handed out.

### *3.5.5 Nurses' perceptions of encounters with adolescents*

Since adolescent informants frequently perceived nurses' comments and questions to be intrusive, nurses were asked to describe the content of the 'advice' they provided to teenage clients and their motivations for providing it. Nurses at all the clinics confirmed that they gave advice which consisted primarily of 'encouragement' to abstain from sex. This was particularly motivated by their concerns about the 'statistics' of HIV, other STDs and cervical cancer, and their observations that many teenagers became pregnant at an early age and dropped out of school. As one nurse explained, 'you start by giving them lectures about the dangers of early sex before they can convince you to give them what they want', whereas another said 'we tell her the dangers and stress the abstinence method and only then talk about artificial contraceptives, at their age they are causing erosion on the cervix and the sore, the cancer, [that] doesn't heal'. Similarly another reported that she explained to the teenagers that if you have sex 'you are playing with your life because there are so many diseases, and you can get cancer because your body is not yet developed'. Beyond their concern with the perceived health risks of early intercourse, there was also a moral motivation for the nature of the advice which nurses gave, as they frequently told teenagers that just because they had started on contraceptives it didn't mean that they must go 'running around' with many partners; in the words of one nurse, 'she has to stick to normal morals'.

Nurses reported that teenage clients generally responded to these comments by becoming shy and looking down silently. They perceived this reaction to be rooted primarily in shame, as one explained: 'she feels it's not good for her to come for family planning, to have boyfriends while at school, they really feel they have gone beyond the boundaries'. It was also said to be derived from tradition, which dictated that younger women must not 'face' elders. One nurse explained "it's our tradition, neither can you talk to your mother and say 'I'm pregnant' or 'I want to go for family planning', it's something one can't talk publicly about". Interestingly, this implies that nurses were perceived, and perceived themselves, to be primarily part of the social category 'elders', rather than 'professionals', which in many social contexts is a distinct category which is not bound by the same hierarchical 'rules' as age-related social categories. Other explanations for the shame were said to be that teenagers often knew the nurses personally (as a neighbour) or that nurses perceived that they were reluctant to allow others to know much about them; as one nurse said, 'they think you're going into them too deeply'.

Nurses in a township clinic however reported that some teenagers would 'answer back' and 'make up stories that they may get raped when going to the shops'. Some teenage clients were perceived not to listen to or understand nurses' advice because 'they follow their peer group' and 'want to experiment', and in the words of one nurse 'once they have tasted sex, it's quite impossible for them to leave it, they are already in their ways'. Nurses said that this frustrated them and was a source of substantial stress because they felt they provided important messages which were constantly ignored. Consequently many said that they could not deny sometimes scolding teenagers; as one nurse explained, 'the idea of such a young girl falling love and having sex' was why they were harsh to them. Several also mentioned that overwork and tiredness contributed to nurses' attitudes, as well as the fact that clients sometimes told lies to the nurses, who would then 'react' to them. Nurses characterised lying teenagers as 'cruel', said they 'plan their false statements outside' and didn't 'recognise you to be a professional who knows some of the things she says'. The lies were mainly excuses for 'defaulting' or related to attempts to use the injection to abort.

When asked, most nurses thought that the comments and lectures about the dangers of early sex would not prevent adolescents from attending clinic. One nurse even said 'they enjoy it, they're not afraid, as long as you are not harsh with them', while another perceived that being open in 'highlighting this information' provided teenagers with the opportunity to discuss their fears with the nurses. Many nurses perceived that even if it did cause adolescents to be reluctant to come to the clinic, they were obliged to provide the lectures and ask the questions, primarily because they felt that teenagers 'must know that they are still very young'. One nurse for

example related how a teenage client had told her that she had friends who were too afraid to come to the clinic, but she perceived that nonetheless it was ‘necessary’ for her to ‘interview and give advice’ to all sexually active teenagers. Several nurses suggested that a more important obstacle to teenage access was a reluctance on the part of adolescents to ‘expose’ that they were sexually active (‘it’s her secret, and it’s a scandal for nurses to know’), presumably because they were repeatedly told that it was wrong.

Interestingly, nurses experienced retaliation when they encountered teenagers outside their clinical domains. One township nurse for example commented that “*they are cooperative in the clinic but outside they’ll start pointing at you, saying ‘there’s that woman who was asking all those questions’, you try to ignore them, but then the others will say ‘hey! she can’t ask all those questions’, and then you feel small because you are outside the clinic*” (when asked which questions she thought teenagers objected to, the nurse mentioned the following: why do you have sex so young, why do you wear mini-skirts, why do you want to start contraception at 14). The clinic was thus perceived to be a space where nurses’ authority was paramount and unchallengeable and where nurses had the freedom to say and ask what they wanted.

Several nurses admitted to being afraid of teenagers in schools, in the words of one nurse, ‘they are very naughty, they challenge you, they cross-question you, questioning about something they already know so they can find out how far your knowledge goes, or maybe they just want to embarrass you’. This nurse also reported that boys, in particular, were liable to ask the nurses’ age, and then reply, when the answer was ‘over 40’, that ‘you’ve enjoyed your life, now don’t stop us enjoying ours’. Another nurse narrated how during one session at a school the class asked her what her parents had died of, and when she said sugar diabetes, they replied ‘so they didn’t die of AIDS and STDs, but these diseases will always be around so we have to have sex, because even if AIDS wasn’t there we would still die’. These comments from the teenagers, who evidently gain confidence in groups, are clearly strategies of resistance against the perceived intrusions and moralising of nurses.

### *3.5.6 Perceptions of nurses’ roles*

Nurses perceived that it was their responsibility to discourage teenagers from being sexually active and teach them ‘right and wrong’, and particularly felt that they had to fill this role because parents failed to educate their children about sexual matters due to a cultural taboo against inter-generational discussion of sex, based on a perception that such communication was ‘shameful’ and would amount to ‘giving permission to go and mess with boys’. Interestingly, one older nurse (who admitted that she found it impossible to talk to her own

daughters about sexual matters) felt that although giving ‘lectures’ on sex to teenagers was advisable, ‘it’s a tough job, because I consider them to be children’, a comment which indicates that she perceived inter-generational discussion of sex to be problematic, even within her professional nursing role. Many nurses, however, were critical that parents were ‘afraid’ to educate their children about sex, saying that this contributed to teenage pregnancy and that teenagers simply acquired false information from peers instead. One nurse at an urban clinic challenged the perception of taboo: ‘it’s not correct when people say it’s not our culture to speak of it (sex), because they are doing it there at the mountains (at initiation school)’. However, some argued that they understood parents’ reluctance and thought that it would be preferable for sexuality education to be given in schools and clinics rather than at home.

Most nurses said that giving contraception to young teenagers did not make them ‘feel very good’, although they were somewhat consoled by the thought that they were helping to prevent adolescent pregnancy and early educational drop-out. Nurses perceived that if a teenage client insisted on being given contraception, they had to provide it because if a client had been refused a method and subsequently became pregnant, the nurses would be blamed for the pregnancy. One nurse explained that they had been taught on a course that a nurse ‘cannot deny a person of her rights, so we should give (contraception) but explain the consequences thereof’. Some informants, however, said that they knew of colleagues who refused to give contraception to teenagers or refused to give it without parental consent.

#### **4.0 Discussion**

##### *4.1 Nurse-adolescent relationships*

From the teenagers’ perspective, one of the most visible themes which emerged in the course of the research was their experiences with what they perceived to be obstructive, judgmental and moralising attitudes from many clinic nurses. In some cases teenagers said that they themselves had considered defaulting from contraceptives because of the derogatory way in which nurses had reportedly dealt with them, while others said they had friends who were reluctant to go for contraception out of fear that the nurses would scold them for being sexually active or would refuse to give them the method. This supports anecdotal evidence that fear of verbal harassment from nurses is an important barrier to contraceptive use among adolescents.

Many nurses for their part admitted that they occasionally scolded or were ‘harsh to’ teenage clients, and factors which contributed to this were said to be overwork, low pay, and frustration with clients who lied and played games with them (such as forging the dates on the clinic cards, and trying to use the injection to abort when pregnancy was suspected). Another important factor was that nurses felt concerned that teenagers should know that they were too young to be

sexually active, and perceived it to be their responsibility to tell them. In particular, they explained that they felt it necessary to provide teenage clients with 'advice' about the physical and emotional dangers of early sexual activity, challenge them for being sexually active at such a young age and 'encourage' them to practise abstinence, even if this discouraged some from seeking contraception. Nurses had several motivations for this, in particular their concerns about the prevalence of STDs, HIV/AIDS and cervical cancer, their observations about the social consequences of teenage pregnancy (especially educational drop-out and malnourished children), and their perception, despite considerable depth of understanding about peer pressure and the sometimes forced circumstances of teenage sex, that contemporary teenagers had 'low morals' and regarded sex as a 'game' (rather than as an activity to be reserved for marriage).

Although nurses' comments to teenagers are clearly well-intentioned and derive from valid concerns about their sexual and emotional health, the fact that they are often expressed in (what adolescents perceive to be) a judgmental and moralising manner, must be recognised to be a serious problem which evidently has a very detrimental effect on teenagers' willingness to obtain and use contraception. If only because of the seriousness of these consequences, nurses need to be provided with the opportunity to think with more awareness about the effects of these messages and the way in which they are expressed. This opportunity could be provided in the form of value clarification workshops and extra training courses which build on the very notable degree of understanding which nurses exhibit about the circumstances and nature of teenage sex.

In this study there was an obvious conflict between teenagers and health workers in the different ways in which each constructed nurses' ideal roles and responsibilities: while nurses perceived their primary role to be to provide moral guidance and information to teenage clients, teenagers perceived that it ought to be to attend to their contraceptive needs in a professional, straightforward and mainly clinical way. Nurses could be encouraged to think constructively about how to reformulate their professional relationships with adolescent clients. Some teenage informants in this study indicated that adolescents perceived that nurses sometimes transgress their prescribed role as health workers (for example by asking what they perceive to be particularly personal and irrelevant questions about their sexual behaviour). This is an important point, because the words of some nurses also indicated that they did not entirely see teenage contraceptive clients straightforwardly as *clients* who have certain informational and clinical needs just as adult clients do, but as *children* who behaved badly and so ought to be told off verbally. Another example was a nurse who said that she found it 'tough' discussing sexual matters with clients whom she perceived to be 'small children', a comment which suggests that

she did not see herself as a health worker in those situations, but as an elder woman having to convey to a 'child' information whose inter-generational transmission (many argue) is taboo. This perception of teenagers as *children* helps nobody, particularly not the client herself (who likely as not will continue to be sexually active), and is at the root of the judgements and 'scolding' which many teenagers find so off-putting. If teenage clients were to be regarded as *autonomous individuals* who want to prevent pregnancy and so have specific contraceptive needs, and these straightforward clinical needs were to be dealt with and respected without moral judgement, it is likely that many more adolescents would be willing to obtain and use contraception, and more unwanted teenage pregnancies would be prevented.

#### *4.2 Management of side-effects*

Nurses were often reluctant to change clients to a different method and in some cases this contributed to teenagers' defaulting. The approach seemed to be in part a consequence of nurses' lack of confidence in dealing with side-effects because of inadequate training. It was also caused partly by the construction (by some nurses) of the majority of side-effects as either psychosomatic conditions or 'minor ailments', and the perception that the body would take time to adjust to the hormonal content of the method. However some nurses indicated that the clinics had a very limited range of choice of methods, and this affected their approach to side-effects. Nurses also seemed generally reluctant to prescribe oral contraceptives to teenagers on the grounds that they were not responsible enough to remember to take it every day, and this obviously contributed to a reluctance to change adolescent clients experiencing side-effects on Nuristerate to the pill.

#### *4.3 Contraceptive methods*

An important observation from this research is that nurses were generally unfamiliar with the concept and dosage of emergency (post-coital) contraception (two-tablets of a high oestrogen oral contraceptive such as Ovral, taken twice at a 12 hour interval, within 72 hours of intercourse). This is a potentially very important service which could be more widely publicised and made use of and which may be particularly useful for teenagers, who are likely to have higher levels of unplanned, spontaneous and unprotected sex than other women.

Three other comments can be made about methods. Firstly, it would be preferable if nurses could find a way around having to write down in the ledger the names of individual clients who are given condoms, as teenagers in particular see this practice as off-putting because of the lack of confidentiality it potentially entails. Secondly, it could be beneficial if oral contraceptives were more widely promoted as an option equal to Nuristerate. The current perception among

teenagers and some nurses is that the pill is unreliable because if one is forgotten, pregnancy is likely to occur (this is not technically the case as a double dose the next day can be effective). A less rigid view of this method would benefit at least those adolescents who default from Nuristerate because of debilitating side-effects. Thirdly, as nurses at one clinic pointed out, Schering's clinical leaflet dictates that after the initial four doses of Nuristerate, contraceptive protection is acquired for 13, rather than 8, weeks. If this were more widely known by nurses, it would have important implications for how defaulters are managed. Currently women who are a few (often as few as two) days late for a repeat dose are told to return when they menstruate (and use condoms in the meantime), or get a pregnancy test from the hospital before they can be injected again. However, given Schering's instructions, nurses can in theory immediately give a repeat dose to women who have defaulted, as long as they have previously had four doses of Nuristerate and it is within 13 weeks of the previous dose.

#### *4.4 Provision of information*

One of the greatest needs of teenagers is clearly information, particularly because they reported not receiving it at school or home (and in some cases were deliberately denied access to it). The implementation of comprehensive sexuality education in schools must remain a national priority. Particular queries were about the different contraceptive methods and their effects on the body, and the types of STDS and how to prevent them. Some teenagers stated that they felt unable to ask nurses for information about methods or ask for explanation about the causes and implications of side-effects which they were experiencing, because they perceived that the nurses were too busy or because they were afraid of how the nurses would react to such questions. The majority of teenage informants had queries for the researchers, mostly focusing on the availability of methods and differences between them, and on the causes and significance of side-effects.

These informational needs could be usefully addressed by nurses and by leaflets, as long as issues are discussed in lay terms. A good example of such a leaflet is one called *Nuristerate: Because having a child is a woman's choice* which is produced by Schering but which was not available in any of the 14 clinics visited for this research. It describes how Nuristerate 'works' to prevent conception (by stopping the 'egg nests from making new eggs'), how long it can be used for (as long as contraceptive protection is required, with annual check-ups) and how it can 'affect' you (it stops the womb from 'building up a nourishing lining making it unsuitable... for 'planting' a baby', and 'the longer the injection is used the less the lining build up...so there may not be a period at all'). This leaflet addresses in lay terms some of the concerns expressed by teenagers, although important ones are omitted, such as whether (and why) return to fertility

is often delayed after using Nuristerate. When nurses do provide information to teenagers, they need to take care of the way in which they express it, as some of it may come across as misleading. In particular, teenagers in one focus group said their friends had heard directly from nurses that the injection caused infertility.

#### *4.5 Pregnancy testing in clinics*

Nurses and clients alike would benefit from having a pregnancy testing facility in the clinics, in particular because currently women who are late by a few days for their repeat dose of the injection or women who are not menstruating on their first visit to the clinic are sent to the hospital for a pregnancy test (or told to return when menstruating). In the latter case, not having pregnancy testing in the clinic puts women at increased risk of pregnancy, as due to the effects of the injection on the menstrual cycle, some women may not menstruate again until several months later and in the meantime they may be unprotected from pregnancy (particularly because condoms are generally unacceptable).

## **5.0 Recommendations**

From the findings of this study we recommend that:

1. nurses who provide contraceptive services should receive continuing education, including training on flexible management of side-effects, emergency contraception and pregnancy testing;
2. value clarification workshops be held with nurses around adolescent sexuality, adolescent contraceptive needs, their responsibilities towards teenage clients and client autonomy;
3. regular on-site supervision is introduced and that managers make clear their intention to take disciplinary action against nurses who breach professional ethics by scolding clients or refusing to provide contraception;
4. the family planning training curriculum be revised to focus on problem-solving rather than rigid prescriptions for method use;
5. comprehensive sexuality education, including information about contraception (pre- and post-coital), be implemented in schools;
6. information leaflets be made available for contraceptive clients in clinics;
7. a pregnancy testing facility be made available in clinics and all nurses trained to do tests;
8. the accounting rules be changed so that nurses need not record the names or precise numbers of clients who are given condoms.

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