Factors Influencing Emergency Contraceptive Use: Perspectives of Students in Durban, South Africa

by

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Abstract

Emergency contraception (EC) has been identified as an effective method of preventing pregnancy after unprotected sexual intercourse. This study sought to determine the perspectives and experiences of users of emergency contraception. The study draws on qualitative data from in-depth interviews with 20 female students at a university in Durban, South Africa. The study found that respondents used emergency contraceptive method because they were not using other methods of contraception to prevent pregnancy. They gave a number of reasons for preventing unplanned pregnancy including the desire to complete their education, their lack of financial stability and their unstable relationship status. Respondents revealed that they feel that EC is an effective method to prevent pregnancy, although some women who fell pregnant indicated that they needed more information and guidance about why emergency contraception sometimes does not work effectively and results in pregnancy. Furthermore, the study indicates that health care facilities, cultural and religious beliefs are the main barriers for young people not accessing contraceptive methods. Thus, the study recommends that there should be more research done on the effectiveness of use of EC. Proper training of health care providers on how to address young people when they seek health services is recommended.

Key words: Emergency contraception, sexual behaviour, unwanted pregnancy, young people.

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“For I know what I have planned for you, “says the Lord”. I have plans to prosper you, not to harm you. I have plans to give you a future filled with hope.”

Jeremiah 29:11

List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
DoH	Department of Health
EC	Emergency contraception
ECP	Emergency Contraception Pill
HIV	Human Immune-deficiency Virus
KZN	KwaZulu-Natal
ICPD	International Conference on Population and Development
ICEC	International Consortium for Emergency Contraception
IDI	In-depth Interviews
IUD	Intrauterine Device
MAP	Morning after Pill
MRI	Medical Rescue International (MRI)
SAMCC	South Africa Medicines Control Council
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
STD	Sexual Transmitted Disease
UKZN	University of KwaZulu-Natal
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Figures and Tables

Chapter One: Introduction and Background

1.1 Introduction

Every year there are at least 20 million abortions, many of them being unsafe and subsequently resulting in maternal deaths, most of these abortions occur in developing countries (Grimes *et al*., 2006). This might be attributed to a number of factors including limited information and barriers in accessing public health care services in developing countries (Free *et al*., 2002). Croxatto and Fernandez (2006) assert that if emergency contraception (EC) was available and accessible without barriers, the number of unplanned pregnancies and the number of induced abortions is likely to decline. South Africa has a high rate of unwanted pregnancies and this is most evident among young people (Department of Health, 2003). Wood and Jewkes, (2006) indicate that young people in South Africa become pregnant before the age of 20, despite contraception being widely accessible at public health facilities. A study conducted by Macphail *et al.,* (2007) on contraceptive use and pregnancy among young women, reported that 65% of pregnancies were premarital and unplanned. Thus, it is important for young people to access information on sexual and reproductive health because they might know about different contraceptive methods available in health facilities in South Africa.

Over the past few years, new methods of contraception have made a major contribution to family planning programs as young people can avoid unwanted or unplanned pregnancy and abortions by permitting improvements in the timing of childbirth (Simmons *et al*., 1997). South Africa has several contraceptive methods that are offered in health care facilities such as condoms, oral contraceptives, emergency contraception and injection. Therefore, health professionals can advise young women to use EC when they had engaged in unprotected intercourse so that they may prevent an unintended pregnancy. According to the United Nations Population Fund (UNFPA) 60% of South African girls and women aged 15-49 use modern contraceptives, a rate far higher than the sub-Saharan average of 20% and global average of 57% (Blaine, 2012). Moreover, A study conducted in four provinces in South Africa (KwaZulu-Natal, Mpumalanga, Gauteng and Eastern Cape) found that 9.3% of young women were using the pill, 5.2%

intrauterine devices (IUDs), 25.6% injectable, 57.6% male condoms, 5.9% female condoms and 8.9% dual methods (Seutlwadi *et al*., 2012).

The International Conference on Population and Development (ICPD) stated that they will place people firmly at the centre of development so that they are more involved in the initiation of sexual and reproductive health programs and are not passive recipients of external inputs (Castle *et al*., 2002). This helps the society to take actions on the family programs introduced to them, whether they understand different contraceptive methods available to them. The conference held in Cairo identified different contraceptive methods that could be used by women to protect themselves against pregnancy in cases of unprotected sexual intercourse (Castle *et al*., 2002). In that conference emergency contraception was highlighted as a useful pregnancy prevention measure for women. Emergency contraception is an important option for women who recently have had unprotected intercourse or experienced contraceptive failure and who do not want to become pregnant (Castle *et al*., 2002).

Research shows that current programs often do not match the needs and health-seeking behaviours of young people. Behavioural theories argue that young people must be educated about generic and health-specific skills necessary for adopting healthy behaviours (Hughes and McCauley, 1998). Thus, there is a need for sexual education programs and awareness of sexual reproductive health in schools and at the tertiary level in order to assist young people who are not aware of preventative measures used to protect themselves from unsafe intercourse. Ehlers and Phil (2010) assert that effective use of contraceptives can allow young people to develop into mature adults, as they can complete their schooling and start their lifelong careers, become economically independent and begin childbearing when they are financially stable. It is important to mention the methods that will reduce unintended pregnancy in order for students to pursue their studies and avoid raising a child without a support as a result of an unplanned pregnancy. For example, a study in Nigeria found that most schools in Nigeria do not permit pregnant girls to remain enrolled, so the pregnant woman is likely to abandon her education (Nichols *et al*., 1986).

1.2 Rationale for the study

WHO (2005) describes emergency contraception as a method that women can use within the first few days after unprotected sexual intercourse or in the event of potential contraceptive failure to prevent an unwanted pregnancy. EC is also known as the postcoital or morning after pill, and can be taken within 72 hours of unprotected sex (Faúndes *et al*., 2007). Emergency contraceptive pills (ECPs) are important in helping women to avoid unwanted and unintended pregnancy. This hormonal contraceptive method acts by inhibiting or delaying ovulation or by preventing fertilization of an egg (Faúndes *et al*., 2007). Furthermore, Weisberg and Fraser (2009) states that EC offers women a safe means of preventing pregnancy following unprotected sexual intercourse or contraceptive failure, and it is accepted as a legitimate method of fertility control.

A study demonstrates that young people are poorly informed about sexual and reproductive health issues such as family planning programs (Hughes and McCauley, 1998). Tertiary students form an important high-risk group in the community. According to Roberts *et al*., (2004), tertiary students are at much higher risk of unprotected sexual behaviour because they are more likely to experiment and explore all kinds of activities such as alcohol, using drugs, engaging in unprotected sexual intercourse and they are more likely to experience peer pressure. With poor knowledge, some young people may face problems of unwanted pregnancy because they do not know the methods used to prevent pregnancy or family planning programs available to them. Kitshoff (2010) states that one may assume that tertiary students may know of available methods of contraception because of the higher levels of education they have obtained. Thus, it is important for this study to focus on university students to explore their perspectives and experiences on using EC in order to get information on their reasons in using EC method.

1.3 Objectives of the study

The overall aim of this study is to investigate factors influencing the use of emergency contraceptive among young people attending a university in Durban, South Africa.

The specific objectives are to:

- Explore experiences and use of emergency contraception among young women
- Investigate factors facilitating and inhibiting use of EC
- Opportunities and constraints in changing protective behaviours

Some of the key questions that guides the study:

- What is the main reason for using EC?
- What is the main source of information about EC?
- What are the experiences of young women using EC?
- Have students experienced barriers in obtaining EC from health care facilities?
- What are factors that inhibiting the use of EC?
- What are factors facilitating use of EC?

1.4 History of family planning in South Africa

The history of contraceptive provision in South Africa is influenced by many factors including urbanization; socio-economic development; women‟s education, cultural norms and beliefs; religious beliefs and knowledge and attitudes of individuals (Department of Health, 2003). At the end of the 1930s, the white population birth rates decreased while the black population rapidly increased. Therefore, with the rapid population growth in the country in the 1960s, the white government decided to initiate new family planning programs and policies that will respond to the growth of the black population (Department of Health, 2003). In the late 1960s, the government launched a national family planning program. The political rationale for family planning was primarily to control the black population in order to reduce the non-White population growth rate (Department of Health, 2003). The government promoted family planning programs as a means of improving the health and status of women and children while decreasing the rate of population growth. The program was relatively successful in facilitating a decline in fertility by increasing access to family planning services and increasing contraception use (Cooper *et al*., 2004).

South African health legislation since the end of apartheid in 1994 has been characterized by a strong policy obligation to reproductive health, rights and equity (Cooper *et al*., 2004). As a result of a broadly consultative process, South Africa, over the years, has formulated a reproductive health policy package that is widely accepted as one of the most progressive in the world. Reproductive health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matter relating to the reproductive system and to its functions and process" (Castle *et al*., 2002:21). "Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed or to have access to be safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulating of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (Castle *et al*., 2002:21).

Contraception policy and the promotion of emergency contraception, in particular, offer a useful platform for a critical analysis of the policy context surrounding reproductive health in South Africa since 1994. Contraception policy formulation has also corresponded with an increased global understanding of the importance of EC to the reproductive rights and the health of women (Cooper *et al*., 2004). In the Department of Health‟s Framework for the National Contraception Policy Guidelines, EC is graded as an essential contraception option that should be more actively promoted, especially among young people (Department of Health, 2003). The guidelines states that ECPs in the form of regular oral contraception pills should be available at all levels of service delivery but acknowledge that they are currently require more wide promotion (Department of Health, 2003).

1.5 Availability and cost effectiveness of EC

Family planning is the most effective and cost effective way of giving young people a chance to plan their own lives (Blaine, 2012). South Africa is one of the many countries that make emergency contraception pills available directly to those that need them without a prescription. In 2000, the South Africa Medicines Control Council (SAMCC) reclassified ECPs so that pharmacies could sell them without a prescription by eliminating the barriers associated with obtaining a prescription from health care provider within 72 hours of unprotected intercourse (Blanchard *et al*., 2005). Therefore, women will not need to go to their doctor for a prescription, which takes a longer time. This is important since ECPs should be taken as soon as possible after unprotected intercourse for those women who are not planning to have a child. Blanchard *et al*., (2005) states that pharmacies are useful to women during holidays or weekends because EC is available over the counter, there will be no need for a prescription that will delay the uptake of the method. In addition, pharmacies have less restricted operating hours and are open on weekends and after hours, which could explain the higher uptake of EC, regardless of the costs involved. Smit *et al*., (2001) argue that by making EC more affordable through pharmacies or other similar facilities, providers may enhance the provision of information and access to improve public health sector information and distribution.

Contraceptives including ECPs are widely available free at public health facilities in South Africa (Mqhayi *et al*., 2004). As a result, women should access these services if they find themselves in a situation of unprotected intercourse, being raped, or failure to take the oral contraception or the condom had burst. Health professionals‟ point out that ECPs are cost-effective and relatively safe compared with a surgical procedure or childbirth (Harper and Ellertson, 1995). Thus, women should rely on useful and safe methods to prevent unintended pregnancy. Emergency contraception reduces expenditures on medical care by preventing unintended pregnancies, which are expensive (Trussell and Calabretto, 2005). Since the early 1990s, there have been a number of efforts to increase access to ECPs as a cost effective measure to prevent unintended pregnancies and abortions (Harper and Ellertson, 1995). Therefore, the provision of

family planning limits the number of abortions and unplanned pregnancies in the country. Ellertson *et al*., (1995:256) assert that " postcoital contraceptives are inexpensive to produce, their cost is low to donor agencies and to governments providing subsidized contraception in developing countries, as well as to potential consumers in the private sector", thus women who cannot afford it can get it free of charge in public health facilities.

There are different types of emergency contraception pills available worldwide. In South Africa Norvelo, Ovral, and Nordette are commonly provided (Koch, 2011). Norvelo was introduced in 2001 and must be taken within 120 hours after unprotected sex; this is considered the most effective emergency contraceptive (Koch, 2011). The cost of Norvelo is relatively expensive in private sectors and pharmacies in South Africa (Mqhayi *et al*., 2004). Ovral is a regular oral contraceptive which can be used as EC; a woman takes two pills within 120 hours after unprotected sex and two more 12 hours later (Koch, 2011). Nordette is a combined oral contraceptive which can be used as EC, and a woman takes four pills within 120 hours after unprotected intercourse and four more 12 hours later (Koch, 2011). Smit *et al*., (2001) found that EC is pre-packed by dispensary staff and is seldom accompanied by written instructions for users.

Other emergency contraception pills that can be obtained world-wide are the progestin-only method uses the progestin levonorgestrel regimen in a dose of 1.5 mg (Ellertson *et al*., 1995). The levonorgestrel regimen of emergency contraception has two historical differences from the other regimens. First, this regimen was largely discovered and refined in developing countries (Ellertson *et al*., 1995). Second, the regimen was originally developed as an on-going postcoital method, although it has been studied subsequently as an emergency regimen. Levonorgestrel is currently the only postcoital contraceptive available in two separate postcoital regimens. In the emergency regimen, a woman takes 1.5 mg of levonorgestrel separated into two doses 12 hours apart and initiated within 48 hours of unprotected intercourse (Ellertson *et al*., 1995)

The Yuzpe Regimen was discovered more than 40 years ago by the Canadian physician Albert Yuzpe (Ellertson *et al*., 1995). This consists of elevated doses of regular combined oral contraceptives that could be used postcoitally to prevent pregnancy. The Yuzpe regimen consists of 200, mg of ethinyle stradiol and 1.0 mg of levonorgestrel, the same amount of hormones found in four tablets of a brand of combined oral contraceptives commonly used at the time. The total amount is divided into two equal doses, taken 12 hours apart, and initiated within 72 hours of unprotected intercourse (Ellertson *et al*., 1995). Hormones that make up the Yuzpe regimen are readily found in many brands of combined oral contraceptives that are currently available, although low-dose formulations may require women to ingest four tablets per dose instead of two (Trussell *et al*., 1992).

The synthetic steroid danazol was first tested in the early 1980s as an emergency contraceptive producing fewer side effects than the Yuzpe regimen (Rowlands *et al*., 1993). The regimen consists of 600 mg of danazol taken within 72 hours after unprotected intercourse and another 600 mg taken 12 hours later. Derived from ethisterone, danazol is used to treat endometriosis as well as certain forms of angioedema and fibrocystic breast disease (Trussell *et al*., 1992). The postcoital danazol regimen has a lower incidence of nausea, vomiting, and breast tenderness than does the Yuzpe regimen. One study by Rowlands *et al*., (1993) cited in Ellertson *et al*., (1995) found a six-fold decrease in the incidence of nausea.

In the late 1970s, Lippes and his colleagues discovered that copper-bearing intrauterine devices (IUDs) could prevent pregnancy when inserted within five days after intercourse (Lippes *et al*., 1976). Another research has suggested that depending on the day of unprotected intercourse, this method may be effective for up to seven or even 10 days postcoitally. Several brands of IUDs contain copper and may, therefore, be used postcoitally. Advantages of the method include its longer time frame for administration, absence of side effects, the on-going contraceptive protection it gives women who opt to leave the IUD in place following emergency insertion, and a failure rate that may be minimal (Ellertson *et al*., 1995). The IUD insertion can cause discomfort and requires

trained staff and facilities (Cheng *et al*., 2008) and an IUD may cause cramping and bleeding during the first few days after insertion (Stewart *et al*., 2007).

1.5.1 Rights and regulations on EC

Weisberg and Fraser (2009) argue for the rights for women in using emergency contraception. They state that women either alone or in consultation with their partners have a right to choose from a variety of safe contraceptive methods, which must include EC and the decision of an individual woman to use EC needs to be respected. They continue to state that since there are no serious contraindications to this safe method, women must have the right to obtain EC without compulsory counselling, insistence on STIs checks or moralistic questioning by either medical practitioners or pharmacist (Weisberg and Fraser, 2009). However, they argue that the pack of EC should have adequate, easily understandable information in simple, non-medical language about how to use it, efficiency rates and information about STIs for women that require more information about EC. Furthermore, they argue that women have the right to obtain EC over-the-counter without intrusive questioning about their sex life and there should be no age restrictions for young women under 18 years of age. Women should have the right to access EC from a variety of sources dependent on their convenience, the cost of the product and their preference for provider which could be a doctor, nurse or pharmacist. Lastly they indicate that there should be no legal or religious impediments to availability of EC (Weisberg and Fraser, 2009).

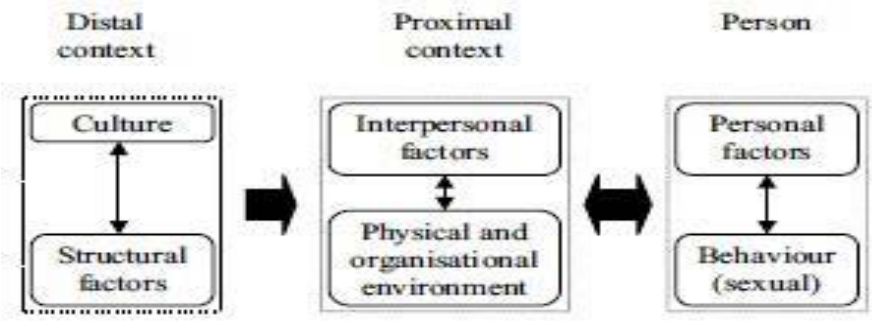
1.6 Theoretical framework

Most interventions focusing on the sexual and reproductive health of young people over the past years have arisen in response to two primary concerns: reducing early age childbearing and the spread of HIV/AIDS. The theoretical perspectives that have the most effects in shaping these programmes are the cluster of health behaviour theories (Hughes and McCauley, 1998). Thus the theoretical framework that will guide this research is based on a model developed by Eaton *et al*., (2002) which discusses the

factors promoting and perpetuating unsafe sexual behaviour among South African youth. Many theories have been applied to understand sexual-risk behaviour; these theories include the Health Belief Model; Theory of Reasoned Action; Theory of Planned Behaviour and Social Cognitive Learning Theory.

It is important to consider the model of sexual behaviour for this research because its helps to understand the social, personal, and cultural context that influences young people. The model identifies three levels: within the person, within the proximal context and within the distal context. Personal factors include "cognitions and feelings about sexual behaviour relating to behaviour HIV/AIDS, as well as thoughts about one‟s self (such as self-efficacy and self-esteem), the proximal context comprises interpersonal relationship, the physical and organizational environment and lastly the distal context includes culture and structural factors" (Eaton *et al*., 2002:2). Personal factors and the proximal and distal contexts interact to encourage risk behaviour in ways that are not fully captured by social-cognitive models and these models are useful to the study of young people‟s sexual behaviour and prevention in developing countries (Eaton *et al*., 2002). By applying the model developed by *Eaton et al*., (2002) it will help in investigating individual‟s perceptions about their risk of pregnancy and their reasons for using the EC method. These factors are explored using qualitative research methods in order to gain a more detailed understanding of the experiences of young women who had ever used EC. Figure 1.1 below indicates the model developed by Eaton *et al*. (2002).

Figure 1.1 Model of Sexual Behaviour developed by Eaton et al., (2002): personal factors, proximal and distal contexts



Source: Eaton *et al*., (2002: 150)

1.7 Structure of the thesis

This dissertation consists of five chapters. Chapter one examines the rationale for the study and provides background information on emergency contraception in South Africa. Chapter two reviews existing literatures that broadly discusses factors facilitating and inhibiting use of emergency contraceptive in South Africa, other developing countries and developed countries. Chapter three outlines the research methodology used in this study and outlines the sampling strategy, data collection procedures, and limitations of the study. Chapter four outlines the findings from the in-depth interviews, which are tape-recorded, transcribed and analysed. The findings from this chapter highlight the dynamics of female emergency contraception use. The chapter presents experiences of young women in using emergency contraceptive pills and their knowledge and perceptions of the method. Chapter five provides a discussion of the main findings and recommendations for future research.

Chapter Two: Literature Review

2.1 Introduction

It is important to begin with a review of relevant studies on emergency contraception that focus specifically on South Africa and the rest of the world. The review will look at knowledge and source of supply of emergency contraception and assist in identifying factors facilitating and inhibiting use. Theron and Grobler (1998) states that family planning is necessary as it holds advantages for every family member, and prevents the serious social and ecological effects of overpopulation at national and global levels.

2.2 Reason to use or advantages of EC

According to Mqhayi *et al*., (2004), some women use emergency contraception because they are raped and they may not be prepared to have a child so EC is the option available to them to prevent that unplanned pregnancy. In order to take advantage of emergency contraceptives, women at risk of pregnancy who do not wish to become pregnant must be aware that unprotected mid-cycle intercourse has taken place, and must know about and have urgent access to emergency contraceptives (Trussell and Raymond, 2012). In the study of public health facilities in rural KwaZulu-Natal and in urban areas of Gauteng researchers found that of those women who had heard of EC only one woman gave a burst condom as her reason for using EC, while the other said she had missed her periods (Mqhayi *et al*., 2004). Trussell and Raymond (2012) assert that there are no studies that show births to women who have already been pregnant when they used EC.

Harper and Ellertson (1995) in their study found that university students gladly gave support to emergency contraceptive pills especially for women who had less control over the act of unprotected intercourse. It shows that EC is very important for women because they may use it when they are raped or when they are not prepared to have a child. Some students thought that although the ECPs is not the most satisfying treatment to take, acting fast to avoid pregnancy is more responsible than delaying until abortion is the only option (Harper and Ellertson, 1995). Stewart *et al*., (2007) observe that EC is a safe,

backup method if the contraceptive method fails and after use fertility returns to normal unless a contraceptive method (such as injectable or condoms) is continued.

2.3 Disadvantages for using emergency contraception

Trussell and Calabretto (2005) argue that the side effects of EC had shown no deaths or major difficulties. However they note that if ECPs is used often it will be less effective which could result in pregnancy, "if the typical woman used combined ECPs for a year, her risk of pregnancy would exceed 35% and if she used progestin only ECPs, she would still have a 20% chance of pregnancy" (Trussell and Raymond, 2012:11). Side effects include nausea and vomiting, abdominal pain, breast tenderness, headache, dizziness and fatigue (International Consortium for Emergency Contraception, 2000). These usually do not occur for more than a few days after treatment, and they generally resolve within 24 hours. About 50% of women who take combined ECPs experience nausea and 20% vomit (International Consortium for Emergency Contraception, 2000). If vomiting occurs within 2 hours after taking a dose, some health providers suggest that the woman should take another pill because its might happen that the medication was not effective (Trussell and Raymond, 2012). ECPs do not continue to protect against pregnancy during the rest of the cycle and it does not protect against sexually transmitted diseases (STDs), and does not treat existing infections (Stewart *et al*., 2007).According to Weisberg and Fraser, (2009) they argue that using EC recurrently will have a higher failure rate than using an oral contraceptive over a 12-month period.

2.4 Source of knowledge and awareness of emergency contraception

A major barrier to emergency contraception use in South Africa is a lack of awareness of the method (Klitsch, 2002) so better intervention is necessary to make the public aware so that they know of reproductive services that prevent unintended pregnancy. In their review of the literature, Maharaj and Rogan (2008) observed that in South Africa the level of awareness of EC is very low especially among public health sector clients. Mqhayi *et al*., (2004) indicated that women face problems accessing the method in health

care facilities and they often have limited information about the use of EC to protect themselves from unplanned pregnancy. Basic information on EC needs to become part of routine reproductive health counselling and specific health service interventions in order to improve EC awareness in South African and other resource-limited areas (Myer *et al*., 2007). Thus, information should be available to people at all times. It can be transferred through different sources including media (such as the television, radio, newspapers, and pamphlets), workshops conducted by qualified health professionals as well as through word of mouth which will assist an individual to make an informed decision about contraceptive methods. Gupta *et* al., (2003) had shown that individuals" exposure to mass media messages promoting family planning might affect their contraceptive use behaviour. As the media is influential in the lives, of young people they should be more programs on television and radio that will transfer messages or create awareness about the use of EC or other form of contraceptive methods in order to prevent unplanned and unwanted pregnancies. Exposure to messages broadcast through a variety of channels is currently the most effective way to change knowledge, attitudes and behaviour (Gupta *et al*., 2003).

A study conducted in Tanzania exploring the impact of multimedia on promotion of family planning and the contraceptive behaviour of women found that only 3% of women who had not been exposed to family planning messages in the media were using modern methods, compared with 18% women who had been exposed to a family message in the media (Jato *et al*., 1999). The media plays an important role to inform young people about the different contraceptive methods available in health sectors. A cross sectional study of four tertiary institutions in Nigeria assessed the knowledge and practice of emergency contraception among 600 undergraduate students (Nworah *et al*., 2010). Their results showed that 38.1% of students were aware of EC while only 8.5% used it, 34.7% of students indicated that their source of information about EC are friends while 20.6% indicated the media as a source of information. None of the participants cited family planning clinic as their source of information on contraceptives (Nworah *et al*., 2010).

Smit et al., (2001) argue that clients accessing public health facilities are mostly informed about EC from friends rather than from health professionals. WHO, (1980) study found that approval of friends or relatives was most frequently reported by women, the degree of social approval for each contraceptive method tended to reveal differential community knowledge and use of different contraceptive methods. Discussions help because knowledge is transferred through networking and working with diverse groups of people in the society. Most women indicate that it is better to be given advice by other women who have used the EC method because they get to know their experiences with different methods (WHO, 1980).

Little is known or documented about knowledge and use patterns of EC in South Africa (Mqhayi *et al*., 2004. Findings point to the need for access to a broader range of contraceptive options, and EC is an important method in this context (Mqhayi *et al*., 2004). Only about one in four women attending public health clinics in South Africa reported having heard of EC. According to a study conducted in three provinces of South Africa the levels of knowledge were lower in rural areas and among less educated and older women (Klitsch, 2002). Klitsch (2002) support this view pointing that awareness and knowledge of EC amongst young women is very low, especially in rural KwaZulu-Natal, despite the fact that it is available at no cost at public health facilities.

A recent study in a rural area of South Africa looking at age-specific fertility rates, showed a different bi-modal pattern, high premarital fertility among women aged 12-26 years and marital fertility among women aged 15-49 years. Pre-marital fertility counted for 47% of births among women aged 12-26 years (Mqhayi *et al*., 2004). Moreover, sexually active young urban women 76% were currently using a method of contraception, compared to young rural women 53% (Mqhayi *et al*., 2004). The authors believe this high rate of pre-marital fertility is an indication of a low incidence of contraceptive use before the first birth especially among young people. Many women usually begin using contraceptives only after their first birth (Mqhayi *et al*., 2004). It is likely that young women do not have sufficient awareness of EC. Women who do not know about reproductive health methods available to them may experience an unplanned pregnancy.

In an earlier review, Robinson *et al*., (1996) found that nearly all clinic managers interviewed knew that their facility offered emergency contraception, but 57% of women who knew of the method did not know if they could obtain it from the facility where they were interviewed. Moreover, even women who had heard of emergency contraception in general often were misinformed about its specific qualities (Robinson *et al*., 1996). Health facilities must inform women when they consult clinics; about ways of protecting themselves against unsafe sex as some women indicated that, they did not know about EC (Robinson *et al*., 1996). A recent review indicates a limited knowledge among women on the use of EC methods, especially how to use them, and where to get services (Maharaj and Rogan, 2008). Maharaj and Rogan (2008) indicated the lack of client knowledge of EC availability was related to poor information material or literature available in health facilities. In line with Smit *et al*., (2001) almost all of the women who had used EC had purchased it from private sources (doctors or pharmacies), suggesting a lack of awareness of EC availability at public health clinics. This may also indicate that women who know and use EC are of higher socio-economic status than other women. Most women either did not know if EC was available at the clinic they were attending, or thought that it was not available at the clinic (Smit *et al*., 2001).

EC use in public health facilities is very low, even though most South African women rely on the public health facility for their contraceptive supplies (Maharaj and Rogan, 2011).A major problem pertaining to the prevention of unplanned pregnancies is the reality that many young women obtain contraception services only after the initiation of sexual activities (Kallipolitis *et al*., 2003).This may be caused by lack of knowledge about the contraception services and that they have not been consulting the health facility for information so they realize only when they are pregnant that there are preventive methods to avoid pregnancy. A study found that many students did not know the period for taking emergency contraceptive pills or the method‟s chances of working effectively (Harper and Ellertson, 1995). Therefore, the providers may specify the important information about the method. Students in the study clearly indicated that they should be given as much information as possible so that they can participate in decisions about their reproductive health (Harper and Ellertson, 1995). This indicates that young people with

more information on sexual and reproductive health are more likely to make sound decisions on family planning.

Surveys among university and postsecondary students in several African countries found that a quarter to three-quarters of young people had heard of emergency contraception, but accurate knowledge about its use was minimal. In one study in Nigeria, 75% of students surveyed were aware of emergency contraception, but only 12% knew that the first dose of emergency contraception pill should be taken within 72 hours of unprotected intercourse (Arowojolu and Odekunle, 2000). In Ghana a study found that, only 11% of the students surveyed (22 of 196 surveyed) knew the correct period for starting ECPs (Baiden *et al*., 2002). Many unplanned pregnancies occur within a year after first sexual intercourse. For example, in Zimbabwe, Parker (2005) found that; among 16-year-olds delivering at Harare Maternity Hospital more than half of the 200 surveyed had become pregnant within just three months of starting sexual activity. Young people in general are not experienced in using contraception, and those young women who do initiate a family planning method often do not plan and have limited information or motivation to use it correctly and consistently (Parker, 2005).

Gold and Coupey (1997) in their study based on focus-group discussions with Princeton University students, who have convenient access to EC through their student health service, found a high level of basic awareness of the method within this group, but a lack of specific knowledge about appropriate use, and how the pill works. Students noted how rarely emergency contraceptive pills are discussed, and were curious to know more, they requested routine education on the method, as well as more general discussion (Gold and Coupey, 1997).

A study conducted in three main tertiary institutions at Durban showed that students had limited knowledge of emergency contraception (Roberts *et al*, 2004). The study indicated that there is a need for sexual and reproductive health interventions in tertiary institutions to further the knowledge of students because they are at higher risk of being sexually active. The study revealed that 56.5% had heard of emergency contraception. However,

only a few knew the specific methods of emergency contraception and only 11.8% knew the correct time limit in which it must be used. Only 7.8% knew how effective emergency contraception was in preventing pregnancy. 11.8% students had used emergency contraception and 50% responded that if they had to, they would use it or recommend it to a friend (Roberts *et al*., 2004).

Ehlers and Phil (2010) in their study of adolescent mothers‟ non-utilisation of contraceptives in Zimbabwe found that none of the 41 adolescent mothers knew about emergency contraceptives. Consequently, none of these 41 adolescents used emergency contraceptives to prevent an unplanned pregnancy (Ehlers and Phil, 2010). Most respondents were unemployed and their household incomes suggested that they lived in poverty, making the effective utilization of contraceptives important for their own as well as their children‟s survival (Ehlers and Phil, 2010). They did not use contraceptives because they had limited knowledge, wanted to prove their fertility by having a baby prior to using contraceptives or feared that contraceptives would make them infertile (Ehlers and Phil, 2010).

In another study, Kallipolitis *et al*., (2003) found that 30% of university students participating in the study did not know when ovulation takes place and 63.5% did not know when conception takes place; they also found that the students had little knowledge of contraceptive methods (Kallipolitis *et al*., 2003). Kallipolitis *et al*., (2003) therefore suggests that students should be taught and given proper guidance regarding contraception and when conception takes place. Netshikweta *et al*., (2002) in their study among pregnant nursing students; they found that most students had limited knowledge of the EC method regardless of being well educated and involved in a health care training. This lack of awareness among health care professionals is likely to affect the use of EC in public health facilities (Netshikweta *et al*., 2002).

2.5 Access to contraception and emergency contraception

Ellertson *et al*., (1995) argue that for women to use emergency contraception, they do not need only the knowledge about the method but also access to them and to a service-delivery system. Literature shows that there are still barriers when accessing emergency contraceptive in health care facilities especially for young people. Problems have been experienced in implementation due to provider resistance and services remaining inaccessible to many women, especially younger ones and those from rural areas (Mqhayi, *et al*., 2004).

A study conducted in the United States showed that students might not find it easy to go to the health centre after unprotected intercourse, since the visit would document that unprotected intercourse had occurred (Harper and Ellertson, 1995). Ultimately, the decision to take emergency contraceptive pills can itself be not easy (Harper and Ellertson, 1995). Sometimes students may fear to use ECPs. They might fear going to the health facility because they are afraid of ruining their reputation for not practicing safer sex. Researchers also argue that young people find it hard to consult in clinics because of fear of being judged by health workers (Harper and Ellertson, 1995). As a result, this increases the number of pregnancies because they may not use reliable contraceptive methods or they may resort to an abortion due to barriers faced in accessing emergency contraception (Harper and Ellertson, 1995).

2.6 Risky Behaviours

In a study examining attitudes to emergency contraception, students felt that access to emergency contraceptive pills would be problematic because it would encourage use of EC method in place of barrier contraceptives such as condoms; this indicate the concern that they may rely more on ECPs (Harper and Ellertson, 1995). Some students in the study suggested that ECPs could encourage many sexual partners because they are used after intercourse and because they might be substituted for methods that protect against sexually transmitted diseases (STDs) (Harper and Ellertson, 1995). This shows that some young women are taking responsibility for their behaviour, as they do not think about

pregnancy only but other infections that can be contracted after unprotected intercourse. Alcohol use could also result in unprotected intercourse and heightened risk of unplanned pregnancy. Students noted repeatedly that drinking decreases the likelihood of contraceptive use, and that alcohol consumption is common on campus (Harper and Ellertson, 1995). In a South African study, it has been documented that many young people involve themselves in sexual risk-taking behaviours such as unprotected sex, low levels of contraceptive and condom use and that they have different partners (Wood and Jewks, 2006).

Parker (2005) have shown that women who use ECPs, including women who have received them in advance or who have easy access through clinics, do not necessarily substitute more effective contraceptive methods such as condoms and engage in unprotected intercourse. People who are against the use of EC argue that over-the-counter availability will encourage unsafe sexual intercourse, increase multiple uses over a limited time period, undermine the use of more reliable methods of contraception and lead to increase promiscuity and pregnancy among young people (Croxatton and Fernandez, 2006).

2.7 Advance dosage on emergency contraception

"Making emergency contraception available in advance of need enables it to be used as soon as possible after unprotected sex, when it is most effective" (Whittaker *et al*., 2007:158). A study reveal that women given an advanced provision of EC did not engage in more sexual risk taking behaviours, but were more responsible for their sexual health (Meyer *et al*., 2011). Studies show that clinic policies promoting advance dosage of EC methods are influential, because women prefer the ECPs to be easily accessible (Whittaker *et al*., 2007). Glasier *et al*., (2004) in their study, they show that increased use of EC when women have advanced dosage available at home has not reduced the abortion rate; they indicate that some women do not see the risk of pregnancy and therefore they do not recognise the use of EC). Glasier *et al*., (2004) further indicate that

some health professionals do not promote advance supply of EC to women who consult in their health care facilities thus there is an increased risk of unintended pregnancy.

A clinical trial conducted by Gold *et al*., (2004) assessing whether providing an advance supply of EC corresponded with an increase in risk-taking behaviours among sexually active women. They found that at the twelve-month follow-up, those in the advance provision group were more likely to report having unprotected sex in the past six months, the study also suggested that advance provision increases use of EC and improves EC use following unprotected intercourse (Gold *et al*., 2004). Most studies found no negative effects in on-going contraceptive use or risky sexual behaviours. However, Belzer *et al*., (2005) found that women in the advance provision group were more likely to report having unprotected sex at the 12 month follow-up. Although EC use appeared to increase with advance provision, a related decrease in pregnancy was not seen. In addition, women in the advance provision group were more likely to use EC because they did not want to use other contraceptive methods (Belzer *et al*., 2005). A family planning service facility in Hong Kong indicated much use of EC, without encouraging the use of condoms or other contraceptive methods. These results suggest that advanced provision of EC, as a public health approach to lower unintended pregnancy may not work effectively (Lo *et al*., 2004).

2.8 Emergency contraceptive use: Comparing developing countries and developed countries

"Demand is growing in developing countries for sexual and reproductive health programs for young people on the other hand, little scientifically based evidence exists about which program or approaches are most effective in shaping healthy behaviours" (Hughes and McCauley, 1998:233).Research indicated that awareness is lower in South Africa than compared to Europe and North America. Nevertheless, is similar or higher than what has been reported in other developing countries such as India, Kenya, Mexico and Nigeria (Trussell and Calabretto, 2005). Mostly data on use of emergency contraception have come from developed countries, where most women have access to health services and

where contraception is usually provided in health facilities (Robinson *et al*., 1996). Therefore, there is a need for public awareness and researchers‟ need to further investigate this issue because one can hardly find recent statistics on the use of EC in South Africa. The studies were done many years ago which makes it difficult to compare them with recent trends on the use of EC in South Africa (Trussell and Calabretto, 2005).

In developing countries, where thousands of women experience unwanted pregnancies and an estimated 70,000 to 200,000 women die each year from problems related to secret abortions performed in unsafe conditions; only emergency contraception could save many lives by preventing unwanted pregnancies (Robinson *et al*., 1996). As a result, it shows that EC is not well known in developing countries. In the United States, for example, several family planning programs provide an emergency contraceptive kit and counselling on emergency contraception to women who seek family planning services. "The kits are provided in advance of need, in case a woman needs a backup method after a condom breaks or a diaphragm dislocates, or in case she is unable to use an on-going method correctly" (Robinson *et al*., 1996:73). While in developing countries health facilities often lack qualified staff and a place to provide confidential counselling; thus, many females face provider-related obstacles in obtaining such services and in receiving quality information and counselling regarding sexual health care or contraceptive methods (Ehrle and Sarker, 2011).

2.9 Gender inequity

Women are at risk of sexual violence and unexpected and unprotected intercourse, which make it difficult for them to control their fertility, as does their partners refusal to use certain contraceptive methods, like condoms (Ehrle and Sarker, 2011). In addition, many young unmarried women do not seek contraceptives and reproductive health services because they fear disclosing their sexual activity to the health provider and coming back with the information from the clinics may cause some difficulties to their partners, so they avoid going to health care facilities (Ehrle and Sarker, 2011). The role of gender inequalities and various forms of oppression in undermining women‟s power for making

independent decisions about controlling their fertility necessitating the use of covert contraceptive methods (such as the injections) that are easy to use privately (Wood and Jewkes, 2006). Therefore, male dominance in decision-making both in the family and in the community obstructs the choices of women to use family planning methods (Keele *et al*., 2005).Gender inequities often make it hard to address the issue of contraception for young people. While condoms are available to young people in many countries, lack of power within relationships can make it difficult, if not impossible, for young women to negotiate condom use with their partners. In many cultures, sex-related issues are rarely discussed, even between spouses (Parker, 2005). Many young women also experience coerced sex. Fourteen studies conducted in developing countries found that 15% to 30% of sexually active girls reported that their first sexual experience was coerced (Parker, 2005).

Wood and Jewkes (2006), in their study conducted in Limpopo indicated that male partners used manipulative strategies to try to stop their female partners from using contraceptives. As a result, women fear to use contraceptive methods because of the brutal behaviours they encounter from their partners. Other women from the study even mentioned that their partners tear the clinic card and throw the pills away thus some women became pregnant while others used contraception privately (Wood and Jewkes, 2006). The attitude of men is important in influencing use of contraceptives. Men argued that a woman who uses contraceptive methods might become promiscuous and other men condemned contraceptive use as it out of their control because women may use them secretly with the support from health workers (Keele *et al*., 2005).

Some other men stated in the focus group that "they widely agreed that the final decision to take emergency contraceptive pills is a woman"s decision, and that the role of the male partner depends on the nature of the relationship" (Harper and Ellertson, 1995:151). A problem that was brought up by both men and women in the focus groups is that men might use the availability of ECPs to pressure women into unplanned or unprotected intercourse (Harper and Ellertson, 1995). Women may face challenges of using the EC method more often because their partners are relying on it. Similarly, many women lack

control over their reproduction, even in places where contraceptives are mostly available (Ellertson, *et al*., 1995). Thus, male dominance in sexual matters prevents women from using family planning programs.

2.10 Culture

Cultural issues play a vital role in the decision making process as it guides people‟s beliefs. In this context, family planning efforts in African countries are not likely to succeed. Keele *et al*., (2005) argue that for the promotion of family planning to be successful in Africa, it must integrate modern contraceptive use with traditional beliefs, rather than replacing traditional beliefs with Western perspectives. The modern method could be effective when they are used in combination with traditional methods because for some women it might be difficult to switch to modern methods because of their strong traditional beliefs (norms and values).

Other factors were found to influence contraceptive use, including strong beliefs in polygamous relationships (Keele *et al*., 2005). Women in polygamous relationships are less likely to work outside the home than other women from monogamous relationship hence, they have less independence in social, economic and reproductive decision-making (Keele *et al*., 2005). In this context, women in polygamous relationship are not exposed to other women at work and as a result, they are less likely to share their experiences with other women. These women are unlikely to use emergency contraception because they have no other options available to them.

A study by Ziyane and Ehler (2006) conducted in Swaziland investigated perceptions and attitudes of the high adolescent pregnancy rate. The study showed that child bearing was important for determining and maintaining the social position of the family in the Swazi culture. The study also found that the prevalence of pregnancy was influenced by cultural values and health practices (Ziyane and Ehler, 2006). As a result, some of the family planning programs such as contraceptive methods may not be effective in such culture as they have their own cultural methods (Ziyane and Ehler, 2006). Furthermore, Wood and

Jewkes (2006) in their qualitative study in Limpopo province found that girls were pressured by their partners and family to have a baby to prove their fertility, leading young women to not fully access health services or have limited information about family programs and access to services for contraception (Wood and Jewkes, 2006).

2.11 Religion

One barrier to acceptance of modern contraceptives in Africa is religion, particularly religious beliefs that are pronatalist (Keele *et al*., 2005). In many parts of Africa, religious leaders and practices do not permit the use of modern contraceptives even in areas where such methods are available. Therefore, without the encouragement from religious leaders family planning programmes may not be effective in African countries (Keele *et al*., 2005).In addition, some of religious leaders in African churches preach that contraceptive use "punctures and spoils the eggs" suggesting that contraception could cause infertility (Wood and Jewks, 2006:111).

"The Quran warns against using "unnatural" methods of birth control, suggesting that in using such methods such as hormonal contraceptives, the woman is killing life inside of her, rather than simply preventing the possibility of life" (Keele *et al*., 2005: 36). This indicates that there is a need for government and health professionals to provide correct information on contraceptive methods, as there are many myths and misconceptions about hormonal contraceptives. The Catholic Church also claims that they are abortifacients whose sale and use should not be accepted in the public (Ehrle and Sarker, 2011). Faundes *et al*., (2007) argue that their opposition is based on the belief that emergency contraception prevents implantation of the fertilized egg and that the fertilized egg has the same rights as a living person. As a result, they continue arguing that using emergency contraception is the same as an abortion.

"Emergency contraception has been under strong attack by the Catholic Church and anti-choice organisations in Latin America, that claim that the interference with implantation of the fertilized ovum is equivalent to an early abortion" (Faundes *et al*., 2007:130).

There is a need to provide more information to prevent such claims. The Catholic Ethical and Religious Directive 52 states that "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples ... instruction ... in methods of natural family planning" (White, 1999:1713). This shows that contraceptives in other religions are forbidden which could make it difficult for a woman to seek these services from health facilities, as they are not allowed to use them. A survey found that 82% of Catholic hospitals do not provide emergency contraception to rape victims (White, 1999). This poses significant problems for rape victims living in communities where the only local hospitals are Catholic. A survey also found that 75% of "sole provider" Catholic hospitals refuse to provide emergency contraception, and victims in those communities may have no other place to receive treatment for injuries resulting from rape (White, 1999).

In the study conducted in Matemwe, East Africa it was clear that "women‟s views on family planning are heavily influenced by their religion, as most women interviewed felt strongly that the number of children they should have is "God‟s business" and that parents should not try to interfere with God‟s will" (Keele *et al*., 2005:36). Thus, such beliefs may really hinder the utilisation of emergency contraception. Hollander, 2003 stated that some centres that did not offer EC typically said that they faced administrative or clinical objections, because the school‟s religious affiliation prohibited it or a nurse whose religion forbid the use of the method ran the clinic and they could not provide medications. Most centres that did not offer the method referred clients to clinics or pharmacies that provided the pills (Hollander, 2003).

2.12 Health professionals' perspectives

A study in South Africa that examined pharmacists attitudes and practices towards emergency contraception presented that half of the pharmacists indicated that the increased availability of emergency contraceptive pills would lead to promiscuity, 60% felt that increased availability of ECPs would decrease the use of the barrier methods of contraception, and 58% indicated that increased emergency contraception availability

would most likely increase the incidence of sexually transmitted infections (STIs) (Haripasard, 2001). These results indicate pharmacists could hinder EC usage because they often suggest that women should not rely on the EC because it leads to promiscuous behaviours. Therefore education is needed for pharmacist to spread positive messages about EC and this will prevent women from facing barriers when attempting to use the EC method. With regard to awareness, the respondents stated that the best way to inform people about emergency contraceptives is through media advertisements (Blanchard *et al*., 2005) as some people have radios and television and this will increase the usage of EC and decrease unintended pregnancy in the country. Even teenage pregnancy might decrease because they will be aware of the method used to prevent an unwanted pregnancy. Delbanco *et al*., (1997) asserted that health professionals and providers should promote EC so that the patient‟s awareness of EC and its availability will likely increase.

Sometimes health providers prescribe EC for young women who may need them in their facility. Providers in the study indicated that there was no minimum age for them to prescribe EC hence they were willing to provide EC to young people over 16 years (McFadyen *et al*., 2003).While a lack of knowledge among providers is a problem, negative attitudes toward providing young people with ECPs poses an equal challenge. Among 300 providers in Ghana, about three-quarters approved of ECP use in general, but only half thought they were not appropriate for youth (Parker, 2005). Other studies show that providers are not willing to prescribe EC to young people. For example, a study conducted in Limpopo Province found that providers often impose age restrictions that prevent young women from accessing contraception methods (Netshikweta and Ehlers, 2002). In addition, Ehlers, 2003 reported that ECPs were not appropriate for women younger than 18 and admitted to denying young people access to them.

Blanchard (2005) argue that in South Africa, where knowledge of emergency contraception is limited and unintended pregnancy rates are high, interventions that encourage pharmacists to provide pills in advance would likely increase women‟s use of the contraceptive. Although some pharmacists reported unwarranted fears about health risks and increases in unprotected sex, leading to a greater exposure to HIV and STIs,

these misperceptions did not appear to prevent them from selling the medication. They knew that these methods help to prevent pregnancy but their fear is because women might be infected by STIs (Blanchard *et al*., 2005). Some health care providers, parents, and policy-makers fear that young people‟s knowledge or use of ECPs may lead to more unprotected intercourse and a decrease in the use of a regular method of contraception. For example, a study in Kenya found that providers and others believe that ECPs will discourage regular contraceptive method use among the youth (Parker, 2005).

There are those pharmacists who classify emergency contraception as an abortifacient so they do not normally prescribe the EC to their clients (Blanchard *et al*., 2005). Furthermore, some providers may restrict emergency contraception to women based on their own beliefs or values (Robinson *et al*., 1996).This might be problematic to a woman who is really in need of the method. In a survey among nurses and nursing students in Kenya, only 21% approved of ECPs for young women, some thought ECPs contributed to immoral behaviour or promoted risky sexual behaviour. About half of the women believed incorrectly that ECPs function as abortifacient or were illegal (Parker, 2005).

Pharmacies have the potential to address many of the problems related to young people‟s reluctance to go to clinics for ECPs, particularly where prescriptions are not required, but pharmacies have some disadvantages as well. A study in Zambia by the Population Council and local collaborators found that pharmacists were the best provider of both ECP, compared to clinic-based providers, peer counsellors, and community sales agents (Parker, 2005). About half of the 400 young women in the study turned to pharmacists for information, and nearly three-quarters of those seeking ECPs went to pharmacists. However, the pharmacists were the least likely of the groups to offer detailed information about ECPs or information on alternative contraceptive options (Parker, 2005). McFadyen *et al*., (1999) pointed out that pharmacists are fairly knowledgeable about ECPs, however, their counselling on STIs and use of long-term contraception is relatively poor. Pharmacists generally do not consider counselling as their responsibility, and many lacks the time or facilities to counsel in private, so young people are less likely to receive counselling from pharmacies than from clinic staff. Similarly, counselling on regular

family planning methods and prevention of STIs may be lacking or non-existent in the pharmacy setting (Parker, 2005). Other problems mentioned in the study is limited information based on the lack of time and privacy for pharmacists to counsel clients and the need to clarify regulations on ECPs (Parker, 2005).Maharaj and Rogan (2011) in their study found that providers in the pharmacies do not have opportunity to counsel women about EC because of time constraints and they do not have private counselling rooms in the facility.

Maharaj and Rogan (2008) argue that poor knowledge of EC of health professionals prevent them from discussing it with their client when they access services from their facilities. A micro-study of health facilities in Durban, KwaZulu-Natal found that most of the pharmacists and doctors prescribed the EC dose incorrectly (Hariparsad, 2001). In addition, few of the health professionals were able to detect common side effects connected with EC, while half of the pharmacists and 35% of doctors considered that EC should not be used more than once because it can cause a health risk (Hariparsad, 2001).

2.13 Summary

The literatures reviewed in this chapter touched on the matters of emergency contraception use in South Africa and globally. The reviews suggest that there are many barriers to using EC, in terms of access and limited information on the method. The perspectives of health professionals have revealed how they feel about selling the ECPs; some support it and others are against it based on their cultural and religious reasons. Comparing developing countries with developed countries has shown that people from developed countries have more awareness of and access to EC compared to South Africa and some other developing countries. As a result, it was important to draw from different literatures to observe the main factors facilitating and inhibiting the use of EC based on gender inequity, culture and religion.

Chapter Three: Research methodology

3.1 Introduction

This chapter describes the methods used to collect and analyse the data. It covers a brief description of the study setting, the sample, the sampling strategy, data collection tools, as well as techniques of data analysis and limitations of the study. The study uses qualitative data drawn from twenty in-depth interviews with young women who are students at a tertiary institution in Durban, KwaZulu-Natal. The study was conducted to investigate factors influencing emergency contraception use among young women.

3.2 Research setting

This study took place in KwaZulu-Natal, one of the nine provinces in South Africa. KwaZulu-Natal has the highest contraceptive prevalence of all the provinces in South Africa (Department of Health, 2003), thus this study is finding the main reasons for female students to use emergency contraception. The study is conducted at a well-known tertiary institution in KwaZulu-Natal; and it is one of the largest universities in South Africa. The University of KwaZulu-Natal is a multi-ethnic tertiary institution with diverse cultures; students come from different parts of the world (UKZN, 2013). The university was formed on 1 January 2004 because of a merger between the former Universities of Durban-Westville and Natal. The institution brings together the academic expertise and research capacity of two regional universities (UKZN, 2010). The institution is divided into five campuses: Westville, Nelson Mandela Medical School, Pietermaritzburg, Howard College and Edgewood but the study was only conducted at the Howard College campus. The university offers degrees from undergraduate to postgraduate level. The institution provides a vibrant environment for basic and applied research offering internationally recognised postgraduate research degrees. It has fostered strategic initiatives in the areas of HIV/AIDS, conservation, and economic development and water (UKZN, 2010).

There are different services and facilities available for registered students such as accommodation, libraries, student counselling centres, financial support, computer facilities, security and campus health clinic. The campus clinic offer services on assessment and treatment of health issues, assessment and referral of drug and alcohol-related problems, reproductive health counselling and contraception, treatment of STDs, free HIV/AIDS testing and pre and post-test counselling (UKZN, 2010). Figure 3.1 shows a picture of the campus where the data is collected.

Figure 3.1: Howard College Campus

3.3 Research methodology

The study adopted qualitative research methods. "Qualitative research is concerned with understanding the process and the social and cultural contexts which underlie various behavioural patterns and is mostly concerned with exploring the "why" questions of research" (Maree, 2007:51).According to Holloway and Wheeler, (1996) qualitative research studies people or systems by interacting with and observing the participants in

their natural environment and focusing on their meanings and interpretations. Qualitative methods allow researchers to study the individual‟s point of view, and obtain rich descriptions (Obermeyer, 1997). Qualitative methods deemed appropriate for this study because the data was collected from respondents that had already used emergency contraception in order to gain in-depth understanding on young women‟s views on emergency contraception. Qualitative methods allowed the respondents to express themselves based on their experiences in accessing EC and on how they felt after using EC. Qualitative methods assist the researcher to get rich information from each respondent involved in the study.

In-depth interviews form part of collecting data in the qualitative research, thus this study uses in-depth interviews to collect data. The in-depth interview is a qualitative research technique that includes conducting one on one interview with a limited number of respondents to explore their perspectives on a particular idea, program or situation (Boyce and Neale, 2006). Turner (2010), states that in-depth interviews are useful because they help the interviewer to gain more in-depth information from the respondents. The respondents are encouraged to answer in their own words. The interviews assist to provide more detailed information on what has happened in the program (Boyce and Neale, 2006). Twenty female students who have used emergency contraception were interviewed in the study to share their experiences of using this method. Furthermore, in-depth interviews are used when a respondent is not comfortable to talk openly in the group or when a researcher wants to differentiate individual opinions from group opinions. Since the subject discussed in the study was sensitive, it was ideal to conduct in-depth interviews. In the interviews, respondents are given the opportunity to talk freely and they are informed that the information will be kept confidential. The limitations of in-depth interviews, however, are that they are a time-intensive evaluation activity (Boyce and Neale, 2006); the interviewer has to spend a couple of hours interviewing each respondent separately and these constraints usually result in a small sample (Bless *et al*., 2006). The presence of an interviewer may cause a respondent not being free in answering the questions on confidential and private topics, while they could answer better when they are left with a questionnaire to fill (Bless *et al*., 2006). To ensure

that all respondents felt free to express their views and experiences on the use of emergency contraceptive, the researcher build a rapport with each respondents.

3.4 Sampling method and sample size

Non-probability sampling was used for the study. Non-probability sampling refers to the case where the probability of including each element of the population in a sample is unknown; it is not possible to determine the likelihood of the inclusion of all representative elements of the population into the sample because some elements may not be included in the study sample (Bless *et al*., 2006).The researcher used a snowball sampling for this study. Snowball sampling is a technique used for finding research subjects, where one subject gives the researcher the name of another subject who might be potential participants (Vogt, 1999). Browne (2007) argues that a way to gain initial contacts is to use personal networks and ask friends and acquaintances to be part of the study; they in turn ask their friends and partners if they would be willing to participate. Abdul-Quader *et al*., (2006) argue that snowballing sampling can achieve broader coverage using social networks and the researcher asks study respondents to refer other potential respondents for the study. For this study, respondents were identified at university residences. The researcher went door-to-door at the women residences around campus where the participants were identified and asked whether they have used EC. Some of the respondents also referred their friends that had used the method before which made the recruitment phase easier. As Tansey (2007) argue that snowball-sampling method involves identifying an initial set of relevant respondents, and then requesting that they suggest other potential participants with similar object of the study. The problem with snowball sampling is that the samples are biased and do not provide the basis for valid generalizations to the populations from which the sample was drawn (Abdul-Quader *et al*., 2006).

In this study, a sample of twenty female students was selected. These students were between the ages of 18-25 and had previously used EC. The aim of the interviews was to determine the experiences of women with the method. Zungu and Manyisa (2009)

suggest that African women are most likely than other women to have an early and unplanned pregnancy. For this reason, the study only focused on African women. Female students were chosen for this study because they are specifically the ones who mostly likely to access and use emergency contraceptives. University students were targeted for this study because they are more educated therefore assumed to have higher awareness of family planning methods. It was important to target female students in order to assess issues affecting their sexual and reproductive health such as the use of emergency contraception. The study focused on this group because they are more likely to experiment and explore all kinds of activities (Roberts *et al*., 2004), for example, it can be drugs, alcohol and young people engaging in unprotected intercourse. Behavioural factors that frequently put young people at greater risk of pregnancy include experimentation, and risk taking behaviour (Parker, 2005). Furthermore, this age-group is more likely to be sexually active, at the age of 18 years they are likely to have given birth, or as documented already more than 30% of women nationally have their first child before they reach the age of 20 (Maharaj and Rogan, 2011).

3.5 Data collection

The fieldwork for the study lasted approximately three months, beginning in August 2012 and ended in October 2012. Female students were approached at the university residences and asked if they would be willing to participate in the study. The study was conducted at the residences on campus and African students predominantly stay at the residences. It was also easy for the researcher to access the students at the university residences. The women were asked if they had ever used EC and if they had and they agreed to participate in the study an appointment were made to conduct the interviews. The respondents were recruited through word of mouth where a respondent will refer a friend to the researcher who may be interested to contribute to the study. Respondents showed more enthusiasm in being part of the study since they had used EC so they were willing to share their experiences with EC. Before the interview started the consent form were read to them to assure them of confidentiality and anonymity. Respondents signed the form to indicate their agreement to participate in the study. The interviews collected

detailed information including the demographic and reproductive history of the women as well as their knowledge of EC and their experiences with using the method. Interviews were conducted in a private venue that would make respondents comfortable to answer the questions and it was tape-recorded with respondents‟ approval.

The study faced challenges in recruiting respondents. One woman agreed that she had used EC but then she declined to be interviewed for the study. Sometimes, the researcher will make an appointment with a user, but only to find that she is not available in the room, so the researcher would have to reschedule the interview for another day. Students reported that they were not available because they were writing a test or submitting an assignment. Others stated that they had an emergency that they urgently needed to attend at home so they could not make their appointments.

3.6 Data analysis

The data were analysed using thematic analysis that is useful for identifying, analysing and reporting patterns (themes) within data (Braun and Clarke, 2006). According to Braun and Clarke (2006), it organises and describes data in more details and it allows for interpretation of various aspects of the research topic (Braun and Clarke, 2006). “A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (Braun and Clarke, 2006:82). The researcher transcribed the data that was derived from in-depth interviews and analysed them. The researcher organized individual ideas into categories that shared the same meaning in order to group themes that were found from the in-depth interviews. The themes included „experiences of the ECPs‟, „contraceptive use‟, „providers attitudes‟, „attitudes of friends and partners‟, „sexual education‟, „factors inhibiting EC use‟, and „advantages and disadvantages of EC‟.

3.7 Ethical considerations

Before continuing with the research at the University of KwaZulu-Natal, a proposal for ethical clearance was submitted and approval obtained from the relevant committees. During the recruitment of the sample, the women were clearly informed of the purpose of the research and they were asked whether they were willing to participate in the study. Respondents were assured of confidentiality and anonymity in their participation in the study. Respondents were given a consent form to sign to indicate their full participation in the study and that they understood the purpose of the research. They were informed that they could withdraw from the study at any time if they felt uncomfortable to continue with the interview or did not want to answer some of the questions. The interviews were tape recorded with the permission of the respondents and the tapes were later transcribed. The transcripts of the interviews are used to illustrate particular findings. Respondents were assured that the digital recordings would be destroyed after the research has been finally completed.

3.8 Limitations of the study

The study is limited in that it uses a snowball sampling which identifies the females who wanted to participate in the research. The study focused primarily on African students therefore not reflective of young women of all race groups in South Africa. The university has a diverse population and other groups are not represented in the study. Furthermore, it is limited to women who had ever used the ECPs it is possible that there will have been memory lapses with some not remembering all the details of their experiences with the method. Some of the respondents had limited responses; the researcher could observe that they were scared to express themselves openly since it was a sensitive topic that touched on their sexual behaviour, although the interviewer had created a rapport with them.

3.9 Summary

This chapter provides the steps employed to collect data and it is the most important chapter that determines the results of the whole research study. The information gathered will assist in understanding the factors that influence female students to use emergency contraception. Thus, the results derived from the study will help future research to investigate further the dynamics of emergency contraception use.

Chapter Four: Results

4.1 Introduction

This chapter presents results from in-depth interviews conducted with twenty female students at Howard College Campus, University of KwaZulu-Natal who have ever used emergency contraception. The chapter firstly outlines the socio-demographic characteristics of respondents. It follows by examining awareness of contraceptive methods and a source of supply. It also explores perception of risk of pregnancy, attitudes towards EC use and its accessibility at the campus clinic and other health facility and factors influencing use. In addition, it explores the impact of religion and culture on the use of EC.

4.2 Sample description

Table 4.1 present the socio-demographic characteristics of the sample of the study. In total, 20 interviews were conducted with female students. The respondents included both undergraduates and postgraduates. The most dominant ethnic group in the study were Zulu (15) including a few Xhosa (4) and Sotho (1) female students. All respondents interviewed belonged to the Christian religion. Eighteen respondents reported that they were in a stable relationship. Of these, two respondents were engaged to be married. There were only two respondents in the total sample that did not have a regular partner. Ten respondents reported that they had ever been pregnant; nine had at least one child. Two women reported that they had lost their children, and one respondent was currently pregnant at the time of the interview.

Table 4.1: Sample characteristics of respondents					
	Age	**Ethnic group**	**Partner status**	**Previous pregnancy**	**Children**
1.	24	Zulu	In a relationship	Yes (1)	No
2.	25	Xhosa	In a relationship	Yes	Yes (1)
3.	25	Xhosa	In a relationship	Yes (2)	Yes (1)
4.	22	Zulu	In a relationship	No	No
5.	20	Zulu	Engaged	No	No
6.	24	Zulu	In a relationship	No	No
7.	22	Zulu	Not in a relationship	Yes	Yes (1)
8.	21	Zulu	In a relationship	No	No
9.	20	Zulu	In a relationship	Yes	Yes (1)
10.	19	Zulu	In a relationship	No	No
11.	20	Zulu	In a relationship	No	No
12.	21	Zulu	In a relationship	Yes	Yes (1)
13.	22	Zulu	Not in relationship	No	No
14.	22	Xhosa	In a relationship	No	No
15.	23	Xhosa	In a relationship	Yes	Yes (1)
16.	21	Zulu	In a relationship	Yes	Yes (1)
17.	22	Sotho	Engaged	No	No
18	23	Zulu	In a relationship	Pregnant	No
19.	22	Zulu	In a relationship	No	No
20.	24	Zulu	In a relationship	Yes	Yes (1)

4.3 Awareness of contraceptive methods

Awareness of sexual and reproductive health issues was relatively high in the sample. Most respondents were exposed to sexual education at school. Educating young people about the importance of protecting themselves when they engage in sexual intercourse enables them to make positive decisions about their health and their wellbeing. Eighteen out of the twenty respondents indicated that they were exposed to sexual education through the life skills programme in school. As a result, they were aware of the risks associated with unprotected intercourse as well as the measures that can be used to protect against such risks. They were aware that unprotected sexual intercourse heightened the risk of pregnancy and sexually transmitted infections (STIs) including HIV/AIDS. The respondents also mentioned different types of contraceptives to prevent pregnancy and STIs such as the morning after pill, condoms, injectable, the patch, oral contraceptive pills and the intrauterine device (IUD).

"I heard about sexual education in life orientation but it was not obviously an explicit one. It was a general review of sexual relations. They [schoolteachers] just spoke about how you should protect yourself if you have engaged in sexual activities. We had counselling where they spoke about how to protect yourself if you were to be raped or if you start at an early age to be sexual active, they said there are condoms and contraceptive pills that you take when you had unprotected sex" (IDI #11)

"We had LO [life orientation] from grade 8 to grade 12 and we were taught about all the different methods that can be used like the patch that was still new then, contraceptive pills, condoms, the IUD and we were taught about STIs. They even taught us about abortion because it has been legalised even though they were not for abortion but they gave us an idea of what it is. They were telling us that this is our own decision, you might want to have an abortion and if you will do it in the wrong way then it will affect your reproductive system. So there were just giving us information to make us aware if ever you are in the situation" (IDI#19)

One respondent stated that she was not really taught about the protective measures against the risk of pregnancy and HIV/AIDS. Although she did obtain basic information during life orientation, classes but it did not give her detailed information. If young people are not taught about sexual and reproductive health, they might be an increase in unplanned pregnancy in the country.

> *"We just did life skills which just taught us about bodily changes. It did not necessarily provide in-depth information about sex but just general information about sexual reproduction" (IDI#7)*

A respondent stated that she was not completely satisfied with the information she received at school. She explained that a child should be taught about sexual and reproductive health topics because young people have a tendency to engage in sexual experimentation. For example, a young woman may find herself pregnant because of limited knowledge of preventative measures against the risk of pregnancy.

> *"At a certain age especially when you are young you tend to be more experimental, so when you teach a child or a teenager about the bees and the birds for me you not doing justice to those kids because sometimes they tend to go and experiment. I would have expected them to mention the penis or the vagina; those are the main sex organs that you should know in your body. So when you get to school I think that should be the place where you are properly educated especially about sex" (IDI#6)*

4.3.1 Source of supply of contraceptive methods

Seven respondents in the study reported that they access their contraceptives at the campus clinic. The researcher observed that the place is easily accessible to the respondents since they stay at the university residences. In addition, these services are free of charge. Other respondents mentioned that they normally access contraceptive methods from private facilities. They found it easy to obtain from private doctors or

pharmacies. However, some also said that their boyfriends took responsibility for obtaining and using condoms.

"I use the injection, it a three month injection…I get it here at the campus clinic but if I am not within the premises I go to a private doctor" (IDI#6)

"I do not know the name of the pill but I take them every morning… I get them from the university clinic" (IDI#8)

4.3.2 Knowledge of emergency contraception

Most of them had first heard of EC from their friends who had used it before, some of them had read about it in magazines, and pamphlets available at health care centres and from sexual education programme in school. One may observe the power of education, which is useful in the society because young people tend to be aware of risky sexual behaviours and as a result, they were aware of the different contraceptive methods.

"The first time I heard of the morning after pill was through magazines, I like to buy a lot of magazines that deal with women's health so I was first introduced to it through these magazines" (IDI#6)

"I would say I heard about the morning after pill from life orientation at school and from friends who have used it before but some have not used it but they know of the pill" (IDI#17)

"My friends knew a lot more than I did and they have used the morning after pill before. They have always told me about it, we used to call it MAP [morning after pill] but the first time I saw it was when I accompanied my friend to go buy it" (IDI#19)

Furthermore, one respondent revealed that her boyfriend informed her about the EC because it was the first time she was having sexual intercourse and she used the EC method. This suggests that sexual intercourse is most often spontaneous and is not planned. Male partners are also informed about emergency contraception and they are able to assist their partners when they find themselves in difficult situations.

> *"The first time I heard about the method it was when I had to use it, my boyfriend introduced me to it so that was the time" (IDI#20)*

4.4 Perception of risk of pregnancy

The respondents were aware of the benefits of the emergency contraception. The main reason for using it was to prevent an unwanted pregnancy. Respondents acknowledge the significance of using EC to avoid unplanned pregnancy. One respondent indicated that she liked the EC because it helps woman to prevent pregnancy when they have been raped so they do not have to worry about having a child that was the result of a rape. Another respondent even mentioned that it decreases the chances of not having a child that will eventually be fatherless, as she explained that her partner was not going to be supportive even if she got pregnant.

> *"Well, at the end of the day, you do not have an unplanned pregnancy. You are not stuck with a child the father might not know and your life just does not turn around completely" (IDI#3)*

> *"It prevents you from getting pregnant and if you were raped you can use it to prevent an unwanted pregnancy" (IDI#12)*

One respondent reported that she was relieved when she started her menstrual cycle because it was a sign that she was not pregnant. It shows that EC is beneficial to young people when they are not ready to become parents. It makes them to relax when they know they are not pregnant.

"I have never looked forward to my periods because I have hectic period pains but surprisingly the time I took the pill [EC] I was so looking forward to them, I did not even mind the period pains. The advantage is that its prevents pregnancy from occurring" (IDI#19)

The first reason given by respondents for using EC was that they did not want an unplanned pregnancy because they are still students so they still want to complete their studies. One respondent mentioned that it is better to have children after completing their education. She pointed out that raising a child is expensive and it is important that women complete their education so that they can obtain employment and therefore give their child a better quality of life. Another respondent stated that it was not socially acceptable in her community to have a child before completing her secondary schooling.

"It is safe to take it [morning after pill] rather than getting pregnant and you are still in school. You know that there could be like a major problem so you might as well just take it as soon as you can" (IDI#10)

"I had unprotected sex and I was not ready for a child okay maybe now I am but back then I was not…I was 19 at that time. I had finished my matric in 2008 so imagine the whole thing of being pregnant after immediately finishing matric such a disgrace in my community" (IDI#17)

The second reason given by respondents for using EC was the problems of condom failure or inconsistent contraceptive use. One respondent explained that they used ECPs because the condom had burst. However, sometimes they did not use any protective measures because they forgot to take the contraceptive pill. A respondent noted that she had engaged in unsafe sex and had missed her time to go to the clinic for the injection so she decided to take EC to protect herself against unplanned pregnancy.

"What happened with me is that the condom burst so I used the morning after pill for assurance that I was not pregnant so I had to clean up my system" (IDI#15)

"I had unprotected sex the night before then I was not okay, I am usually on the injection but what happened is that I think I missed a day that I had to go back to the clinic to get my shot [injection]. The next morning I decided to go get the morning after pill and then immediately after that I went to the clinic to get my injection" (IDI#14)

In some cases, respondents stated that they preferred to use EC, than to use condoms. Two female students reported that they used EC because they were careless and engaged in unsafe sexual intercourse. This shows that respondents are focused and able to see that by engaging in unprotected intercourse it will affect them negatively, because they might be pregnant and contract STIs, as they did not use any preventative measures.

"Okay there is a stupid reason; I did not use a condom because I had planned to use the morning after pill" (IDI#2)

"In that night I did not use a condom for some stupid reason I did not use a condom then I had to use a morning after pill because I did not want to be pregnant" (IDI#9)

Another reason for using EC was that respondents did not want to have a child because they are still young and they did not have the financial resources to be able to raise a child. They said that they were still financially dependent on their parents, thus for them to have a child was not a good decision. As a result, they used ECPs to protect themselves against an unwanted pregnancy.

"I used the pill because it reduces the possibility of being pregnant especially if you had not planned for a child and you not financially stable to support the child. So I think using emergency contraceptive is basically the best in those circumstances" (IDI#4)

"I used it because I had unprotected sex and obviously you know being young you do not want to fall pregnant and you not in a financial situation where you can look after a child so I had to use one" (IDI#6)

"I did not want to fall pregnant and I am not financially stable to take care of a baby…I am studying and my boyfriend is studying and my friends also agreed with me that I should take it because I cannot handle having a baby right now" (IDI#11)

Respondents were worried about the consequences of having unprotected intercourse so they decided to use EC to ease their worries about having an unplanned pregnancy. As one respondent stated that even though her partner told her that, nothing would happen since he had used the withdrawal method she did not trust him enough so she decided to use the emergency contraception pill as a backup method.

"My main reason for using the morning after pill; the guy said he came outside [withdrawal method] but because I did not want to take any chances I did not want to ruin my life so I decided to use the morning after pill" (IDI#19)

One respondent indicated that there was no reason to take the emergency contraception pill because they did use a condom but it was her first time engaging in sexual intercourse so she was avoiding an unplanned pregnancy. In addition, another respondent argued that even though she had protected herself with a condom she still used the EC because she wanted to be safe as she was not ready to have a child.

"I used emergency contraception as it was with my first boyfriend- the first partner I ever had and I was basically in shock as I did not want to fall pregnant as I had just started university. So that day we actually did use a condom but I wanted to be sure that nothing happened so I took the morning after pill. There was not really a need to take the morning after pill but I was like scared" (IDI#1)

"I had unprotected sex and I remember when I started having sex I used to use them like a lot [EC]. I will feel guilty even if we had used a condom. I will still use it just to be safe" (IDI#5)

The respondent mentioned the place they took the EC, most of them indicated they took it as soon as possible at the public health clinics and at the pharmacy where they got them. One respondent argued that she took the ECPs at home and she had to hide the evidence so that her parents would not see that she is engaging in unprotected intercourse as she explained that her mother would have shouted at her. The quote below indicates that young people are scared to be punished by their parents and this could result in them not using ECPs.

"I took the morning after pill at home, even though I was scared because I had to hide the box and throw it away so that my mother did not see it and I kept the other pill that I had to take after couple of hours in a safe place"(IDI#2)

4.5 Advanced dosage of EC

When respondents were asked whether they had an advance dosage of EC available at their place, only two out of twenty respondents mentioned they had EC available to them and others said they never thought of having it. Respondents did note that by having an advance dosage it will increase the chances of women not delaying to take EC immediately after unprotected intercourse. This shows the importance of having an advance dosage of EC because it may eliminate the risk of pregnancy. A respondent argued that she used to get them from her former boyfriend who was at the medical school.

"I did have morning after pills because my ex [boyfriend] is from medical school so I used to get them from him" (IDI#13)

"I bought quite a few morning after pills when I used them the first time so they remained from that time" (IDI#16)

One respondent noted that by having it available in the house it will be easier for a woman to drink it immediately after unprotected sex to avoid getting pregnant.

"I think it is better to have them right next to you so that you do not forget or procrastinate, so I think it is better actually to have it somewhere close in case you need them" (IDI#10)

In addition, a respondent said she did not have them available at her house but she argued that it would be of greater use to have them in advance, because it might happen that the time they had unprotected sex she does not have the money to buy EC. However, she also mentioned that having an advance dosage might be a problem since a woman may relax and not use any contraceptive method. She will rely on EC because she knows it is accessible in the house.

"I think it safer to have it in your place because sometimes a condom will break and maybe at that moment you do not have the money and your boyfriend does not have the money to buy it because it quite expensive. Therefore, if you have it in advance in case of an emergency then you can just quickly take it and it is more effective if you take it- the sooner the better. But at the same time it has disadvantages in that it will make you relax because you know if ever you did not use a condom then you can take the morning after pill" (IDI#19)

4.6 Reasons hindering EC use

Respondents were asked about the negative factors that would make them to not take EC again. Respondents mentioned the side effects and even reported that it also changes their menstrual cycle. They argued that if the body becomes used to EC, it might begin to lose its effectiveness, which will result in a pregnancy that is not planned. They indicated that

the EC method must not be used frequently because it has a negative impact on the reproductive system of a woman as it can result in infertility in some women, and as a result, she will not be able to conceive.

> *"Using an emergency contraceptive sometimes messes with your cycle and sometimes messes with your hormones. I remember when I took it my period was not regular. I had to see a doctor and apparently if you use them quite often your body become resistant even if you do take the pill you can still become pregnant" (IDI#4)*

> "*If you use it frequently it makes it difficult for you to have children in the long run even health workers discourage the over usage of it. In terms of reproduction and organs it can tamper or hamper with your organs which could be health threatening especially in terms of having children" (IDI#6)*

> *"The continuous usage of the pill can lead to reproductive complications in your system so even if you use it continuously it can lead a woman to be infertile. It leads to complications, sometimes cysts build up in your bladder because as they say you take it once in a life time and it an emergency, not an everyday usage pill" (IDI#11)*

One respondent stated that she would only recommend EC only in the case of an emergency because she has heard some reports that a woman must not use it repeatedly because it has health risks.

> *"I would recommend it to my friend to use it in case of an emergency. I have heard of rumours. People say you should not be a frequent user of the pill [EC] because it not good for your reproductive system... if it is an emergency and somebody needs the pill- maybe the condom broke then I would buy the morning after pill (IDI#19)*

Correspondingly, another respondent argued that some women might use EC as a regular contraceptive pill, which might cause problems in the end. For example, a female may experience cervical cancer or become infertile because of over usage of EC.

"People tend to have unprotected sex because they know that they can take the emergency pill, some of them use it as a contraceptive instead of as an emergency pill. Another thing is that you are only supposed to take it only twice in your lifetime because if you take it more than that it causes problems, in most cases people do not conceive" (IDI#17)

When the researcher asked the respondents whether they will recommend their friends to use emergency contraception pills most of them said they would rather suggest an on-going contraceptive method such as condoms, oral contraceptives and injections than ECPs. This indicates that the use of EC might not be high because of women"s previous experiences with EC. However, they would recommend it for emergencies to avoid unplanned pregnancies.

"I am not going to act as if no one makes mistakes so if it happened that one time and truly if you do not need a child then I can suggest it, but if it going to be a regular thing then I will suggest that my friend goes on a permanent contraceptive" (IDI#5)

"I will recommend that my friend use contraceptive pills because you take them every day. At the clinic they told me that the contraceptive pill works after 24 hours but if you take it for the first time your reproductive system will be closed; you will not be fertile again if you have unprotected sex after 24 hours" (IDI#8)

"I would recommend it to a friend if they had unprotected sex because at least if they are lucky then she may not get pregnant like I did" (IDI#9)

"If it is the one time I would recommend it but I would not recommend it every day. I would rather recommend the injection, which is like for a three-month period and the pill [oral contraceptive] that you have to take every day. Because firstly it is very expensive to use the morning after pill secondly it harmful to your body and your reproductive organs" (IDI#11)

One respondent stated that she would not recommend it because the side effects she experienced after using it was very unpleasant but she stated that it should be an individual‟s choice.

> *"I would not suggest it to anybody because of my experiences but if another person choose it I am fine with it because maybe they might not react to it the way I did. Maybe there was something in that contraceptive that I was allergic to that I did not know. I was not aware of any allergies that I might come across because nobody gave me information that there was this substance so I could be aware of it" (IDI#3)*

Another respondent said that the EC method does not protect a person from STIs and HIV. She further stated that she would not advice a friend to take EC because sometimes it does not work she explains that a woman still gets pregnant. However, in the case of an emergency, such as the condom burst then she might advise a friend that there are ECPs that prevents pregnancy.

> *"Our first reaction to unprotected sex is the fear of having a baby but you forget about sexual transmitted diseases that could be life threatening. Therefore, you would rather be safe and use a condom at all times, rather than saying that if, it happens I will use the morning after pill. Sometimes it does not work, my friends have said that they have used it correctly and they were not using any antibiotics but they became pregnant. Therefore, it is not something that I would tell people to focus on. Maybe if a condom burst I can recommend it but generally no, I would not advice my friends to use it" (IDI#6)*

Moreover, another respondent said that because EC did not work for her she would not recommend it to anyone; she would rather suggest other contraceptive methods. She had used EC but had still fallen pregnant.

"I would not recommend it since it did not work for me, maybe I would advise them to use other contraceptives such as the injection or the oral contraceptive pill, not the morning after pill" (IDI#16)

4.7 Attitude towards emergency contraception

4.7.1 Users' experience and attitude

The women reported various reactions to emergency contraception. Some women experienced no effects while others reported severe side effects such as nausea, fatigue, vomiting and headaches. Three respondents in the study reported that ECPs was not effective because they became pregnant and they were not sure why the ECPs did not work. They also indicated that it came as a shock to them as they trusted the method would be effective in preventing pregnancy. The following quotes captures their experiences after the EC method did not work.

"My experience was that they did not work. I was told that they can prevent being pregnant but I got pregnant after using them…I was confused because I was told that morning after pills prevent pregnancy so I was kind of like confused why I was pregnant" (IDI#16)

The respondent also reported feeling quite confused and uncertain about her future. The interviewer probed the respondent about her partner"s reaction after the emergency contraception did not work. The quote below indicates that they both supported each other because they both understood that they should take responsibility to raise the baby rather than arguing about the effectiveness of EC.

"Well we were both shocked but then we just had to deal with the consequences" (IDI#16)

The second woman reported that she did not know how she became pregnant because she still had a regular menstrual cycle. She also reported experiencing a number of side effects from EC. The respondent revealed that after she observed that the EC did not

work she felt scared to inform her parents because they had high expectations for her. They wanted her to become a successful professional after completing her degree without a child.

> *"I used it and I thought it worked because I continued to get my periods. I had backaches, headaches, tiredness, dizziness and also lower abdominal pains. I went to a doctor because I thought I was sick only to find out that I was pregnant so the pill did not work…I was so stressed I could not eat, I could not concentrate, I could not do anything and I wish I could just die because I did the most stupid thing ever but I lived… I had to tell my parents that I was pregnant and I am still at school. It was going to be hard especially since my parents had high expectations of me. By getting pregnant I was really disappointing them" (IDI#9)*

The respondent went on to describe her partner"s reaction after the EC was not effective. She felt the unplanned pregnancy placed a huge burden on both of them because they had to raise a child while continuing with their studies. She also stated that her partner accused her of deliberating falling pregnant because the EC did not work but she has come to accept his reaction. The respondent stated that she understands that he was shocked because he was not prepared to be a father at that time.

> *"Well, we had our ups and downs but I cannot blame him for what he did and for his reactions because I understand he was stressed. I was stressed too! We were both at school so I cannot really blame him. I have accepted the fact that he put the blame on me but it is nothing major" (IDI#9)*

The third respondent who had reported that EC did not work expressed her concern that she trusted EC to prevent pregnancy. She was disappointed with the consequences because she became pregnant. She stated that:

"I had side effects the day after I drank the pill …and the morning after pill did not really work the first time I used it because I got pregnant … I felt like I trusted the pill and it did not work" (IDI#20)

Respondents stated that they had severe side effects after they had used ECPs. They said they experienced nausea, vomiting, headaches, and abdominal pains. The quotes below indicate the experiences of respondents after using EC.

"The first couple of hours I was okay. I did not feel anything and the next thing I started cramping. I started vomiting and I just felt dizzy. I felt sick like somebody who has morning sicknesses and then I started spotting. On the following day I menstruated and I had a very heavy flow…I was sick for basically three to four days. I was very sick. I was vomiting nonstop" (IDI#3)

"It is the most uncomfortable feeling I would say because you experience nausea. You do not have an appetite. You feel sick, it messes up your system that is how I would put it, because I have only used it once and that once off experience was not pleasant. I then decided to use contraceptives" (IDI#7)

"I took it in the morning and then throughout the day I was just feeling nauseous. I was vomiting, I felt dizzy and weak and it was reacting in my system and I was weak, really weak and I had like a high temperature but the next day I was normal ... it was just nausea, dizziness, and vomiting" (IDI#11)

Some of the respondents indicated that they did not experience any side effects. They speculated that they did not experience side effects because they used expensive EC, which did not have any side effects.

"I did not experience any side effects. Everything was just normal. Actually, I expected that maybe I was going to experience bleeding or stuff like that because I

did not have that much knowledge about it but nothing happened. It was okay" (IDI#1)

"I think there are different types of contraceptives- some have fewer side effects and are normally expensive. If I use those one I do not feel anything and then when I use the cheaper ones I feel sick, I want to vomit. So I think there are different types of morning after pills" (IDI#8)

"Actually nothing much happened because I had two pills that I had to drink. After drinking them I felt normal, I mean apart from being paranoid like I thought I was feeling dizzy but then there was nothing else" (IDI#14)

One respondent mentioned that she had used emergency contraception pill several times but never experienced any side effects.

"I used it a couple of times, more than once. I cannot remember how many times and in all of those times there were no severe side effects, so like there was nothing that was hectically bad with me afterwards" (IDI#18)

4.7.2 Friends and partners' attitude on EC

When asked whether they had spoken to anyone after using EC, the respondents reported that they told their partners and friends. Respondents said that they were relieved after talking to them because their friends also shared their experiences as they had used EC before. "Friends increase one another's self-esteem; provide information, emotional support, and advice; and help and support one another. Open discussion and communication between friends is important because people can discuss personal feelings to gain advice and support about issues of life such as sexual and reproductive health matters.

"I will say fortunately I have a partner who has a formal education. He did ask about the pros and the cons of it and then even discussed other measures of protecting ourselves especially against pregnancy…The friends I talked to well most of them had taken the pill before and some of them even twice. So we talked about the pill and raised awareness among each other that we should not use it frequently, because for me I have taken it once and that was the last time I took it" (IDI#6)

Some respondents reported that their partners were supportive when they used ECPs. This suggests a more favourable relationship between partners as they are able to communicate openly with each other. The women could have used EC method without their partner‟s knowledge but they decided to make the decision jointly.

"My partner was supportive about it because obviously we had spoken about it and decided on it. We decided that it was best that we opt for the morning after pill because we could not live with the consequences of our actions [unprotected intercourse]*" (IDI#7)*

"I felt better that at least I told my friends about it and not just that it was going to eat me up inside and they were there to support me... My partner was also supportive and it was a decision we took together. At least he was there to support me" (IDI#11)

In most relationship, it might be difficult for couples to come to an agreement. For instance, the respondent wanted to continue with her studies while her partner wanted a child. Because the respondent had a supportive partner that understands that, a woman person should have a better education to enjoy a better quality of life, so her partner decided to wait and allow her to pursue her dreams.

"My boyfriend sometimes he does not want me to take it [ECPs] because he wants a child. But I do not want it and he is fine with it because I am not ready to have a child...I felt good because sometimes other men do not want their girlfriend to take

this pill because they want babies and they think that if you take it you are killing a child" (IDI#8)

However, not all partners were supportive. One respondent indicated that her partner was not supportive as he refused to even give her the money to buy EC; as a result, she had to take the decision on her own because she was not ready to have a baby. Therefore, the decision taken by the female to buy the EC was good because it indicated to her that her partner was not going to support even the child if she got pregnant.

"Well he was not exactly excited about it but at the end of the day it was my body so whether he liked it or not it was my decision. It was my body and I did not want to have a baby at that time and he had no control over it. It was just me basically telling him: „listen, this is me and this is what I am going to do. You have no say." This is because he did not want to pay for it. I ended up paying for it and I think at that time it was twenty or twenty five rand" (IDI#3)

Lastly, a respondent reported that she discussed using the EC with both her partner and mother. This is in contrast to the popularly held perception that young people would never discuss sex matters with their parents; they would rather keep silent because parents may shout at them. They may say all kind of negative words without advising them to use protective measures such as condoms or contraceptive pills.

„I spoke to my mother. She was basically telling me that there are options that prevent things like pregnancy. She was basically helping me to know things so she was being a person who was concerned about my wellbeing and whether I have this information" (IDI#15)

4.8 Accessing health facility

4.8.1 Accessibility

Two respondents gave their reason for using the pharmacy because it was accessible over weekends. Thus, these respondents explained that they could not wait to get the EC from the campus clinic because they are only open during weekdays so they decided to get it from the pharmacy. EC is most effective within 72 hours, so it was better for the respondents to go to the pharmacy rather than to wait because they could have increased their chance of being pregnant.

> *"The campus clinic closes on weekends, hence we cannot access services and pharmacies are more convenient and less dramatic" (IDI# 4)*

> *"It was a weekend so the clinic does not open on weekends, so I bought them at the pharmacy" (IDI#16)*

Other respondents mentioned that they did not go to the clinic because they do not trust the service offered there. Their reason for not trusting the service was because at the government clinic, medication is free and there is no choice of treatment. Therefore, they decided to go to the pharmacy where they will pay for the EC and they have a choice of buying EC with fewer side effects.

> *"I just think pharmacies are more reliable and sometimes you just find out that at the government clinics they just give you whatever just to get you out of their way. I just do not trust clinical pills I would rather go to the pharmacy and get the prescribed one" (IDI#11)*

> *"I went to the pharmacy because they have a variety of options and maybe in clinics they are restricted in certain type of pills. And in the pharmacy I know I would be able to have a variety of pills to choose from" (IDI#15)*

Clinics are normally overcrowded and there are long queues and clients have to wait for a long period of time before they are given proper service. Thus, when a woman needs EC it can be difficult to wait for many hours to get them and EC should be taken within 72 hours after unsafe sexual intercourse. In the study, a respondent mentioned that she did not go to the clinic because she will need to wait in the queue before being attended by a nurse.

"I did not want to wait. I just wanted to get it as soon as possible to avoid any delays because the longer you wait the more risk you have" (IDI#12)

4.8.2 Cost effectiveness of EC

Some of the respondents explained that their reason for not accessing EC from the clinic was because they did not know that emergency contraception are free of charge, they only knew that EC is offered over the counter. In addition, other respondents expressed their concern that EC is expensive at the pharmacy and as a result, they rather get them at the clinic where it is free.

"In my first year I did not know what they had to offer at the campus clinic but I knew it was readily available from the pharmacy and they charge money" (IDI#1)

"I normally go to pharmacy but when I do not have money I have no choice but to go to the clinic" (IDI#13)

"I did not know that clinics gives away free morning after pills and I just thought you buy them over the counter" (IDI#14)

The quote below illustrates that the respondent did not have an alternative but to seek services from the clinic since her fiancé refused to give her the money for the EC. Therefore, she went to the clinic to obtain the EC where she knew that it is free of charge.

"When I told my fiancé to give me money to go to the pharmacy, he was like there is no need to do that so the only place I could go to was the clinic"(IDI#5)

4.8.3 Barriers to accessing EC

Respondents argued that it is difficult to go and request for ECPs at the campus clinic, as they do not feel comfortable talking to the nurse because they had unprotected intercourse. They also fear that nurses may see them on campus so they preferred to buy the ECPs from the pharmacy because at the pharmacy they might not remember them as they meet different people every day. In addition, one respondent said that she could not go to the nearest clinic in her community since the nurse knew her mother. Hence, she was afraid that they might tell her parent that she is having sexual intercourse or even engaging in unprotected intercourse.

"At the clinic I knew that there are people who know my mother. Therefore, I was like if I am going to go there the nurse is going to go to my mother, so me and my boyfriend decided we would go to town and get EC. Therefore, that is how I decided to go to the pharmacy because no one knows you there. No one cares" (IDI#2)

"I guess the clinic I could have went to was at Howard College, but because there is a chance you would bump into one of those nurses at campus it is kind of awkward so it best to go to a total stranger as there is little chances of meeting them again" (IDI#18)

Furthermore, a respondent argued that it is better to go to the pharmacy because a person is less likely to encounter a person who is the same age as their parents. Thus, one may feel ashamed to even request ECPs because of the age gap. She even went on to state that it was better to find a White person at the pharmacy, because she would have been embarrassed to ask for the emergency pill from an African person.

"I think it better in the pharmacy because there are ladies… or there is a White lady or White man. It is rare to find black people working at the pharmacy. It is easier to talk to someone who is not of the same race because you are not going to feel judged unlike talking to a black woman who is as old as your mother. You are likely to feel embarrassed" (IDI#19)

4.8.4 Poor attitude of health professionals

Young people find it difficult to go to the clinics because they encounter negative attitudes from nurses. In the study, the respondents who were interviewed argued that nurses often held negative attitudes towards them saying that they are having unprotected intercourse, so they did not want to go to the clinic. Thus, they preferred to go to the pharmacy because they did not ask them too many questions. They said that at the pharmacy they are likely to be given services without having to answer too many questions. They also feared that at the clinic they might be tested for HIV. Some felt that they were not ready to have a HIV test.

"Well you know how it is with our clinics they always have stories, they always just belittle you. The nurses will have things to say, saying that: why I did not have protected sex and I am sleeping around... The pharmacy was better than having a nurse talk to me and ask me question after question. I preferred the pharmacist who did not care and was not even bothered than some nurse that was going to come and curse me or say some stupid things to me that was going to annoy me" (IDI#3)

"There are just being typical nurses if you want to put it that way. I would not say attitude but because they are adults and they are older obviously, they have that attitude of: Oh! My child! Why did you do this? You could have maybe opted for other prevention methods. I think that is how they reacted because they have their own ways or their own motivation and encouragement to practice safe sex or decide to use contraceptives instead of coming through for the morning after pill" (IDI#7)

"I did not want to come across those nurses who are going to scream at me about getting pregnant. I did not want stress I just went straight to a pharmacy because I knew they were not going to ask any questions" (IDI#9)

"The problem with the clinics is that when you go there the nurses shout at you because you had unprotected sex. And they ask you a lot of questions and basically they will persuade you to go for HIV testing" (IDI#17)

Respondents were less likely to receive a hostile reception from private doctors. The majority of respondents had a bad experience with nurses at the clinic; as a result, they opted to seek health care services from private doctors and from pharmacies. They did not want to go to the clinic because of the nurses that will embarrass them in front of the other patients.

"Firstly, the doctor was convenient; it was next to the taxi rank and it meant not going to a clinic. Sometimes nurses are very brutal especially to young girls. A nurse can tell you or caution you about having unprotected sex but it another thing for a nurse to scream at you, for other people to hear and then you already feel guilty and feel miserable. However, you will realise that it not just the pregnancy but also you are at risk at contracting HIV/AIDS. So it is less of burden to go to a private doctor because when you buy the pill they do not even judge you" (IDI#6)

"The nurses are not polite, they judge you. I do not like to go to a clinic; I only go there when I seriously do not have money. The pharmacies are fine you just pay, it is not hectic like going to nurses" (IDI#13)

4.8.5 Information given by health professionals

A respondent said at the clinics they received better information compared to the pharmacy. She argued that it because they do not just give them medication but they will check for any health risks. The respondent favoured the clinic because she was guided

and counselled about the consequences of unprotected sexual intercourse and how to use EC.

> *"I think I preferred the clinic because they can monitor you, because at the pharmacy they just sell it to you over the counter. At the clinic, at least they can monitor you, I remember that they check your blood pressure and all of that and they check if you are not pregnant. But obviously if it is the morning after pill you will get it on that day but I think the clinic is much better" (IDI#7)*

The respondents who went to the clinic emphasised the usefulness of the information given by the nurse. One respondent felt it was actually eye opening because she was informed about the risk of unsafe sexual behaviours.

> *"That actually made me to think a lot because it taught me that it is not just about short term fun but it about thinking about the long term consequences and how the morning after pills affects you in the long run. I was given that information by the nurse at the clinic that this is what happens if you use the morning after pill regularly, rather sticking to contraceptive methods and importantly to use condoms" (IDI#7)*

Respondents were asked how they felt about the information given to them by health professionals at the pharmacy and if they wanted more information about EC. They reported that it made them comfortable to even ask questions because there were no judgmental reactions from the pharmacist. The quotes below indicate their positive responses with regard to the information given to them.

> *"I was glad that they gave me the information and I was really happy that they took the time to actually explain it to me, because I thought that they will just give me the pill and continue with their work. They gave me the information on how to use the morning after pill" (IDI#9)*

"The pharmacist did advice and also she did warn me that sometimes they are not 100% reliable so I was a bit scared with the information I was given" (IDI#17)

"The information was easier to grasp because it made me feel comfortable and I could ask questions especially about side effects. The information given made me aware of the choices I have for using the pill...if the pharmacist is talking to you and telling you everything, it makes you feel more relaxed. And if they are not giving you a judgmental look then it makes you want to ask questions" (IDI#19)

One respondent argued that she was not pleased with the services she received from her private doctor, because she said she knew how EC works and how soon a person must take it after unprotected sex. However, the respondent concern was based on other young people who may come to request the EC method and have limited information about it.

"The information my doctor gave me made me feel worried about other girls because I had more information as compared to someone else who just knows there is something that is called an emergency pill. And they do not know that you have to drink it within 72 hours of having unsafe sex. Some people do not have that kind of information. So, I would have expected the doctor to ask me when I had unprotected sex, instead of just selling it to me. I would have expected the doctor to maybe ask me those questions or make me aware of the side effects of the morning after pill" (IDI#6)

4.9 Religious and Cultural Barriers on EC

Almost everyone in the study reported that they are Christians. The respondents gave their own perspective about Christianity when it comes to issues of contraceptives or even emergency contraception. The majority of them argued that in their religion they do not believe in preventing God‟s plan, everything should happen naturally. The results below indicate the respondents‟ views of using EC as Christians. Respondents argued that in their religion they believe that emergency contraception is the equivalent of

abortion; whereas Christianity believes that a child is a gift from God thus the use of EC is not allowed.

> *"I belong to the Seventh Adventist. They believe that using that kind of method of contraceptives like those emergency pills is abortion in a way because you do not know whether you have conceived or not. And having an abortion in our church is just something that does not exist; if you are raped, they tell you that a child is a gift from God. So they do not talk about much when it comes to those kinds of subjects [contraceptive methods], they do not exist" (IDI#3)*

> *"They do not believe in these things [EC] because they feel that it is taking a life. They do not understand the whole reproductive thing so they feel that it is wrong, either way it is God"s plan"(IDI#15)*

> *"I do not think they would agree with it because mostly our culture and our religion do not support any form of contraceptives because it deprives them from having children and it is seen as a form of abortion" (IDI#17)*

Another respondent showed her knowledge of EC arguing that it does not actually harm the baby if it is already formed. She said that:

> *"The Church does not encourage the use of the morning after pill, they feel like it is wrong to use the pill- it is more like you are killing the baby. I do not believe in it because at the pharmacy they tell you about these kinds of issues. And you will see from the information that the pill does not kill the baby, if the implantation has already happened the baby is still protected" (IDI#20)*

Most of the respondents argued that sex before marriage is not allowed in their religion. Respondents‟ perception is that contraceptive methods are prohibited as they believe a child is a blessing from God.

"We are not allowed to use contraceptive at all not even condoms…In the Catholic religion you do not use contraceptives, be it condoms. I think mainly because you are not supposed to have sex before marriage so in the Catholic religion contraception is not allowed at all"(IDI#1)

"My religion is totally against emergency contraceptives because as a young person who is not married you should not be engaging in sex. It is something that is sacred from God, which is meant to join two people who are married that is why they do not have to worry about things like falling pregnant because if you fall pregnant they will say it is a blessing from God. It is God's way of blessing your union" (IDI#6)

A respondent stated that a person is labelled as being demonic and unholy because she has done something horrible in her body. Thus, she will need to confess in front of the Priest that she has sinned.

"In the Roman Catholic, it is something demonic, it is unholy if you use a contraceptive pill and you need to go to church and confess" (IDI#9)

Some see the use of EC as a sin because a person is not obeying God"s commands or rules that should be not broken unless a person is married and ready to have children. Hence, they normally say that the union is blessed and holy because a person obeyed God"s laws.

"They believe it is a sin because you had sex which does not go with their beliefs of being a Christian. They also say you did the sin of sleeping and now you are committing another sin by killing a baby" (IDI#2)

Another respondent mentioned that in her church, they normally have youth discussion that will touch on the issues faced by young people, these topics include sex education. Thus, she mentioned that even though at their church they do not promote the use of contraceptives she said they cannot stop them from not having sex, so they advise them to

take precautionary measures to protect themselves from sexually risky behaviours and from pregnancy.

> *"For youth congregations, we have gatherings and we talk about the problems that woman and men are facing. We are told not to have sex before marriage but we do it anyway, so they say we cannot control you from having sex but we can give advice on this matter... Even though we are in church, it is better if you are given an advice by someone that you can trust and relate to in a Christian manner. So even though in God's eyes it a sin but we are living in a sinful country they have to speak to us as grownups" (IDI#2)*

Some religions are more accepting of contraceptive use. Thus, some religions allow their youth to use contraceptive methods to accommodate young people in changing times.

> *"Their beliefs are very diverse because back in the days they said no sex before marriage. And for them to now have this emergency pill introduced to them it is something that is really modern. And they are still debating about it I mean because it is happening and it is going on in our youth they have learnt not to accept it but to accommodate such things" (IDI#1)*

Some respondents mentioned that emergency contraception is not discussed. Talking about sexual matters is a cultural taboo. They said that they only advice a woman who is already married about family planning methods.

> *"You should not even be talking about those kinds of things, like sex on its own is an issue that is not mentioned... I am guessing they expect you to start having sex when you married so that is when they give advice to the bride. But at a young age you are not even expected to have sex so the topic of contraception is not even mentioned" (IDI#5)*

"Zulus are basically very traditional people so like we do not speak much about that because when you are not married you not expected to have sex. So it is just a taboo issue. We do not talk about it unless you are married but in our age it not acceptable" (IDI#13)

Another respondent added that taking EC or even getting pregnant is seen as dishonouring their culture, in such a way that a woman may take EC privately by protecting her reputation in her community.

"In my Xhosa culture they do not like the morning after pill because they say it is an embarrassment to them. So I took the emergency pill privately because I was trying to not bring shame upon my ethnic group" (IDI#12)

The respondents said that their parents encourage or advise them to abstain from sex because they will avoid the risk of pregnancy that will lead them in using methods such as emergency contraception. Another one said that it is something that her mother will never discuss with her and she will even be shocked if she finds out that she had used EC. Lastly, a respondent mentioned that maybe her parents may not mind if she used EC because they will see that she is protecting herself by not being pregnant.

"In the Xhosa culture you do not use those things [contraceptives]. My mother would not even tell you about contraceptives, I think she would freak out if she finds out I used it [emergency contraception]" (IDI# P3)

"I think previously it was something that was taboo something that you would not talk about, but now I think it is just one of those things that your parents would actually much more prefer you to use rather than to have a baby. But obviously, they are not promoting it directly but indirectly I would say they are because they want you to complete school and want you to establish yourself. They will encourage you to not have a baby before you get married but indirectly I think they would introduce you to contraceptives because you are starting to date or you start to see the

opposite sex. They will say there are these consequences and there are such methods that you can use to prevent certain things" (IDI#7)

"Using the morning after pill is not acceptable. In fact having sex out of wedlock is not acceptable. Our parents encourage us to abstain from sex" (IDI#9)

Two respondents also commented on the generational gap, pointing out that the new generation is more exposed to modern contraceptives than the older generation. The older generation may not believe in such methods of family planning because they might be still using their traditional family planning methods.

"Contraceptive methods are not really recognised. Well, adults do not really know of things such as emergency contraception pills. They not aware of it as much as we are and it is something that it not common in our culture" (IDI#12)

"I would say according to my grandmother you not supposed to take them as much as you are not supposed to take contraceptives so it is a matter of abstaining rather than taking contraceptives" (IDI#17)

Two respondents further explained that these things were not known during the olden days so in their culture it is something that is new.

"The emergency contraception is a modern phenomenon; it was not there back in the days but nowadays it is known. I do not think they regard it as something you should be taking. So I think in terms of my culture I do not think they regard it as something that is right to do because you should not even in the first place have unprotected sex" (IDI#11)

"With regard to Zulus, I do not think they know about the morning after pill even if it dates back in times of Shaka Zulu I do not think they knew of any contraceptive

method. It is just that before you were not allowed to have sex up until you got married" (IDI#19)

4.11 Summary

This chapter has illustrated young people experiences with using emergency contraception. EC method helps them to deal with unwanted and unplanned pregnancies while they focusing on their careers. Also during their time at tertiary they are financially dependent therefore they cannot afford to raise a child on their own. In some instance, the fathers might refuse the responsibilities of raising the child. thus they seemed to be more concerned about pregnancy after they have had unprotected sex than they were about contracting HIV/AIDS though they seemed to have awareness about the risk associated with unprotected sex except falling pregnant. Respondents mentioned negative effects of using EC based on their personal experiences, some of the experiences include, irregular periods. There was a consensus among the respondents that EC should not be used as a substitute for long-term contraceptives since it does not protect against HIV/AIDS. Hence they were reluctant to even recommend it even to their peers. Attitude of service providers hinder access to public clinics thus young women mostly preferred private doctors and pharmacies because they unlikely to be treated badly. Culture and religious also had influence on the regular use of EC because respondents had different views or perspectives that illustrate their beliefs and norms as they indicated EC is seen as a sin, demonic and an abortifacient.

Chapter five: Discussion and Conclusion

5.1 Discussion

The aim of this study was to provide insights into the experiences of young women who had ever used emergency contraception. As with most studies, this study had its limitations because the sample was relatively small as it consisted only of twenty respondents, thus the findings may not be generalizable to the entire population. Nevertheless, important lessons can be learnt from this study.

The study clearly shows that young women are aware of the risks associated with unprotected sexual behaviour and they are particularly worried about being pregnant while they still at the tertiary level. This finding applies to the model developed by Eaton *et al*., (2002) which is used to guide this study. The model indicates that at the personal level that young people should be aware of the risk associated with sexual behaviours and use protect to prevent negative consequences. Thus, each respondent was aware that emergency contraception is used to prevent an unintended pregnancy. Findings identify that respondent‟s source of information of EC method were friends who had ever used EC. The school is indicated as another source of information where they were taught of different contraceptive methods or about sexual and reproductive health. This finding is similar to that of Graham *et al*., (1996) as they found that the school is the most commonly cited source of information about sexual and reproductive health. Sex education programmes are useful for those young people who have never been exposed to topics such as reproductive health issues in order for them to be encouraged to practice safer sexual intercourse and to use variety of contraception methods that are readily available in public and private health sectors in South Africa. Other sources of information mentioned included the mass media. The media plays an important role because it informs them about sexual and reproductive health issues and encourages them to take responsibility for their health. Multiple media sources (including magazines and television) may help to create an environment where the practice of contraception is perceived as a social norm. According to Westoff and Rodriguez (1995), the emphasis of the media should be on promoting family planning and other reproductive health issues.

The model developed by Eaton *et al*., (2002) supports the findings that the physical and environmental setting impacts behaviour.

Respondents indicated several reasons of using EC that they did not want to fall pregnant because they are not financially stable and they still depend on their parents, so having a child can be a burden because it comes with responsibilities. Some respondents pointed out that education is important to them so they used EC because they want to finish their studies and be economically dependent. According to Ehlers and Phil (2010) they states that EC methods enables young people to actually complete their schooling and start their life long careers. Incorrect usage of contraceptive was another major reason for using EC as they were preventing an unplanned, one complained about forgetting to get the contraception injection at the clinic and the other complained of a burst condom. Limited knowledge lead the respondents to use EC unnecessarily because some respondents stated that they had used the condom but it did not burst or break, but because there were scared and did not know whether they will fall pregnant hence they opted for emergency contraception.

The findings in this study continue to reflect a link between existing studies conducted by Roberts *et al*., (2004) and other authors. The studies indicate that even though EC is relatively easily accessible and free of charge at all public health facilities in South Africa young women are still not aware of the availability of EC at the public facility (Roberts et *al*., 2004). Some respondents in the study reported that they only knew that emergency contraception is available at the pharmacy. Studies still indicate barriers when accessing health sector facilities especially clinics. The findings of this research are also consistent with the existing evidence that young women prefer to obtain services from providers in the private sectors, where assurances of privacy and quality are generally greater than in public health care sectors (Wood *et al*., 1997).The most common barrier to accessing sexual and reproductive health services cited by young people in the study is fear and shame. They mentioned that nurses do not treat them politely because they shout at them for not using protection when engaging in sexual intercourse. Respondents indicated it makes it difficult to maintain a private life, which is the reason most of them opted for the pharmacy because they are not judged and they are not asked too many questions.

According to Weisberg and Fraser (2009) they argue that women must have the right to obtain EC without compulsory counselling, insistence on STIs checks or moralistic questioning by nurse, doctors or pharmacist. However, respondents who went to the clinic stated that, they find clinics more useful because they are given more detailed information on how to protect themselves against pregnancy and they are even checked for other diseases that might occur unnoticed. They are also guided to use other regular contraceptive methods such as condoms and oral contraceptives methods that will prevent unplanned pregnancy, STIs and HIV.

Another barrier in accessing public health facility stated by the respondents is that they had to wait for so many hours to be attended by a nurse. They favoured the accessibility of the pharmacy; because they open on evenings, weekends and holidays, hence for them pharmacies are clearly an ideal source of EC. Respondents also emphasise that they did not have to wait for the campus clinic to open because that might have increased the risk of pregnancy. Thus, the respondents in the study saw the pharmacy as the most accessible for obtaining EC. A similar study by Maharaj and Rogan (2011) indicate that long waiting times for consultation at public clinics is another likely reason for the low uptake of EC in the public health facility. Furthermore, the findings in this study are consistent with that of Barot (2008) revealing that women prefer using the services of the pharmacy because of its accessibility and its diverse forms of contraception. Respondents pointed out that they opt for the pharmacy because they will get a variety of ECPs that they can choose from; unlike in a public health facility a person has limited choice.

Respondents in the study were worried of the effects of EC on a woman‟s reproductive system because they stated that they went through a painful experience. They explained that they had severe side effects that were unbearable. Respondents also assumed that EC might lead to infertility because they have heard that if women use the method for several times it may affect their reproductive system. Results in this study correspond with existing literature, as Ehlers and Phil (2010) in their study also found that the issues that lead to non-utilisation of contraceptives by young women included fears of infertility after the utilisation of contraceptives. Respondents also showed their concerns for their friends who might want to use EC. They reported that they would suggest other regular

contraceptive methods unless it is really an emergency to prevent pregnancy. One respondent in the study stated that after taking EC she soon went to get her contraception injection for the three-month period to prevent pregnancy. Wellberry (2000), reports that women can be given implants or injections if results of pregnancy tests are negative.

The respondents seemed to express mixed reactions to advance dosages identifying both positive and negative aspects associated with it. On the positive side, it allows a woman to take the EC immediately without waiting to go to the pharmacy or clinics because it might happen that a woman does not have transport fair or even money to buy EC. Thus, the availability of an advance supply at home means that it can even work more effectively. On the negative side, it may make women vulnerable in her sexual relationship because her partner may demand unprotected sex since she has an advance dosage of EC available. The young women in the study had concern that if EC is used more often it might be problematic in the end such as causing complications on female‟s reproductive system. Patient education materials accompanying packaged pills emphasize that EC is not to be used as a regular means of contraception (Wellberry, 2000).

The study revealed that young women had some concerns about emergency contraception. Even though the majority of respondents had good knowledge of emergency contraception, some did not know why the ECP was not always effective when used. As three women reported that, they used EC previously but it was not effective because they fell pregnant. They were confused about why the EC was not effective as they took it immediately after unprotected intercourse or within 72 hours. They indicated that it created problems within their relationships and their parents were very unhappy that there were pregnant. Although they were disappointed but they still embraced their children. Male partners seemed supportive of their decision to use EC. Open discussion can create a strong bond in the relationship and confirms that partners care about each other‟s health (Wood and Foster, 1995). The young women indicated that their partners have been supportive of their choice to use EC; they understand that they need to complete their education and they want a better future for themselves and quality life for their future children. However, a few male partners refused to give them money to buy EC. Existing studies does correspond with the findings in this study, as Harper *et al*.,

(2004) indicate that supportive male partners assists to enhance contraceptive use and to decrease unplanned and unwanted pregnancy. By offering young women the chance of involving their male partners in contraceptive counselling this can also create an opportunity for healthy male participation in contraceptive decision-making (Harper *et al*., 2004).

In the study, only one respondent mentioned that she was advised by her mother to use an emergency contraception pill. In general, respondents stated that they were not able to discuss contraceptive use with their parents because they were seen as too young and they were afraid of being scolded by their parents. As a result, they did not reveal to their parents their use of EC because of fear of punishment. Studies indicate that parents refuse to talk about sexual issues or they give their children vague information about contraceptive methods (Kelly, 2000). Cultural taboos prevent communication about sexual matter between parents and children. According to the model developed by Eaton *et al*., (2002), the distal context including culture plays a huge role in influencing the sexual behaviour of young people.

The results in the study are consistent with that of Harper *et al*., (2004) who state that communication with parents on sexual topics typically occurs with the mother, although discussions about contraceptives choices between young women and their mothers often occur only after pregnancy. One respondent indicated that her mother was supportive of her decision to use EC as she even informed her of other methods of preventing pregnancy. This is unusual because parents sometimes are perceived as difficult; they do not want to discuss sex issues with their children but would rather change the subject as they feel it is a sensitive issue. Studies also indicate that parents do not talk to their children because they feel confused, ill informed, or embarrassed about these topics (Hughes and McCauley, 1998). One respondent reported that she had to hide the box of EC so that her mother will not see it. This suggest that respondents had problems in discussing sexual issues with their parents, as talking about sex or contraception methods are taboo. In the study conducted by Harper *et al*., (2004) they reveal that young women had never talked to their parents about contraceptives. In fact, young women argued that they would not seek contraceptive services if they had to inform their parents. “Young

women who do not communicate with their parents are more likely than those who do to follow peer norms about sexual behaviour and condom use" (Harper *et al*., 2004:20).

The findings in this study continue to support the findings of other studies. Keele *et al*., (2005) observe that religion and culture do not permit women to use contraceptive methods. Respondent indicated that their religion and culture cannot stop them from having sex before marriage but they pointed that it is better if they were advised to use contraceptive methods rather than being pregnant and bringing shame to their culture. Some respondents asserted that some churches have youth sessions, which are used to guide and motivate young people to use contraceptive methods to protect themselves against pregnancy and STIs although they emphasize that they are not promoting these methods. Ehrle and Sarker (2011) indicate that the Catholic Church is against the use of contraceptive methods as they speculate that a woman is killing a life inside of her. Respondents in the study also indicate that in their religion they believe that EC is the same as abortion, it is demonic and a sin, because a child is a gift from God thus the use of EC is not allowed. Lastly, respondents showed that EC is still a taboo issue in their culture because older generation do not know much about modern contraceptive methods so they do not talk about the methods but often tell young people to abstain from sex until they get married.

5.2 Recommendations

The findings from the study showed that there is a need for carefully designed education programs on EC. Use of on-going contraceptive methods and condom use need to be stressed to students whenever they access services from health care facilities (Roberts *et al*., 2004). Offering sexual and reproductive health programs in schools or tertiary institutions could assist young people in understanding matters of family planning and to practice safer sexual intercourse by using barrier methods. The use of regular contraceptives methods as well as condoms should be really stressed. The subject should be clearly communicated to avoid risky behaviours especially among young people. The emphasis should be on effective ways of protecting the young people from HIV, STIs and

unintended pregnancy. Introduction of sexual education is critical in efforts to reduce ignorance about sexuality or reproductive health issues and it has been suggested that there should be school programmes at the primary, secondary and tertiary levels (Iyoke *et al*., 2006). This suggests that with a greater emphasis on sex education at the various levels of education; young people can become more aware of the resources that they could use to protect themselves from the early practice of unsafe sexual intercourse. They can learn new ways to prevent unplanned pregnancies using the most effective contraceptive methods for them.

"Programs offering skills development or counselling to young people are rare, as are programs offering sexual and reproductive health services, such as access to a choice of contraceptive methods, diagnosis and treatment of sexually transmitted diseases (STDs), methods for protection against HIV, and, where legal, safe abortion" (Hughes and McCauley, 1998:236). The need for improved information and education programs is because there is an insufficient knowledge about the failure of EC that results in pregnancy because even studies do not provide information on this. Studies do not specify what causes a woman to fall pregnant after using EC. There should be more research about EC failure. These findings from the study highlight the need for a variety of approaches to increase the use of contraception in order to decrease the level of unsafe sexual intercourse and unintended pregnancy among young people. Nichols *et al*., (1986) states that safety concerns may be addressed by providing information on the side effects associated with EC, and by making barrier methods available to those who wish to use them.

In the United States of America, the Food and Drug Administration approved an emergency contraception kit consisting of four combination pills, a urine pregnancy test, patient information book (Wellberry, 2000). It will be better for South Africa if it will adopt this new emergency contraception kit so that women understand the steps that should be followed and it will reduce the risk of pregnancy. The follow-up should be done in health facilities in order for women to understand what might be the health risks associated with EC. In addition, the user should consult with health professionals to get more information on why did EC did not work as the findings in the study revealed that

there are three respondents that got pregnant after using EC. This study also suggests that women who obtain their EC in the health care facilities should first be tested for pregnancy. Educating health professionals on how to use EC is essential in our country for them to inform their patients on how they can utilize EC and when they need to use it. The goal of conducting training workshops with pharmacists is to address the negative perceptions of EC and misinformation about the repeat use of EC and to improve the frequency of counselling on HIV/STI prevention including a component focusing on EC as a back-up method for condoms. A youth-friendly health facility initiative would further engage health professionals and hopefully result in improved access and information distribution. Health care providers should be trained to be able to offer counselling services to all clients in order to improve their acceptance of contraceptives. Young people should be particularly targeted and encouraged early on a positive attitude towards family planning including the use of EC to prevent unwanted pregnancy (Oye-Andenere *et al*., 2006).

Clinics should provide youth-friendly services and create outreach activities within their communities to actually educate young people about the services they offer at the clinics especially EC so that they reduce pregnancy. In a study by Boonstra (2007) young people indicated that they want to receive information about sexual and reproductive health issues to come from trusted sources such as teachers and health care providers. Health care providers and governments should listen to young people‟s issues and understand their concerns about sexual matters and this will enable them to be open about the issues they face. Thus health care providers should provide guidance and support so that young people start to be responsible in their own lives and a better society can be created and information can be transferred to the next generation.

Parents should have good communication with their children by discussing issues of sexual and reproductive health. When parents themselves lack knowledge about contraceptives it makes matters worse for young people to even know about reproductive methods. A study by Hughes and McCauley (1998) reveal that adults are also unprepared to discuss sexuality issues, often because they feel uncomfortable or overworked, or because they disapprove of young people who express an interest in sexuality. Parents

should open-up or allow their children to ask them questions about sexual matters because they have more experience rather than keeping information a secret and shouting at their children when they become pregnant or find themselves in difficult situations. Parents should transfer knowledge of what they used to prevent pregnancy so this can assist young people to be able to share their problems with them rather than going to a stranger who might not advise them better than parents. Parental support and communication can help young women to avoid risky sexual behaviours and an unplanned pregnancy.

The study recommends that there is a need for further research on emergency contraception. In South Africa, the existing body of literature does not provide adequate information concerning the characteristics of women who are aware of EC and have access to it, even about the connection between access to and use of other modern methods of contraception and awareness of EC. This gap seems to result from difficulties most researchers experience in finding and including users of emergency contraception. Boonstra (2007) suggest that achieving a better understanding of the existing channels of information about EC would help in designing interventions to improve awareness. Understanding the reasons for unprotected sexual intercourse, method failure or irregular access of contraception, why women use EC is another critical gap. Failure to meet the sexual and reproductive health needs of young people will result in high levels of unwanted pregnancies, unsafe abortions and STIs, including HIV and will contribute to long-term negative health, social and economic consequences. Investments in young people‟s sexuality and reproductive health education will benefit the health and productive capacity of their societies for years to come (Boonstra, 2007).

5.3 Conclusion

In conclusion, the study collected data on the factors influencing young women that had ever use EC. The study clearly indicated that young women are in favour of the EC method, as it prevents unplanned pregnancy. The study had indicated the reasons of young women for preventing unplanned pregnancy, including the desire to complete their

education, their lack of financial stability and their unstable relationship status. The study indicated the usefulness of sex education, friends and use of media which helped women to gain information about sexual and reproductive health. Existing literature also correspond with the results from this study, since it indicated the barriers associated with accessing EC in public health sectors which resulted for young women to mostly use services from private doctors or pharmacies. The study indicates that health care facilities, cultural and religious beliefs are the main barriers for young people not accessing contraceptive methods. Respondents also expressed concern about the severe side effects associated with EC and concern of the EC effectiveness. Thus, the study recommends that there should be more research done on the effectiveness of EC and proper training of health care providers on how to address young people when they seek health services is recommended.

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Appendix 1: Informed Consent Form

(To be read out by researcher before the beginning of the interview. One copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

My name is Hlengiwe Kunene (student number 207526346). I am doing research on a project entitled "Factors influencing emergency contraceptive use: perspectives of students in Durban, South Africa". This project is supervised by Professor Pranitha Maharaj at the School of Development Studies, University of KwaZulu-Natal. I am managing the project and should you have any questions my contact details are:

School of Built Environment and Development Studies, University of KwaZulu-Natal, Durban.

Email: 207526346@stu.ukzn.ac.za or kunenehs@gmail.com

Thank you for agreeing to take part in the project. Before we start, I would like to emphasize that:

-Your participation is entirely voluntary;

-You are free to refuse to answer any question;

-You are free to withdraw at any time.

I would like to record the interview, and the recording will be transcribed word for word. The recording and the transcription will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report but will not include details that will identify you.

Please sign this form to show that I have read the contents to you.

(Signature)---------- (Date)----------

(Print name)----------

Appendix 2: Interview Guide

Section1: Demographic and socio-economic/ reproductive history profile

1. How old are you?
2. Level of study at the university?
3. What is your religion?
4. Do you have a partner? If yes, married?
5. Do you use a contraceptive method?
    - If yes, what is your current contraceptive method?
    - How often do you use it?
    - Where do you access contraceptive methods?
6. Have you ever been pregnant?
    - If yes, how many children?
    - Are they still living?
7. Did you have sex education in school?
    - If yes, please describe.

Section 2: knowledge of emergency contraception

8. Where had you heard of emergency contraception (EC) or morning after-pill?
9. Do you have an advance dosage of emergency contraception available to you?
10. What were your main reasons for using EC?
11. What were your experiences when you used EC, please describe what happened?

Probes

- Where did you get the EC?
- Why did you choose to go there instead of …(clinic, pharmacy)
- Who did you have to speak to?
- What information did they ask for?
- How would you describe their attitude?
    - How did that make you feel?
- What information did they give you?
    - How did that make you feel?
- Where did you take the EC? (at home?)

- What happened after you took the EC?

12. Other than myself, who else have you spoken to about using EC?
    - What was their reaction?
    - How did that make you feel?
13. What cultural or ethnic group do you identify with?
14. What are the general beliefs of this group in relation to something like EC?
15. What is your religion? How frequently do you attend religious gatherings?
16. What are the general beliefs of this religion in relation to something like EC?
17. What are the advantages of using the method?
18. What are the disadvantages of using this method?
19. Would you recommend a friend to use EC?
20. Would you use the method in future?
    - If no, why not?
21. Any questions or comments concerning the research?