Factors contributing to the high rate of teenage pregnancy at Makhado Local area Vhembe District of Limpopo Province in South Africa

By

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DECLARATION

I declare that **FACTORS CONTRIBUTING TO HIGH RATE OF TEENAGE PREGNANCY AT MAKHADO LOCAL AREA, VHEMBE DISTRICT, SOUTH AFRICA,** is my own work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any degree or at any institution.

TMiriri........ 24.04.2015

T.M MIRIRI **DATE**

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Abstract

This study sought to explore and describe the factors contributing to high rate of teenage pregnancy among teenagers residing at Makhado Local area, Vhembe district, South Africa. A quantitative descriptive research approach was used. Population consisted of all pregnant teenagers and teenage mothers attending antenatal and postnatal clinic within six weeks after delivery during June to October 2012 at healthcare facilities in Vhembe district, South Africa. Simple random sampling technique was used to select the clinics in which the study focused. Convenience sampling was used to include seventy pregnant teenagers and teenage mothers who satisfied the inclusion criteria.

Data were collected through structured self-administered questionnaires. Descriptive statistical data analysis was used. Ethical considerations were ensured. Findings revealed that teenagers were falling pregnant at an early age (47%) of the respondents were between the ages of 18–19 years. Findings further reveled that as many as (41%) of the respondents never use contraceptives.

Pregnancy prevention strategies were recommended based on the results. The strategies focused on reproductive health services, male involvement and adult-

teenager communication programmes as well as parents' involvement in sex education of their girl children.

Key concepts: Teenagers, Pregnancy, Peer pressure, Poverty

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ABBREVIATIONS AND ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome

CTOP - Choice on Termination of Pregnancy

DOH - Department of Health

HIV - Human Immunodeficiency Virus

ICPD - International Conference of Population Development

LP - Limpopo Province

MRC - Medical Research Council

NBS - National Bureau of Statistics

NCPT - National Campaign to prevent teenage pregnancy

NGOs - Non-Governmental Organizations

PSHE - Personal, Social and Health Education

SA - South Africa

SAPP - South African Population Policy

SPSS - Statistical Packages of Social Science

STIs - Sexually Transmitted Infections

TOP Termination of pregnancy

TPO - Teen Pregnancy Organization

UK - United Kingdom

USA - United States of America

WHO - World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Teenage pregnancy continues to be a social problem today due to its continuing rise that has an adverse impact on the teenager, their families, taxpayers and society as a whole. Many teenage girls frequently encounter numerous risks and challenges from family, community and societal influences National bureau of statistics (NBS 2009). This study sought to explore and describe the factors contributing to high rate of teenage pregnancy among the teenagers residing at Makhado local area, Vhembe district, South Africa (SA). Teenage pregnancy is a public health concern both in the developed and developing countries. As pregnancies increase, so do births with all its consequences. In 2008, there were 42 births per 1,000 in SA among teenage girls, which was six per cent higher than 2007 (NBS 2009).

However, abortions in this age group increased by three (3%) per cent from 2009 to 2010 SA Population Policy (SAPP) (2010:36). Globally, 15 million women under the age of 19 years gave birth, representing up to one-fifth of all births and 529,000 women die due to pregnancy and child birth related complications every year. The risk of death due to pregnancy-related causes is double among women aged 14-19 years compared to women in their twenties. Young women are also at risk of unwanted pregnancies, sexually transmitted infections (STIs) and unsatisfactory or coerced early sexual relationships (Mashao 2008:243). Given the above consequences, teenage girls need information on biological changes, sexual issues and reproductive health services so that they can use protection when having sex. Additionally, they require parental guidance as well as that of teachers, and health providers, which is crucial in order to achieve full potential. Ziyane and Ehlers (2007:6) warned that within the African continent, teenagers are a low priority in both policies and programmes at national level. The researcher therefore, seeks to find out what influences high rate of teenage pregnancies at Makhado local area, Vhembe district, SA.

1.2 BACKGROUND OF THE STUDY

In many parts of the world, as indicated in the World Health Organization (WHO)'s report (2011:45), teenage pregnancy is conceptualized as a social problem. There are many factors that lead to this perception. Firstly, teenage pregnancy has been associated with physiological harm to the teenage mother and that of her child (Hogan & Kenny 2007:122). Teen Pregnancy Organization (TPO), a site managed by the National Campaign to Prevent Teen-pregnancy (NCPT) (2009:5) and Unplanned Pregnancies, states that there are 750,000 teen pregnancies annually. The United State of America (USA) has a birth rate of 41.9 births per 1000 females' aged15-19 years, significantly (up to 7 times) higher than in other Western industrialized countries. Additionally, after a 14 –year decline, current and preliminary data indicate that the teen birth rate has increased for 2 consecutive years, rising 5% between 2005 and 2007. Of all teen ages 15-19 years who become pregnant, 57% deliver a live infant, 27% obtain an abortion and 16% have a spontaneous miscarriage.

The teen birth rate across states also differs widely, from a rate (2005) of 62(1000) teens aged 15-19 in New York and Texas to a rate of 18% per 1000 teens aged 15-19 in New hemisphere. Adolescent pregnancy has been associated with numerous interpersonal, and environmental factors, including decreased parent-child connectedness, decreased parental monitoring, more permissive parental attitude regarding teenagers sexual activity, community and family disorganization and disruption, parental characteristics, absence of positive norms and low partner support for contraceptives use(Farrer 2010:30).

In Russian teenage pregnancy rate is very high and, despite the high rate of abortions, 5.5% of teenagers still give birth. In Bangladesh, where girls as young as 12 years old are married, one-fifth of teenagers have had a baby before they are 15, and 80% before 20 years old (Mashao 2008:241). Increasing sexual activity amongst the youth is one cause of the increase in teen pregnancies. Other contributing factors include the poor familial communication between the parents and their youth.

Although sexual activity among teenagers is widespread around the world, the determinants and consequences are likely to differ from one region to another. Early pregnancies are more pronounced and detrimental in Sub-Saharan Africa (SSA) countries, most of which experience high level of poverty. However, most of empirical literature on teenage pregnancy is based on developed countries. There is paucity of empirical studies on cases of teenage pregnancies in African countries (Were 2007:327). In the study on the determinants of teenage pregnancy among teenagers aged 10-19 years at Busia district in Kenya, Were (2007:329) found that the problem of teenage pregnancy was attributed to poverty, over 50% of respondents concurred that their pregnancy occurred due to peer pressure. Level of education of respondents showed to be a contributing factor to teenage pregnancy, those with lower levels of education was more vulnerable to teenage pregnancies.

SA has a huge teen pregnancy problem - one in three girls has had a baby by the age of 20 years. Integrated regional information networks (IRIN) (2007) indicate that schoolgirl pregnancies have doubled in the past year, despite a decade of spending on sex education and HIV/ AIDS awareness. The number of pregnant schoolgirls jumped from 1,169 in 2005 to 2,336 in 2006 in Gauteng, the country's economic heartland and most populous province, according to statistics released in the provincial parliament.

In a country where HIV prevalence is 18.8%, the high level of teenage pregnancy has heightened concerns. SA Medical Research Council (MRC) reported that, "The latest national survey into HIV prevalence recorded that 16% of pregnant women under the age of 20 tested HIV positive." (As cited in IRIN 2007)

The problem is not equally serious in all parts of the country: on average, two to three girls fall pregnant in a typical school with 1,200 to 1,400 pupils. But what is clear is that there are hotspots where things are horribly wrong. The Gauteng figures showed 71% of pupils pregnant at one school in Soweto, a huge township on the outskirts of Johannesburg.

Somehow there are schools where 60 to 70% of pupils were pregnant. There is no doubt that this is associated with things like gang activity, coercion and substance abuse. According to a 2006 survey, 30% of girls in SA said "their first sexual experience was forced or under threat of force".

But other factors are also driving the high teenage pregnancy rate in some areas. According to a recent MRC study, 'Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive use in SA', "Nurses' attitudes were a major barrier to teenagers getting hold of contraceptives. The nurses were uncomfortable about providing teenagers with contraceptives, as they felt they should not be having sex. They responded to requests for contraceptives in a manner that was highly judgmental and unhelpful. The girls described it as harassment (Tjallings 2010:99).

The study also found that social pressures often prevented young women from using contraceptives: "The girls felt they would only be accepted as women once they had proved their fertility - many mothers wanted their teenage daughters to become pregnant so they could have a baby at home again.
The majority of the respondents in their study had their first intercourse between the ages of 14 and 17 years (Ziyane & Ehlers 2007:8).

Statistics show that four out of 10 females became pregnant at least once before the age 20 years. Education is important for these females in order to break the poverty cycle that trap most of them. Despite being allowed to return to school after becoming mothers, the girls face many challenges in trying to balance motherhood and the demands of schooling Department of Health (DOH 2009:20). Sunday Times 19 March

2011, reported that one of the SA province, KwaZulu-Natal had seventeen thousands (17,000) teen pregnancies within the secondary schools.

The Minister of Health in SA, Dr. A Motswaledi raised concerns recently regarding the secondary school learners who become pregnant and deliver in the class room premises without midwives; teachers who are not trained to deliver babies are now acting as midwives in that context and face all the complications of delivery. The Minister further indicated that he is going to engage the services of retired midwives as part of school health services, to appoint them to individual secondary school so that they can monitor those pregnant learners. This was suggested by the Minister as a reactive plan to put in place because of the very high statistics of teenage pregnancies in all the provinces of the SA as well as Makhado local area of Vhembe district in which the study was focused.

Teenagers, in any country, who become pregnant, face severe health risks whether they are married or not. Teenagers are not fully physically developed; at menarche a young woman's pelvis has not finished growing therefore, pregnancy and birth at such a young age poses serious risks for both mother and child. Mothers under 20 years suffer more complications in pregnancy and delivery than women who bear children at age 20 or later. Deaths from anaemia, eclampsia and obstructed labour are more common in young mothers than among older women (Maja 2007:33).

SA, like many countries in Africa and elsewhere, has serious problems in relation to sexual and reproductive health issues. Probably, pregnancies are more than the reported numbers due to under reporting. Teen pregnancy is at its highest among younger women as young as age 14 and 17 years as is indicated by the statistics from one of the maternity registers at the Makhado Reproductive and Child Health Clinic in 2010.

Adolescent sexuality and the potential for unplanned teenage pregnancies are issues to be considered not only in terms of the pregnancies but also with a view to the world population, and concerns for the pregnant females' welfare. Outlined as major population concerns in SA are the high incidence of unplanned and unwanted pregnancies, increased risk of child bearing and maternal mortality, incidence of sexually transmitted infections (STIs) including HIV and AIDS, and these deserve vigorous response from all concerned. In line with the Programme of Action agreed upon at the International Conference on Population and Development (ICPD) in Cairo in 1994, one of the major strategies of the SA(SAPP) (2010:36) was the promotion of "responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS, through the provision of life skills, sexuality and gender sensitivity education, user-friendly health services and opportunities for engaging in social and community life'. In order for policy makers and practitioners to fully implement some of these proposed solutions, first need to understand the current context within which these concerns are evident. The following table 1.1 shows the rate of teenage pregnancy in some of the clinics in Makhado local area.

Table 1.1: Pregnant teenagers attending ante-natal clinic at the Clinics at Makhado local area (2010)

Age: 14-19 years old.

Month	Clinic A	Clinic B	Clinic C	Clinic D	Clinic E
January	16	17	13	16	14
February	10	12	14	10	9
March	9	10	7	11	15
April	11	13	10	9	9
May	14	9	13	12	6
June	15	11	11	10	11
July	19	6	5	7	5
August	8	12	8	14	13
September	12	14	9	6	8
October	10	8	12	11	4
November	13	9	6	8	7
December	18	10	15	13	12
Total	159	149	123	137	113

Source, Register: Makhado local area Reproductive and Child Health Clinic 2010.

1.3 RATIONALE OF THE STUDY

Based on research available in SA, various gaps in current literature have been identified. These include the paucity of information available regarding teen pregnancies, barriers to service provision, including the perceived attitudes and treatment received from healthcare staff members (Ziyane& Ehlers 2007:11). Studies seem to concentrate broadly on pregnancy without concentrating on pregnant teenagers and the contributory factors, hence they focus on teenagers' sexual and reproductive health in general, with limited focuses on pregnancy as such (WHO 2010:12). As a result, this study recognizes that teenagers are not a homogeneous group and their situation and needs vary greatly from socio-economic status, education, geographical location and setting.

This study acknowledged that the context of teenage pregnancy is impacted upon by the perceptions and attitudes of teenagers and other social groupings in their communities. This leads to ignorance of the factors that lead to pregnancy among teens. Therefore, the study had gathered explanations on factors contributing to teenage pregnancy at Makhado local area. Four government hospitals in Vhembe district of Limpopo province (LP) recorded a total of 7754 live births which were borne by teenage mothers during the 2009 calendar year only (Four Hospital Maternity Register 2009). These 2009 statistics provided a point of reference as to whether the study is of importance or not.

1.4 PROBLEM STATEMENT

Despite the extensive efforts given to teenage sexuality and teenage pregnancies by the democratic government of SA, extra ordinary number of teenagers continues to fall pregnant. Van Eijk (2007:2) support by indicating that teenage pregnancy has become a national epidemic, partly because more and more teenagers who give birth decide to keep and raise their children and receive social grant for their babies. The alarming figures released by Morake (2011:5) for SA Provincial Education Department, indicate that schoolgirl pregnancies have doubled in the past year, despite a decade of spending on sex education and Human Immunodeficiency Virus (HIV) and AIDS awareness. Premature sexual intercourse results in high rates of sexually transmitted diseases, HIV transmission, adolescent pregnancy and Termination of Pregnancies (TOP) (Mkhwanazi 2006:53). Through her professional experience in the labour ward at Makhado Reproductive Health unit and Child Health Clinic, the researcher became concerned at the number of teenage mothers aged 14 to 19 years, who always come to deliver their neonates at this healthcare centre. Lyamuya (2008:49) warns that social and health outcome for teenage pregnancy were poor; most complications that occur were birth asphyxia, prematurity and meconium aspiration, which result in increased foetal death as well as neonatal death.

Females under the age of 14 – 19 years are at high risk of pregnancy-related problems and complications during pregnancy and delivery. The above concerns raised the curiosity of the researcher and led to the need for exploring factors contributing to high rate of teenage pregnancy at Makhado local area, with an aim to provide additional recommendations to the already existing guidelines on the prevention of teenage pregnancies in SA.

1.5 RESEARCH QUESTIONS

Stemming from the research problem, the following research questions and resulting purpose and objectives were formulated for the current study.

1.5.1 The research questions

Considering the research problem the research questions was stated as follow: .

- What are the factors contributing to high rate of teenage pregnancy at Makhado local area?
- Do teenagers have knowledge of causal factor of pregnancy?

- What strategies to be used to prevent teenage pregnancies at Makhado local area of LP?
- Who is responsible for the source of information among teenagers at Makhado local area?

1.5.2 Purpose of the study

The purpose of the study was to explore and describe factors contributing to the high rate of teenage pregnancy at Makhado local area in order to prevent the escalating statistics of unintended pregnancies. The findings of the study would assist in designing appropriate intervention programs.

1.5.3 Objective of the study

Since the study was descriptive and does not intend to establish a cause-effect relationship, it has proceeded without a hypothesis. Burns and Grove (2009:410) state that exploratory descriptive studies "may be guided by research questions and/or research objectives rather than by hypothesis per se". According to Burns and Grove (2009:156), objectives are "clear, concise, declarative statements expressed in the present tense and for clarity with only one or two variables". The objective of the study was to:

- Explore the factors contributing to the high teenage birth rate at Makhado local area.
- Assess the teenagers' level of knowledge of reproductive health issues and causes of pregnancy.
- Identify the source of their knowledge of reproductive health issues.
- Propose possible areas of intervention or services needed to prevent teenage pregnancies.

1.6 SIGNIFICANCE OF THE STUDY

Identification of the factors contributing to teenage pregnancies would assist in solving the problem; it will assist health workers to facilitate the formulation of some recommendations. The results of this study would add to the existing body of knowledge regarding teenage pregnancy. Policy makers could consider the results of this study to improve the existing guidelines and policies on the prevention of early pregnancy. Health workers could utilize the results of this study to improve the overall quality of health information and care rendered to teenagers when visiting Reproductive Health Care services for contraceptives. Strategies could be developed or strengthened and implemented in collaboration with the government, Non- Governmental organizations (NGOs), the private sector, key players and other collaborating agencies and institutions supporting health and development work in SA.

1.7 OPERATIONAL DEFINITIONS

1.7.1 Teenager

Berry and Hall (2010:298) defines a teenager as a person aged between 11 and 20 years, who are going through extensive physical changes .In this study a teenager was perceived as a person aged between 14 - 19 years, as this group is variable in terms of unintended pregnancies.

1.7.2 Pregnancy

Pregnancy is the condition of having a developing embryo or fetus in the body after successful conception. The average duration of pregnancy is about 280 days. According to Berry and Hall (2010:298), pregnancy is a gestational process, comprising the growth and development within a woman of a new individual from conception through the embryonic and fetal periods to birth. In this study pregnancy was referring to the gestational period of a teenager aged 14 – 19 years who comes to a healthcare facility for antenatal and post natal care.

1.7.3 Factors

Factors are things that affect situations or results (Oxford dictionary 2008:144). In this study factors refers to the circumstances that influences teenage pregnancies.

1.8 RESEARCH DESIGN AND METHOD

The study was a quantitative study since it was concerned with numbers and frequencies with which factors contributing to teenage pregnancies. The researcher used an exploratory research type. Lewins (2007:245) defines explorations "as a flexible procedure in which the scholar shift from one to another line of inquiry, adopts new points as the study progress, moves in new directions previously unthought-of". The researcher has explored from teenagers factors contributing to high rate of teenage pregnancy, hence getting more information about this issue that is unknown to the researcher from the respondents of the study. The purpose of the descriptive research design is to provide an opportunity to identify the variables within a phenomenon of the interest (Burns and Grove 2009:451). Descriptive research attempts to provide truthful account of a phenomenon and experiences in the world around by analyzing conversations and interactions that researchers have with their subjects (De vos, Strydom, fouche & Delport (2007:270). In this study a descriptive design was used to describe factors that contribute to high rate of teenage pregnancy as they are explained by the participants.

1.8.1 Population

According Burns and Grove (2011:290) a population is the total number of individuals who have the same characteristics defined for a specific study. The population comprises of pregnant teenagers and teen mothers between the ages of 14-19 years, who meet the inclusion criteria, attending antenatal and postnatal clinics at randomly selected clinics with in Makhado local area.

Target population and accessible population are associated terms. The target population, according to Burns and Grove (2009:423), refers to the population of all potential study units that meet the study inclusion criteria in which the researcher is interested. While the accessible population is defined as the portion of the target population that are accessible to the researcher as a pool of subjects for the study (Burns & Grove 2011:290). In this study, the accessible population comprised all pregnant teenagers and teen mothers who visit the clinic for postnatal care following delivery of their neonates within six weeks after delivery from the randomly sampled clinics, who visited the sampled clinic at the time of data collection. The main motivation for selecting 14- 19 years age groups was to explore the contributory factors of teenage pregnancy.

1.8.2 Sample and Sampling technique

LoBiondo-Woods and Harber (2010:223) maintains that sampling is a vital step in any research as it forms a part of delineating the inquiry. A sampling method is a strategy used to obtain a sample. The method can either be probability or non-probability sampling (Burns& Grove 2011:298). Probability sampling approach was used for the study. In probability sampling approach, each unit in the population has a chance of being selected and the sample can be representative of the population from which it has been selected and as such, generalizations of finding can be made to the population (Burns & Grove 2011:298). A probability simple random sampling technique was used in this study for the sampling of clinics. Participants were sampled using a non- probability convenience method. According to Brink, Van der Walt and Van Rensburg (2012:140) convenience sampling involves the choice of readily available participants or objects of the study. The researcher used this method due to difficulty of getting pregnant teenagers and teenage mothers.

1.8.3 Data collection instrument

The data collection instrument for the study was a questionnaire. Burns and Grove (2011:353) state that a questionnaire is a printed self-report form designed to elicit information and is developed with specific items to assist with the data collection. It was used to gather information from a large number of participants. A structured questionnaire has been developed from literature review to elicit responses relevant to achieve the aim of the study. The aim of the questionnaire was to obtain information regarding the factors contributing to the high rate of teenage pregnancy. The advantage of using a questionnaire to collect data for this study was the fact that it requires less time and energy to administer (Brink et al 2012:154).

1.8.4 Measures to ensure validity and reliability

Validity and reliability refers to the attributes of the questionnaire. **Validity** refers to the extent "to which the research instrument actually measures what it is supposed to measure", implying that it "reflects the abstract construct being examined" (Burns & Grove 2011:334). In this study, validity was ensured by subjecting the instrument to supervisors and healthcare professionals in the field of Reproductive Health Services (RHCs). Construct validity was ensured by aligning the content of the instrument based on literature related to reproductive health and teenage sexuality.

Reliability refers to the "degree of consistency or dependability with which an instrument measures the attribute it is designed to measure to determine clarity of the items and the consistency of the responses" (Burns & Grove 2011:334). In this study reliability was determined using a pre-test to test the feasibility of the study including clarity of questions.

1.8.5 Data collection

The researcher used self-developed, structured, self-administered questionnaire to collect data.

1.8.6 Data analysis

Data was analyzed with the assistance of a statistician and the statistical package of social science (SPSS) was used to analyze data. Data from the questionnaires was analyzed using the SPSS V19.0 software computer programmed by the Statistician. Descriptive statistics, frequency tables and percentages was used in the data analyses to determine the factors contributing to the high rate of teenage pregnancies.

1.9 ETHICAL CONSIDERATIONS

Protecting the rights of the respondents and institutions in which data was collected, the researcher ensured strict compliance with ethical standards, relevant to collected collecting and scientific integrity was maintained throughout the study (Burns & Grove 2011:103). Approval was sought from the Higher Degree Committee of the University of Venda as well as the DOH provincially. Written informed consent was signed by the respondents as according to the Choice on Termination of pregnancy (CTOP) Act no.92 of 1996 allows teenagers from the age of 12 years to give their own concern regarding reproductive health issues.

The purpose of the study and the objectives was explained to the respondents of the study. Anonymity and confidentiality were ensured that the identity of the respondents could not be linked with their responses, their names were not written in the questionnaire.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

Only three health clinic were randomly sampled from the list of all the health clinics within Makhado local area in LP for this study. The study focused on teenagers who are pregnant and teenage mothers aged between14-19 years consequently, the results of this study might not be generalised beyond Makhado local area in the LP.

1.11 STRUCTURE OF THE DISSERTATION

The layout of the study report will be divided into five chapters as follows:

Chapter 1

The chapter contains the introduction, background and the problem statement of the research, significance of the study, the purpose of the study, research objectives and the definitions of key concepts that has been used in the study. The research design and method, reliability and validity, ethical considerations and the limitations of the study are also included

Chapter 2

The chapter outlines relevant literature review from global, regional and local perspective on concept pertaining to this study.

Chapter 3

The chapter contains the methodology used in this research and it includes the design, population, sample and sampling techniques, methods of data collection and analysis as well as reliability and validity.

Chapter 4

The chapter outlines the research findings from data analysis presented in table figures and graphs. The narrative form was also used.

Chapter 5

Summary, conclusion and recommendations were presented as well as some of the study's limitations.

1.12 CONCLUSION

This chapter outlines an orientation to the study. The purpose of the study, research questions and objectives were explained. Relevant concepts were defined, and an outline of the study was provided. In the following chapter, which is chapter 2, a review of the relevant literature was presented.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter addressed the research problem, purpose and significance of the study, definition of key concepts, foundations of the study, research design, and measures of ensuring validity and reliability of the study, ethical considerations, the scope and limitations of the study. This chapter focused on the review of relevant literature on factors contributing to teenage pregnancies worldwide including Makhado local area of Vhembe district in SA.

The purpose of a literature review is to familiarize the reader with practical or theoretical issues relating to the problem and to help the researcher lay a foundation for the study. A literature review indicates what is known about an area of enquiry and suggests ways of conducting the study on the topic of interest. The literature review on factors contributing to teen pregnancies has assisted the researcher to formulate appropriate research objectives that had guide the study, and gain further insight into the problem and the factors contributing to the high teenage pregnancy rates at Makhado local area.

2.1.1 Teenage Pregnancy within the South African context

Teenagers, like all age groups in SA, are greatly affected by the HIV and AIDS pandemic. According to Ziyane and Ehlers (2007:9) HIV/ AIDS and STIs exposes young people aged 14-24 years at risk for contracting the disease. It is therefore important that safe sexual behavior is encouraged and practiced and that pattern of high risk sexual activities, of which teenage pregnancy is one consequence, are also understood within the context of the HIV pandemic. In 2009, 12% of teenage girls aged 14-19 years were pregnant (SAPP 2010:12). This is lower than the reported teenage pregnancy rate of 27% in the 2008. The proportion of teenagers that are pregnant rises rapidly with each successive year as from the age of 14 years (2 %) to 19 years (27%).

Although considerable attention has been paid to the prevalence of teenage childbearing in the less developed world, limited information is available concerning the likelihood that a young woman will become pregnant while she is still enrolled in school. Few studies examined the direct association between continued school enrolments and teen pregnancies. Most of these study used focus-group discussions and semi-structured interview to identify policy factors perceived to contribute to the risk of pregnancies among teenagers. Various studies have reflected on how adolescent relate to the consequences of teenage pregnancy; had identified some factors influencing whether or not a young woman could return to school following a pregnancy. Although these studies have contributed to the way that schoolgirl' pregnancies are conceptualized and have identified issues for policy interventions, few quantitative studies exist to facilitate generalization of these result.

Farrer (2010:130) examine the extent of prior school dropout among pregnant schoolgirl; however they failed to report whether or not these girls had been enrolled in school at the time of their pregnancies. Ziyane and Ehlers (2007:9) examine the relative role of pregnancy and non-pregnancy-related school dropout in shaping the gender gap in educational attainment. These authors did not report on what happen to girls who become pregnant while enrolled in school but did not drop out.

2.2 FACTORS CONTRIBUTING TO TEENAGE PREGNANCY

Teenage pregnancy and childbearing emerged as a social problem in the media and social policy debates in the USA in the 1970s as indicated by Phipps, Rosengard, Weitzen, Meers and Billikoff (2008:11). In the last decade there has been much interest in the field, and a substantial amount of work has been undertaken. Much of the research conducted in SA has been framed by the questions and methods dominating the early literature from developed countries which preceded it. With few exceptions, the SA literature reverberates the early American and British view of teenage pregnancy as a 'catastrophe' (Phipps et al 2008:12). Phrases such as an 'epidemic' of adolescent child-bearing and 'children have children have become common parlance (Maja 2007:45).

Researchers and service providers express humanitarian concern for teen mothers and their children because the consequences of early reproduction are depicted as deleterious (Whitehead 2007:153). This is partially to do with the 'untimely' nature of the activity. Teenage pregnancy, it is argued, leads, *inter alia*, to a disruption of schooling; poor obstetric outcomes owing to the teenager's biological immaturity; and inadequate mothering, including neglect, maltreatment and abuse, owing to the teenager's emotional immaturity.

Fundamental to arguments concerning the causes and consequences of teenage pregnancy is the assumption of 'teenage-hood' as a real thing. In order to speak of teenage pregnancy, in order for adolescents' sexual and reproductive behavior to be the target of interventions, adolescence needs to be accepted as a separable stage of development, as an identifiable phase in the life span of a human during which she/he is no longer a child, but not yet an adult. Certain 'truths' concerning the nature of adolescence and adolescent sexuality need to be considered.

The dominant 'truth' concerning adolescence in developmental psychology is that adolescence represents a transitional stage between childhood and adulthood (Harvey & Gaudoin 2007:58). It is seen as a time of natural, inevitable, universal development in which the body moves, following a developmental blueprint, from a less to a more complex organization of physiological, cognitive, emotional and psychological attributes. Adolescence fulfills the function of preparing the person for adulthood, while still maintaining some of the vestiges of childhood.

This develop mentalist framework, which has for the most part been uncritically taken up in the SA psycho-medical literature, has deployed 'an entire lexicon of supposedly benign words which makes human development seem independent of the social and political context (Tlakula 2011:115). Historical analysis illustrates, however, that adolescence has only emerged as a category in the West in recent history (Horgan $ Kenny 2007:120). The category of adolescence furthermore, presupposes 'childhood'. There is a growing body of literature which problematizes the notion of childhood, and by implication adolescence. These writers have illustrated that childhood has a history, and that it is not a timeless, transcultural phenomenon. They have understood childhood as the product of a number of cultural processes and modernist ideas, which have come to define a specific life stage as different from others and as in need of special treatment. One of the cultural processes involved in the construction of adolescence.

The incidence of teenage pregnancy is increasing and has become a worldwide concern. Among the developed countries, USA has approximately 850,000 teenagers who become pregnant each year. Although the countries are making much progress in lowering those rates by developing good strategies, it still has a long way to go (Realini 2009:33). In 2008, the United Kingdom (UK) had the highest teenage pregnancies. About 38,690 girls under the age of 18 years became pregnant and 44.8% of those pregnancies resulted in legal abortions, 7,617 of the conceptions were by teenagers under 16 years, and 54.5% of the conceptions ended in legal abortions. This generally endangers the life of the teenage girl and necessitates developing strategies to reduce the high incidence rate (Simbayi, Chauveau & Shisana 2008:607).

In the 2003 SADHS, the median age of first intercourse is reported consistently, across all age groups, to be around 16 years. Nationally representative survey 2007 reported the average age of girls' sexual debuts to be about 15 years. Simbayi et al (2008:612) nationally representative survey reports a slightly different age of 14 years. In the 2001 SADHS survey 46 % of women reported that *their* first sexual encounter occurred before the age of 17. In many African countries, more than 20% of women aged 14 to 19 years have given birth to at least one child. Studies showed that most of the contributory factors to teenage pregnancies are early menarche, teen sexual behaviors, socio-cultural and economic factors, educational status as well as peer pressure.

2.2.1 Early menarche

The early occurrence of menarche, the earlier the biological possibility of conceiving. In Dar-es-Salaam, Tanzania, Nasoro (2003:83) found that the age of menarche was between 13 and 15 years, and was associated with increased sexual activity, which put teenagers at risk of unwanted pregnancies and STIs. Oner, Yapici, Kurt, Sasmaz and Bugdayci (2012:139) found that the average age of menarche was 11 years, and those girls first sexual intercourse was reported to happen between the ages of 11 and 14. Due to lack of knowledge, advice and emotional support, the youngsters practiced unsafe sex and were not aware that they could get pregnant or contract HIV/AIDS.

2.2.2 Teen sexual behaviors

The latest National Attitudes and Sexual Lifestyles Survey according to Ritcher and Mlambo (2005:60), is a major source of information on sexual attitudes and behavior among young people. In 2000 over 11,000 males and females aged 16–44 were surveyed across Britain. The median age at first intercourse among respondents aged 16–19 in 2000 was 16. This was the same among both males and females. Among those currently aged 25–29 (who were 16–19 ten years earlier) the median age was 17.

The proportion of men reporting intercourse before age 16 (30%) has remained fairly constant over recent years. In contrast, the proportion of women reporting intercourse before age 16 (26%) is higher among those under 30, but has shown little change over the past decade. First sex before 16 is more common in those from manual social classes, without qualifications, who did not live with both parents up to age 16, those leaving school before age 16, and those who do not cite school as their main source of information about sex. Early intercourse was more commonly reported by women who were younger than 13 years old at menarche. Earlier first intercourse is less likely to be an autonomous and a consensual event, and more likely to be regretted and unprotected against pregnancy and infection (Davies, DiClemente, Wingood, Person, Dix, Harrington, Crosby, & Oh 2006:45).

Phipps et al (2008:10) indicated that in Britain, sexual behaviors were reported as early heterosexual experience. The tracking survey to inform the National Evaluation of the Teenage Pregnancy Strategy surveyed more than 750 young people aged 13–21 across England in June 2003. It showed that approximately four in ten had fairly accurate perceptions of the proportion of young people who had sexual intercourse before the age of 16. It was indicated that more than half of young people had sex before they were 16. There is a great surge of genital sexual development during adolescence. Due to the increased hormones, secondary sexual characteristics appear. Masturbation and sexual fantasies are common. In general, adolescents face a confusing and difficult time and need parental guidance (Horgan & Kenny 2007:120). Bankole, Ahmed, Quedraogo, Neem and Konyani (2007:212) found that early sexual activity is affected by developmental characteristics, such as early puberty and high levels of androgen hormones (i.e. testosterone), which are associated with increased adolescent sexual behavior.

Some research has pointed to the fact that a minority of young women planned their pregnancies. In the surveys conducted by Oner at el (2012:140) for the rest, pregnancies were unintended. Psychological factors influencing teenage pregnancies ranged from maladjustment to the desire to have a child, although many studies indicated that most teenage girls did not intentionally attempt to become pregnant (Tlakula 2011:123).Teenagers who did not have a close mother-child relationship during their own childhood years, tried to compensate for this lack by having a child in the hopes of developing a close bond with the infant. Also reported was the fact that girls might have felt that they could win their boyfriends' affection by having a child since a pregnancy confirms the boyfriends' manhood. Other psychological factors included: becoming independent; trying to be equal to their mothers, to be like other pregnant friends, and to signal for help (Tlakula 2011:117). Discussing sexuality issues is difficult, especially between parents and children. Sexuality might be seen as something that cannot be talked about in public but should rather be discussed with peers. Research conducted in Kenya describes society in parts of Sub-Saharan Africa as having similar cultural barriers deterring members of one age group (parents) from discussing sexual matters with members of another age group (children or immediate juniors) or people of the opposite sex. The same study mentioned that this practice also existed even in modern, educated families who are knowledgeable about HIV and AIDS (Mashao 2008:224).

2.2.3 Socio-cultural and economic factors

Early dating provides a context for many sexual experiences. Unconventional psychosocial attitudes and some risky behaviors, such as early use of alcohol, tobacco and drugs; school problems; delinquency, and physical aggression are associated with earlier onset of adolescent sexual intercourse. Other factors include lower family incomes, less supervision, negative parental modeling, and more permissive attitudes in single-parent families. Having sexually active siblings and friends is also strongly associated with earlier onset of sexual activity (Ikamba and Quedraogo 2003:120). Regarding socio-economic and cultural factors associated with pregnancy among adolescent girls, Whitehead (2007:152) found that adolescents were at high risk of pregnancy at the ages of 14 to 16 years. Moreover, the risk was fifteen times higher in respondents with no formal education and no employment. Also, girls were affected by the mothers' education and the living patterns in the home; living with one parent only or with a guardian compared to living with both parents, and finally, girls from families of low socio-economic status had a higher risk of pregnancy. While in Kenya, Were

(2007:333) found that a lack of necessary material resources to meet the needs of adolescents, because of parents' poor socio-economic status, puts adolescent girls at greater risk of pregnancy. It revealed that teenagers from low socio economic status are lured into sexual intercourse for minor things such as soaps, perfumes and pocket money.

According to Bates, Dodge, Ferguson, Horwood, Pettit and Woodward (2003:811), the fathers' absence had a greater impact on their daughter's sexual activity and teenage pregnancy than on other behavioral or mental health problems or academic achievement. This shows the importance of fathers' involvement and responsibility in raising their children. In Logan, USA, Miller (2002:24) revealed similar results in a study on family influence on adolescent sexual and contraceptive behavior. The cultural practices of socializing adolescents into adulthood range from taboos against premarital sexual encounters to encouragement of child indulgence in premarital sex. Furthermore, Ziyane & Ehlers (2007:8) found that some mothers at times encouraged their sons in sexual activity, as they wanted them to be "real men", and asked their sons if something was wrong if there were no signs of relationships with girls.

2.2.4 Government's policy on sex education in schools

In keeping with the multiple spheres of influence on teens' sexual behaviors, a number of prevention interventions have been instituted in SA. These include school-based sex education, peer education programs, adolescent-friendly clinic initiatives, mass media interventions as well as community-level programs. While the focus of these interventions has primarily been on preventing HIV, they have conferred benefit on teenage pregnancy because of their impact on sexual behavior. Separate interventions for teenage pregnancy and HIV are neither desirable nor feasible. To prevent pregnancy from being overshadowed by a focus on HIV, however, a distinct focus on teenage pregnancy is required. But the range, scale and reach, as well as the quality of implementation of programs vary widely and have limited their impact on adolescent sexuality. In addition, the small number and lack of rigor of evaluation studies limit any conclusions that can be reached about the effectiveness of interventions (SAPP 2010:12).

2.2.5 Educational Status

In SA government review of how the subject is broached in schools recommends that sex education should be a compulsory part of the national curriculum in primary and secondary schools under a new curriculum. However, the plan has provoked controversy – particularly among faith-based groups. As a result, a new review led by the respected East London head teacher, Sir Alasdair MacDonald, will look at the question of whether there should be an opt-out clause for parents who do not want their children to take part in the lessons (DOH 2009:12). According to Were (2007:337), there was a high significant and negative relationship between the level of education and teenage pregnancy. Those with lower level of education are more vulnerable to teenage pregnancies than those with higher level of education. Teenagers with higher level of education are likely to have more access to relevant information and make informed decision regarding sex.

2.2.6 Reasons for the review

According to Mashao (2008:218), statistics in the form of SA teenage pregnancy rates make it obvious that the country has not been successful in delivering this in the past. Currently, secondary schools only have to teach the mechanics of sex in biology classes and not in conjunction with relationships and sexual health. Most schools do teach personal, social and health education (PSHE) but it is not compulsory. A recent survey of pupils showed that four in every 10 had received no sex education at school. Teaching of sex education in the UK also poses particular problems in faith-based schools. For instance, contraception, abortion and homosexuality are against the teachings of the Catholic faith and there has been some controversy within Catholic schools where diocese have issued edicts barring their schools from allowing pro-choice groups into schools to talk about abortion (Harvey & Gaudin 2007:60).

Women with more education are more likely to delay child bearing. In some countries in Sub-Saharan African, more women with less than seven years' education are more likely to have a child before they are 18 than ones with seven or more years of education. In the USA, approximately 30% of young women who have less than a basic education (at least seven years) have a child before they are 18 compared to 5% of those who have at least twelve years of education (Tlakula 2011:113). The risk of pregnancy is greater among adolescents with no formal education than with those with secondary education. Moreover, a lack of parental guidance and appropriate sex education contributes to teenage pregnancy (Chigona 2007:110).

2.2.7 Sexual violence

Were (2007:334) reported that 60% of teenagers have initiated sex due to pressure from partners. Coerced sexual intercourse represents only one of the more extremes of sexual abuse. In Dar-es-Salaam, many victims of rape are between 12 and 17 at the time of the rape, and pregnancy is one of the outcomes (Ikamba & Quedraogo 2003:17). This has adverse consequences for young women's future sexual and reproductive health. In the USA, Whitehead (2007:152) report a significant increase in sexual activity among females aged 14, 15 and 16 compared with young women of the same age 15 years ago. The younger the age of first sexual intercourse, the more likely that the experience was coercive and forced, and there is great risk of unwanted pregnancy and STIs, and less likely the use of contraceptives. Generally, these youngsters have more sexual partners. Regarding the prevalence of sexual abuse in childhood (age below 15), Marsigilio and Mott (2000:519) reveal that many victims have their first sexual experience as a product of coercion or force. This is of grave concern as the outcomes of sexual abuse include unwanted pregnancy and STIs, including HIV/AIDS. Any abuse is a severe violation of girls' basic rights and bodily integrity.

2.2.8 Peer pressure

Peer pressure can result in undesirable behavior that might cause teenage pregnancy. In a study conducted in the district of Busia in Kenya about the determinants of teenage pregnancies, Were (2007:336) revealed that 50% of the teenage mothers concurred that their pregnancy was largely a product of peer pressure to have sex. Additionally, of the teenagers that admitted having male friends, over 60% reported that major problem they encounter in their friendship was persistent pressure to indulge in premarital sex.

In a study on high-risk sexual behavior in Tanzania, Ikamba and Quedraogo (2003:121) found that youth are forced into having sexual intercourse by peer pressure. Peer pressure plays a role in initiating sexual activity, which frequently ends in teenage pregnancies. Poverty among girls (especially with poor parents) is another factor. Initiation rituals for girls encourage sexual activity, as some of the girls immediately practice what they have been taught, and no information is given thereof on how to prevent disease and unwanted pregnancy. Persistent pressure from partners to have sex, and also seeing pregnant friends to be pregnant are other contributing factors for teenage pregnancy (Arai 2003:202).

2.2.9 The Child Support Grant and teenage pregnancy in South Africa

The introduction of the Child Support Grant (CSG) in SA has stirred up similar issues and similar debates regarding welfare. A school of thought has developed in SA which claims that the CSG has some perverse incentives, one of which is to encourage women to have more children, especially teenagers. It is widely acknowledged in SA that teenage fertility is relatively high. About half of all young people between 14 and 19 years of age, slightly more men than women, report having had sex, by 19; close to 80% of SA women have had sex, and about 37% have been pregnant by those ages (DOH 2009:10). In comparison to the 1998 Demographic and Health Survey, in which 16% of young women reported using a condom during their last sexual encounter, by 2002, the rates reported in national surveys was 48%.

2.3 CONCLUSION

In the above discussion the literature related to the topic on factors contributing to high teenage pregnancies among teenagers was discussed. Based on the research topic the following issues were discussed: the factors contribution to teenage pregnancies, factors influencing teenage sexuality and parental contributions on sexuality and prevention of teen pregnancy. The next chapter explicates the research methodology and research design of the research.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter addressed the literature review and its purpose. This chapter discusses the research paradigm, namely the quantitative research paradigm and the research design selected for the study. The latter includes sampling procedures, data collection methods and instruments, data analysis and interpretation, and ethical considerations and measures to ensure validity and reliability. In essence, the researcher embarked on a generic quantitative, descriptive, explorative of the study in order to answer the research questions, and to attain the set purpose and objectives of the research.

3.2 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe factors contributing to the high rate of teenage pregnancy at Makhado local area in order to prevent the escalating statistics of unintended pregnancies. The findings of the study would assist in designing appropriate intervention programs.

3.3. THE RESEARCH QUESTIONS

Considering the research problem the research questions was stated as follows:

- What are the factors contributing to high rate of teenage pregnancy at Makhado local area?

- Do teenagers have knowledge of causal factor of pregnancy?
- What strategies to be used to prevent teenage pregnancies at Makhado local area of LP?
- Who are the sources of information among teenagers at Makhado local area?

3.4 OBJECTIVES OF THE STUDY

Since the study was descriptive and exploratory, does not intend to establish a cause-effect relationship, it has proceeded without a hypothesis. Burns and Grove (2011:46) state that descriptive studies "may be guided by research questions and/or research objectives rather than by hypothesis per se". According to Brink et al (2012:85), objectives are "clear, concise, declarative statements expressed in the present tense and for clarity with only one or two variables". The objectives of the study were to:

- Explore the factors contributing to the high teenage birth rate at Makhado local area.
- Asses the teen's level of knowledge of reproductive health issues and causes of pregnancy.
- Identify the source of their knowledge of reproductive health issues.
- Propose possible areas of intervention or services needed to prevent teenage pregnancies.

3.5 RESEARCH SETTING

The study was conducted at Makhado local area which falls within Makhado municipality, Vhembe district of LP. Makhado local area is composed of five clinics and one Health Center.

Burns and Grove (2011:40) state that the research setting is the site or location in which a research study takes place and can be a natural or controlled environment. Natural settings are real-life study environment without any changes made for the purpose of the study. This study was conducted in a natural setting, in a private room within the clinics at Makhado local area of LP in SA. The study was conducted in the randomly selected health clinics at Makhado local area of LP.

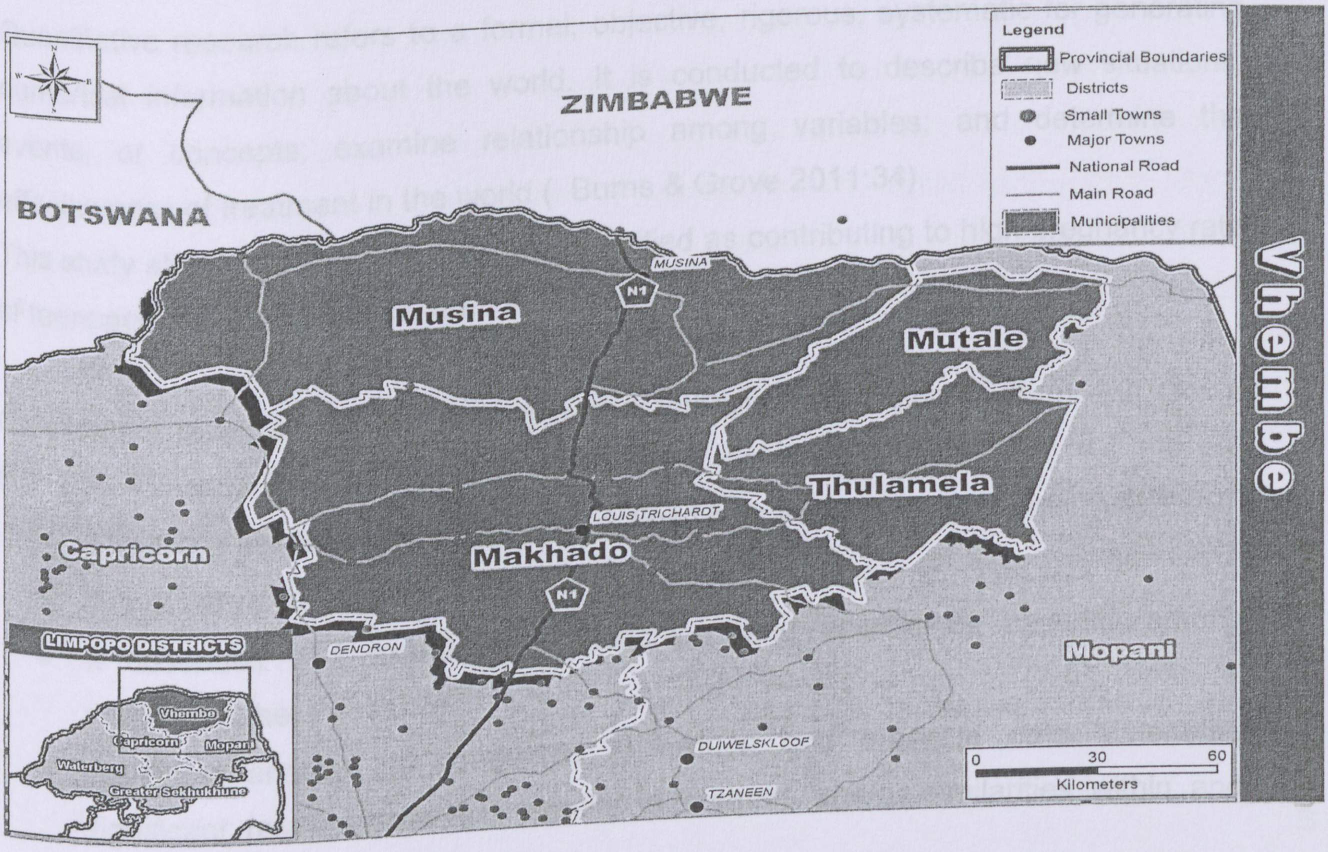


Figure 1.1 shows the map of Vhembe district showing all four sub-districts (local Municipalities)

3.6 RESEARCH DESIGN

Burns and Grove (2011:253) describe the research design as a blue print for conducting a study. The purpose of a design is to maximize control over factors that can interfere with validity of the study findings. The control provided by the design increases the probability that the quantitative or outcomes study results will accurately reflect reality. The researcher chose a quantitative descriptive and exploratory research approach to address the research questions. The respondents in the study were pregnant teenagers and teenage mothers aged 14-19 years attending healthcare services at three randomly selected clinics within Makhado local area.

3.6.1 Quantitative research

Quantitative research refers to a formal, objective, rigorous, systematic for generating numerical information about the world. It is conducted to describe new situations, events, or concepts; examine relationship among variables; and determine the effectiveness of treatment in the world (Burns & Grove 2011:34).
This study attempted to quantify factors identified as contributing to high pregnancy rate of teenagers at Makhado local area in Vhembe district of SA.

Quantitative research has the following characteristics according to Burn and Grove (2011:32-75) as well as Brink et al (2012:97-110)

- There is a single reality that can be defined by careful measurement.
- It is usually concise.
- It describes and examines relationships, and determines casualty among variables, where possible.
- Statistical analysis is conducted to reduce and organize data, determine significant relationships and identify differences and/or similarities within and between different categories of data.
- The sample should be representative of a large population.
- Reliability and validity of the instruments are crucial.
- Comprehensive data collected by employing different methods and/or instruments should result in a complete description of the variable or the population studied.
- It provides an accurate account of characteristics of particular individuals, situations, or group.
- It is a flexible research design that provides an opportunity to examine all aspects of the problem being studied.
- It strives to develop new knowledge.

- The data may lead to suggestions or hypotheses for future studies
- It is usually a field study in a natural setting.

3.6.2 Exploratory

The study was exploratory because it aimed at exploring the factors contributing to the high rate of teenage pregnancy at Makhado local area in Vhembe district of SA. Exploratory research studies attempts to identify new knowledge, new insights, new understandings, and new meanings and to explore factors related to the topic (Brink 2006:102; Lewins 2007:245). The design was exploratory because it attempted to investigate the full nature of the phenomenon (high pregnancy rate among teenagers at Makhado local area in Vhembe district of SA, the manner in which it becomes manifested as well as related factors that could influence the teenage pregnancy rate. Results of exploratory studies cannot necessarily be generalized to a larger population but provide a better understanding of the sample being examined (Brink 2006:211). Exploratory research examines the relevant factors in detail to arrive at an appropriate description of the reality of the existing situation (Brink 2006:104; De Vos et al 2007:270). The researcher deemed this approach suitable for gaining a better understanding of the high pregnancy rate at Makhado local area of Vhembe district of LP in SA.

3.6.3 Descriptive

The study was descriptive in that the researcher collected detailed descriptions of the factors that contributed to the high pregnancy rate from pregnant and teenage mothers. Burns and Grove (2011:256; LoBiondo-Wood and Harber 2010:198) define the purpose of descriptive research as "to provide the opinions of respondents regarding the phenomenon being studied". Descriptive research provides an accurate portrayal or account of the characteristics of a particular individual event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information (Burns & Grove 2011:256). Descriptive studies provide valuable baseline information.

The method is also flexible and can be used to collect information from a large group of respondents (De Vos et al 2007:213). In this study, the researchers had explored and describe factors that contributed to the high pregnancy rate among teenagers at Makhado local area of Vhembe district in SA.

3.7 POPULATION

According to Burns and Grove (2011:290; Polit and Beck 2008:338) population refers to the entire group of persons or objects that is of interest to the researcher that meets the criteria that the researcher is interested in studying. The population for this study comprised of pregnant teenagers and teen mothers between the ages of 14-19 years, who lives at Makhado local area.

3.7.1 Target population

The target population is defined as the entire set of elements about which the researcher would like to make generalization (LoBiondo-Wood & Harber 2010:222). For this study target population was all pregnant teenagers who resides at Makhado local area who attend ante-natal or post-natal care within the selected clinics. Table 3.1 below shows population of pregnant teenagers and teenage mothers.

Table 3.1: Population of pregnant teenagers and teenage mothers in selected clinics

Name of clinic	**Matsa clinic**		**Mphephu clinic**		**Mudimeli clinic**	
Item	Booked	Delivered	Booked	Delivered	Booked	Delivered
January	14	5	16	7	14	9
February	15	6	10	5	8	6
March	9	5	14	6	11	8
April	12	7	8	5	12	7
May	1o	6	9	6	7	5
June	13	8	12	7	12	7
July	9	6	11	6	9	5
August	7	4	7	5	13	8
September	10	6	9	6	8	6
October	8	3	10	4	10	9
November	11	7	8	5	9	5
December	13	9	13	8	12	8
Total	131	71	120	71	124	84

3.8 SAMPLING AND SAMPLING PROCEDURE

Burns and Grove (2011:290) defined a sample frame as the list or data bank that represents all elements /units/participants of an accessible target population; used as a basis for random sampling of participants. Polite and Beck (2008:339) defined a sampling frame as a list of all the elements in the population, from which the sample is drawn.

For the purpose of this study, the researcher obtained the list of all Makhado Health care clinics at the regional Department of Health in Vhembe district of LP. A random sampling technique was used to obtain the three clinics that were used as data collection areas- subset of the accessible study population that was selected to be in the study sample. The study sample refers to the subset of cases, units, or observations from a larger population of cases, units, or observations (De vos et al 2007:450). The sample comprised seventy pregnant teenagers and teenage mothers who were attending antenatal and postnatal clinic within six weeks after delivery of their babies at the selected clinics within Makhado local area of LP in SA.

A non-probability convenience sampling technique was used in this study to select participants. Non-probability convenience sampling refers to the selection of the most readily available persons as participants in a study; also known as accidental sampling (Brink et al 2012:140). Convenience sampling is a non-probability approach to selecting participants based on their (easy) accessibility to the researcher (De vos et al 2007:452).

A convenience sampling technique was selected for this study using the most accessible participants for the study. The key reason for this was the practical difficulty of obtaining probability samples from the pregnant teenagers and teenage mothers. The researcher recruited each pregnant teenager and each teenage mother who visited the randomly selected health facilities during data collection.

3.8.1 Inclusion criteria

LoBiondo-Wood and Haber (2010:222) maintains that it is essential to be specific about the criteria for inclusion in the population and the eventual sample. These criteria are referred to as eligibility criteria. In order to participate in this study, the respondents had to:

- be a pregnant teenager aged between 14-19 years
- be a teen mother aged 14 - 19 years
- be residing within the jurisdiction of the Makhado local area
- has to be present, or visit the clinic for antenatal clinic or well-baby clinic within six weeks after delivery during the time of data collection

- Give a written informed consent for participating.

3.8.2 Exclusion criteria

Exclusion criteria are the characteristics that the potential respondents lack in order not to be included in the study (Burns & Grove 2009:367). In this study exclusion criteria are:

- Non-pregnant teenagers
- Teenagers aged above 19 years or below 14 years.
- Pregnant teens who did not give consent to participate in the study.

3.8.3 Sampling of clinics

Sampling refers to choosing the objects, persons and events from which the actual information needs to be drawn (Brink et al 2012:130). The researcher used a probability sampling technique to select the clinics that were to be included in the study. According to Burns & Grove (2011:298; Brink et al 2012:134) probability sampling is a method in which all the elements of the population has a probability higher than zero of being selected for the sample and it is done randomly. A list of all the clinics within Makhado local area was made. Makhado local area comprised of five clinics and one health Centre, which are the following: Khomele clinic, Mudimeli clinic, Matsa clinic, Mphephu clinic, straighter clinic, Rumani clinic and Makhado health Centre.

A probability simple random sampling was used to achieve the desired sample of three clinics. Names of clinics were written in different slips and they were placed in a bowl, a slip was drawn and the name of the clinic was noted, a bowl was shaken and another slip was drawn until the desired number was reached. Table 3.2 below shows a sample of clinics.

Table 3.2 Sample of clinics

Names of clinics	Sampled clinics
Khomele clinic	
Makhado health Centre	
Matsa clinic	X
Mphephu clinic	X
Mudimeli clinic	X
Rumani clinic	
Straighter clinic	
Total	3

3.8.4 Sampling of participants

This study used a non-probability convenience sampling to obtain a sample of 70 participants. Convenience sampling is also referred to as 'accidental' or 'availability sampling and it involves the use of readily available participants for the study (Brink et al 2012:140).Pregnant teenagers and teenage mothers who were attending antenatal and postnatal clinics and willing to participate when data was collected were the once who were included in the study. A sample size of 70 pregnant teenagers and teenage mothers was selected out of the population of three clinics. Table 3.2 below provides the details of the sample size.

Table 3.3 Sampling of participants

Institution/ Clinic	Number of teenagers	Sample size
Clinic A	202	20
Clinic B	190	19
Clinic C	208	21
Total	600	60

The researcher has selected 10% of the population and further increased the number of participants by 10 respondents to strengthen the representativeness of the sample size.

3.9 DATA COLLECTION

Brink et al (2012:148) refers data as information that is needed to answer the research question. In this study, a questionnaire was used to obtain data relevant to the objectives and questions. The purpose of the study was to identify the factors that might contribute to the high teen pregnancy rate in an effort to prevent unplanned pregnancies. Respondents were recruited through health workers to participate following their antenatal visits or well-baby (postnatal) check-ups at the selected clinics at Makhado local area. A teenager who was interested was invited to a prepared room to complete the questionnaire. The researcher assisted the participants by explaining any misunderstood questions and gave clarity where necessary.

3.10 DATA COLLECTION INSTRUMENT

The data collection instrument for the study was a questionnaire. Burns and Grove (2011:353) state that a questionnaire is a printed self-report form designed to elicit information and is developed with specific items to assist with the data collection. It was used to gather information from a large number of participants. A structured questionnaire was developed after an extensive literature review to elicit responses relevant to achieve the aim of the study. The aim of the questionnaire was to obtain information regarding the factors contributing to the high rate of teenage pregnancy. The advantages of using a questionnaire to collect data for this study were the fact that it requires less time and energy to administer (Brink et al. 2012:153).

3.10.1 Development of the questionnaire

In order to collect the needed data or information in the study, the researcher developed a measuring instrument to be given to all the participants, to ensure uniformity and consistency. The question that was formulated was guided by the objectives of the study and the research questions. Brink et al (2012:154-156) list the following criteria for the development of a questionnaire:

- Questions should be short and simple
- Questions should be understandable
- Leading questions should be avoided
- Questions should be stated in affirmative manner

For the purpose of this study, the questionnaire has been developed following an intense literature review. The instrument addressed issues concerning the factors contributing to the high rate of teenage pregnancies.

3.10.2 Structure of the questionnaire

The questionnaire consisted of four sections **(See annexure E)**:

Section A: Biographical information

Section B: Sexuality and reproductive health issues

Section C: Source of information

Section D: Effects of pregnancy on respondents.

The items contained in the questionnaire, comprised both open-ended and closed questions, in attempting to identify the factors contributing to the high pregnancy rate among the teenagers.

The items contained in the questionnaire, comprising both open-ended and close questions, attempted to identify the factors contributing to high pregnancy rate in Makhado local area of LP in SA.

3.10.3 Administration of the questionnaire

Then the researcher went to the randomly selected healthcare facilities at Makhado local area, LP, SA in person. The in charge of the randomly selected healthcare facilities gave permission to the researcher to recruit the respondents. The researcher identified pregnant teenagers and teenage mothers who visited the randomly selected clinic facility on the day of data collection and addressed them in a private room.

The researcher explained the nature and purpose of the study to the potential respondents, informed them that participation was voluntary, and asked them to participate in the study. Every respondent who were willing to participate received consent form with information about the study to sign. After giving informed consent, the respondents were given questionnaire and a pen to fill in the questionnaire. The researcher was assisted by one enrolled nurse to identify the respondents and also to hand out the questionnaires on the specific data-collection days s. To minimize response bias, the researcher remained silence during data collection unless the respondents asked for clarity. Seventy teenage girls some were still pregnant and some had delivered but visited the health care clinic for post natal care completed and returned questionnaires at the same day. The completed questionnaires were handed to a researcher who took the completed questionnaires to a statistician for data capturing and analysis.

3.10.4 Advantages of the questionnaire

Brink et al (2012:153) stated that questionnaires are a quick way to obtain data from a large group of people and less expensive in terms of time and money.

The advantages of a questionnaire in this study were as follows:

- Questionnaires were less expensive to administer than conducting interviews, as interviews might have required hiring and training interviewers/field workers.
- As the researcher was not present during the completion of the questionnaires, there was no researcher bias, as could occur during interviews.
- The respondents' anonymity was ensured during data collection by not writing their names on the questionnaires, so that the findings could not be linked to any respondent.
- The respondent felt safe, as they were not face to face with the researcher during completion of the questionnaire.

- Time was saved during data collection, as the completion of the questionnaire required about 30 minutes, and all the respondents could complete their questionnaires simultaneously on the specific days.

3.10.5. Validity and Reliability

3.10.5.1 Validity

According Burns and Grove (2011:334), validity refers to "the extent to which an instrument measures adequately the real meaning of the concept under consideration". Validity can be sub-categorized as external and internal validity.

Burns and Grove (2011:335) describe external validity as "the extent to which the results can be generalized beyond the sample used in the study. This usually depends on the degree to which the sample represents the population". Low external validity in this study implies that the results can apply only to teenagers in the Makhado local area. The external validity of this study may have been compromised as there was no guarantee that the respondents had similar knowledge, attitudes and beliefs regarding pregnancy.

Internal validity is the extent to which factors influencing adolescent pregnancy are a true reflection of reality rather than the result of the effects of extraneous or chance variables, not necessarily related to factors influencing pregnancy.

3.10.5.2 Reliability

Burns and Grove (2011:332) describe the reliability of a tool as the consistency with which the tool measures the attribute it is supposed to measure. If a study and its results are reliable, other researchers using the same method will obtain the same results. A pre-test was conducted with respondents similar to the study sample, but excluded from the actual study, to determine the clarity of the items and consistency of the responses.

A pre-test or pilot study is a small-scale trial of the data collection instrument to determine clarity of questions and whether the instrument elicits the desired information (Brink et al. 2012:174). In order to ensure reliability and validity, the questionnaire was pre-tested on ten pregnant teenagers and teenage mothers in Makhado local area to check the clarity of questions and identify vague or non-acceptable question. Adjustments were made based on the outcome of the pre-test results. The data collected during the pre-test was not part of the study. All the respondents completed the questionnaire within 30 minutes and understood the questions.

3.11 DATA ANALYSIS

This is a process of bringing order, structure and meaning to the mass of collected data (De Vos et al. 2007:33). Data were analyzed with the assistance of a statistician and the statistical package of social science (SPSS) was used. Data from the questionnaires was analyzed using the SPSS V19.0 software computer programmed by the Statistician. Descriptive statistics, frequency tables and percentages was used in the data analyses to determine the factors contributing to high rate of teenage pregnancies at Makhado local area.

3.12 ETHICAL CONSIDERATIONS

According to Burns and Grove (2011:103) ethical measured should be applied in research to ensure that there is no violation of subjects, they should be treated fairly and their rights be respected. Nurses face ethical dilemmas in their daily duties, as do researchers, when people are used as study respondents in an investigation. First, the researcher obtained written permission to conduct the study and to use the Community Centre facilities for data collection from the LP Department of Health and from each individual respondent and ethical clearance from the University Higher Degree Committee of the University of Venda. Informed consent was obtained from the respondents and, to avoid researcher bias, the enrolled nurse was used to identify the respondents then recruited to the private room to complete the questionnaire.

Researchers need to exercise care that the rights of individuals and institutions are safeguarded (Brink 2006:31-35; Burns & Grove 2011:103). In this study, the researcher observed the ethical principles of beneficence, respect for human dignity, fair treatment, and self-respect, protection of human rights, benefit and honesty in data processing.

3.12.1 Beneficence

The principle of beneficence encompasses freedom from harm and exploitation (Burns & Grove 2011:102). No physical harm resulted from completing questionnaires, but some psychological discomfort might have resulted from the nature of some of the questions. The researcher's telephone numbers were provided should any respondent wish to discuss any aspect. The researcher would have referred respondents who experienced psychological discomfort as a result of completing the questionnaires to a counselor, but no respondents indicated or expressed discomfort.

3.12.2 Respect for human dignity

Respect for human dignity includes the right to self-determination and to full disclosure (Burns & Grove 2011:107). The respondents' right to self-determination was honored because they

- Could decide independently, without any coercion, whether or not to participate in the study
- Had the right not to answer any questions that caused discomfort
- Had the right not to disclose personal information that they regard as sensitive.
- Could ask for clarification about any aspect that caused some uncertainty

The right to full disclosure was respected because the researcher described the nature of the study as well as the respondents' rights to participate or refuse to participate in the study. This was included in the informed consent. Each respondent voluntarily signed a consent form. The signed consent form was folded and placed in a box prior to completion of the questionnaire. Each completed questionnaire was placed in a separate container. No signed consent form could be linked to any specific questionnaire. This ensured the respondents' anonymity. Confidentiality refers to the researcher's management of private information shared by the respondents (Burns & Grove 2011:117). In this study confidentiality was maintained because no names were disclosed in the research project, which means that no particular information could be linked to any respondent. Any respondent who wished to obtain the findings could contact the researcher.

3.12.3 Self-respect

The respondents' right to maintain self-respect and dignity were observed through protection from physical and psychological risk during the study. Neither participation in, nor withdrawal from the study could jeopardize future care for teenagers. No one could benefit from participation or be harmed by refusal to participate in the study. Respondents had a right to withheld information which they regard as private.

3.12.4 Benefit

The respondents were informed that they would receive no monetary benefit from participating in the study. The findings could benefit the health providers in formulating health education guidelines that will enhance better life styles for teenagers at Makhado local area of LP in SA.

3.12.5 Protection of human rights

The researcher explained the nature and purpose of the study and the type of information required to the respondents. The respondents all clearly understood and then gave informed consent.

3.12.6 Fair treatment

In this study all the respondents were fairly selected and treated, the researcher selected the respondents according to the research problem of teenager's pregnancies.

3.12.7 Data processing

Regarding data processing, the researcher adhered to the principle of honesty with regard to data. Collected data was handed to a statistician to be analyzed, using the SPSS V19.0 computer program. The researcher involved a qualified statistician to ensure that the statistical calculations were applicable to the type of data.

3.13 LIMITATIONS OF THE STUDY

Only five health clinics were randomly sampled from the list of all the health centres/clinics within Makhado local area in LP for this study. Consequently, the results of this study might not be generalised beyond this local area in the LP.

The study focused on pregnant teenagers and teenage mothers, the results will not include the views of other teenagers.

3.14 CONCLUSION

This chapter discussed the research design and methodology of the study. The researcher used a quantitative, descriptive, exploratory design and a questionnaire as data-collection instrument. Chapter 4 described the data analysis and interpretation.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

In the previous chapter, the research design and methods were discussed. This chapter focuses on the data analysis strategy and discussions. Data was analysed using the statistical package for social sciences (SPSS) version 19. The analysis provided frequencies and percentages and the findings were presented mainly in tables and figures. All sections of the questionnaire were highlighted. The percentages were presented as received from data analysis software.

4.2 DATA ANALYSIS

As indicated in chapter 1, the purpose of the study was to explore and determine the factors contributing to high rate of teenage pregnancy between teenagers aged 14 – 19 years at Makhado local area, Vhembe district.

The objectives of the study were to:

- Explore the factors contributing to the high teenage birth rate at Makhado local area.
- Assess the teen's level of knowledge of reproductive health issues and causes of pregnancy.
- Identify the source of their knowledge of reproductive health issues.
- Propose possible areas of intervention or services needed to prevent teenage pregnancies.

Seventy questionnaires were distributed to seventy teenagers who were pregnant and teenage mothers aged between 14 and 19 years who participated in the study. Data analysis was done with the assistance of a statistician.

4.3 Results

4.3.1 Section A: Biographical information

4.3.1.1 Age

The ages of respondents are shown in the Figure 4.1. A large number of respondents 33 (47%) were in the ages between 18 – 19 years. Twenty-three (33%) were between the ages 16 – 17 years. Fourteen (20%) were in the age range 14 – 15 years.

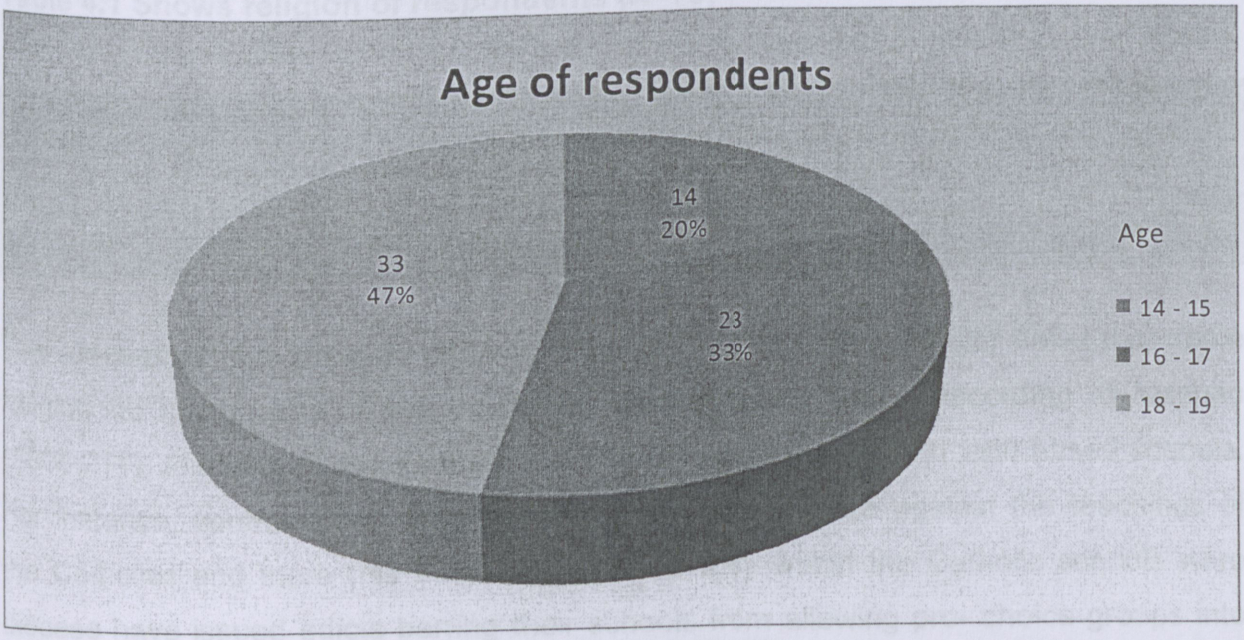


Figure 4.1 Ages of respondents (N=70)

These age groups were indicated in the study as respondents because they are vulnerable group to fall pregnant, due to immaturity and lack of understanding about sexuality and conception. And they meet the inclusion criteria of teenage mothers and pregnant teenagers aged 14 – 19 years. According to the data from the World Fertility Survey, over half of all teenagers 15 - 19 had their first birth before the age of 15 (WHO 2009:17) This study differs with the findings of the WHO, where over half of the teenagers gave birth at the age of 15, in this st[illegible] large number of respondents were in the ages 18 - 19 years.

4.3.1.2 Religion

Table 4.1 below shows religious affiliation of the respondents. Majority of respondents were Christians 66 (94.3%). Three (4.3%) were protestant. Only 1(1.4%) is catholic.

Table 4.1 Shows religion of respondents (N=70)

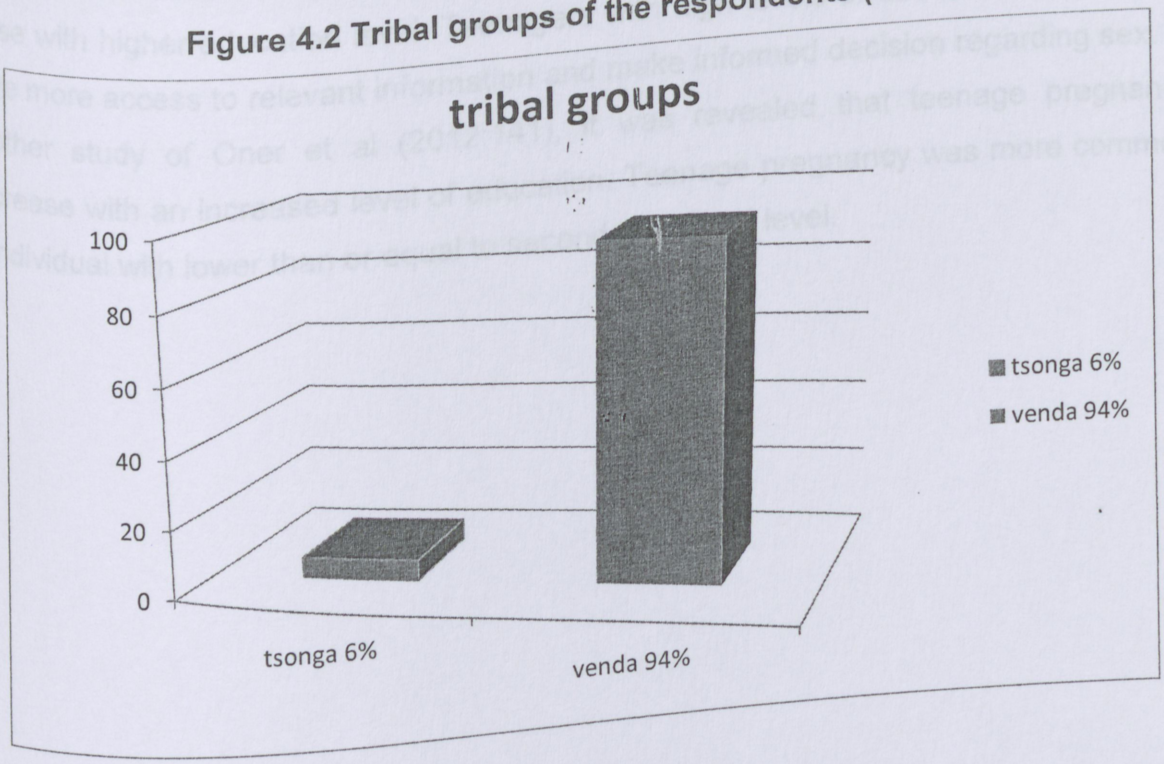
	Christianity	Protestant	Catholic	Total
Frequency(n)	66	3	1	70
Per cent	94.3%	4.3%	1.4%	100%

The researcher had included religion in this study due to the popular belief that some religion do not believe in sex education amongst their youth. According to Mashao (2008:211), teaching of sex education in the UK poses problem in faith based schools. For instance, contraception, abortion and homosexuality are against the teachings of the Catholics and there has been some controversy within the Catholic schools were diocese have issued edicts barring their schools from allowing pro- choice groups into schools to talk about abortion. This is also evident in this study majority of the respondents were Christians, which shows that they are not well informed about sexuality and reproduction.

4.3.1.3 Tribal groups

The study was done at Makhado local areas were the majority of residents are Venda 66 (94%). This is evident of the study results. The largest numbers of participants were Venda; Tsonga only makes a small portion of the respondents 4(6%) figure 4.3 below shows different ethnic groups of the respondents. This is due to the fact that majority of the residence at Makhado municipality were Vhavenda .The clinics that were selected comprise mostly of the Tshivenda speaking people. Vhavenda are a very respectful ethnic group that still uphold their tradition and cultural values, however due to acculturation there is a shift in perspective regarding initiation rites (vhukomba) and sexuality and these cultural/traditional schools are presently undervalued. It is a norm among black ethnic groups to promote childbearing (Arai 2007). In a study on Early risk among black and minority ethnicity teenagers Jayakody, Sinha, Tyler, Khadr, Clark, Klinberg, Booy, Bhui, Head, Stanfeld, Roberts and Viner found that black African teenagers have a high tendency of Sexual risk behaviour like, early sexual intercourse and childbearing.

Figure 4.2 Tribal groups of the respondents (N=70)



4.3.1.4 School attendance of the respondents

About 67(95.7%) of the respondents have attended school. Only 3(4.3%) did not attend school. Statistics on this study showed that most respondents have attended school. This might be related to peer-pressure, because at school teenagers meet and talk about sexuality and relationship. Those that are not in relationship, felt that they do not conform to their peer group and started dating.

4.3.1.4.1 Level of education of the respondents

The largest number of respondents 50 (71.4%), their level of education was between grade 8 and 12. Those with grade 4 - 7 were 11 (15.71%). Grade R - 3 makes up 6.4% and those with tertiary level makes up 6.4%. This shows that teenage pregnancy is common in those with secondary level of education than those with tertiary level. This results was in line with the study that was conducted by Were (2007:236) which showed a high and negative relationship between the level of education and teenage pregnancy, those with low-level of education were more vulnerable to teenage pregnancies than those with higher education level. Teenagers with high levels of education are likely to have more access to relevant information and make informed decision regarding sex. In another study of Oner et al (2012:141), it was revealed that teenage pregnancy decrease with an increased level of education. Teenage pregnancy was more common in individual with lower than or equal to secondary school level.

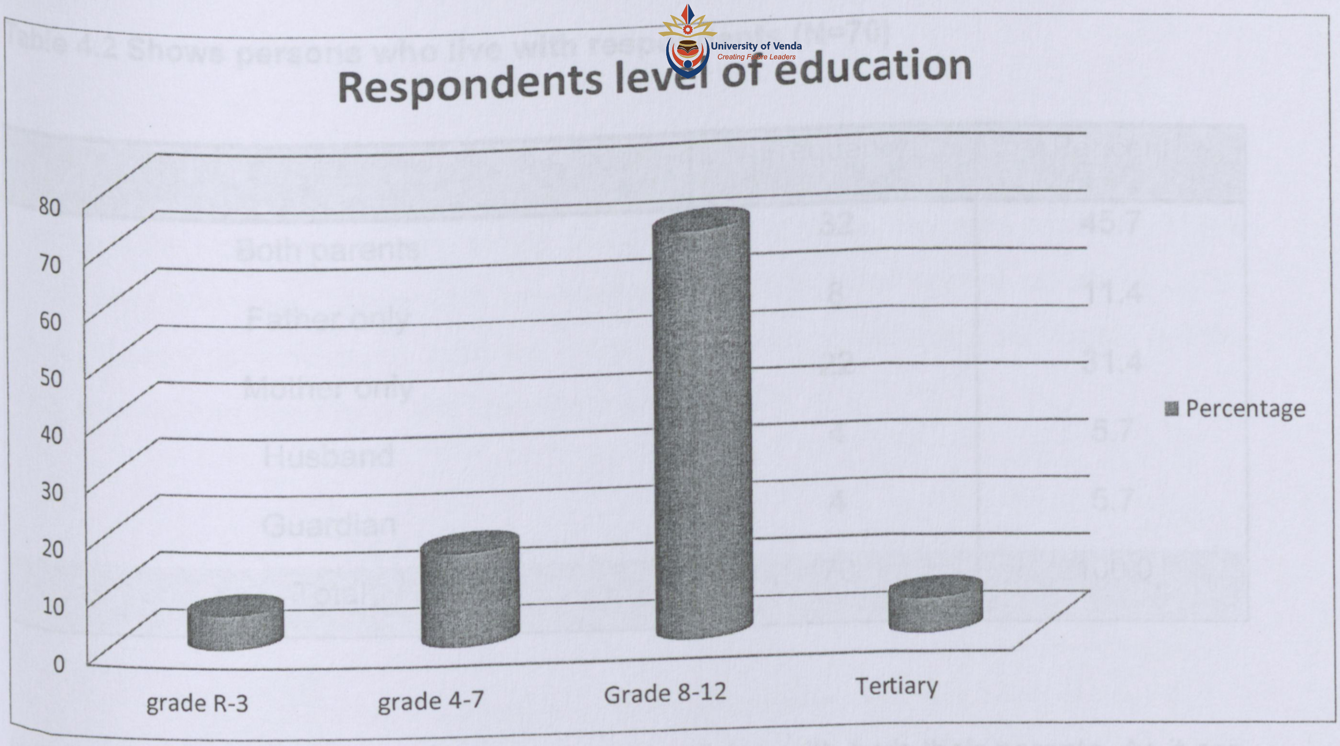


Figure 4.3 Educational level of respondents (N=70)

4.3.1.5 Persons who live with respondents

Those who live with both parents were in majority 32 (45.7%). Eight (11.4%) live with their fathers only. Those who live with their mothers were 22 (31.4%). Four (5.7%) lives with their husbands and the other 4 (5.7%) are living with their guardians. The following Table shows persons that the respondents live with.

Table 4.2 Shows persons who live with respondents (N=70)

	Frequency	Per cent
Both parents	32	45.7
Father only	8	11.4
Mother only	22	31.4
Husband	4	5.7
Guardian	4	5.7
Total	70	100.0

In this study large numbers of respondents were living with both their parents. As it can be seen from the table above, the number of pregnant teenagers who lives with their mothers only is higher than those who live with their fathers only. This study indicated that teenage pregnancy also occurs in families where there are both parents. The findings of this study differs with those of Arai (2007:93) who found that teenage pregnancy was high among those teenagers who live in a single parent house hold. Ramathuba, Netshikweta & Khoza (2008:5) also indicated that parents are the earliest models of sexuality and mostly children from single headed household were likely to indulge in sexual activities at an early age furthermore family factors such as divorce, separation are on the increase and may influence moral behaviour among children.

4.3.1.6 Marital status

Majority of the respondents were single 58 (82.9%). Three (4.3%) were divorced. Three (4.3%) were widowed. Those who are married are only 6 and makes up about 8.6%. Marital status was checked to compare teenage pregnancy with early marriages, but the study showed that majority of the teenagers were single.

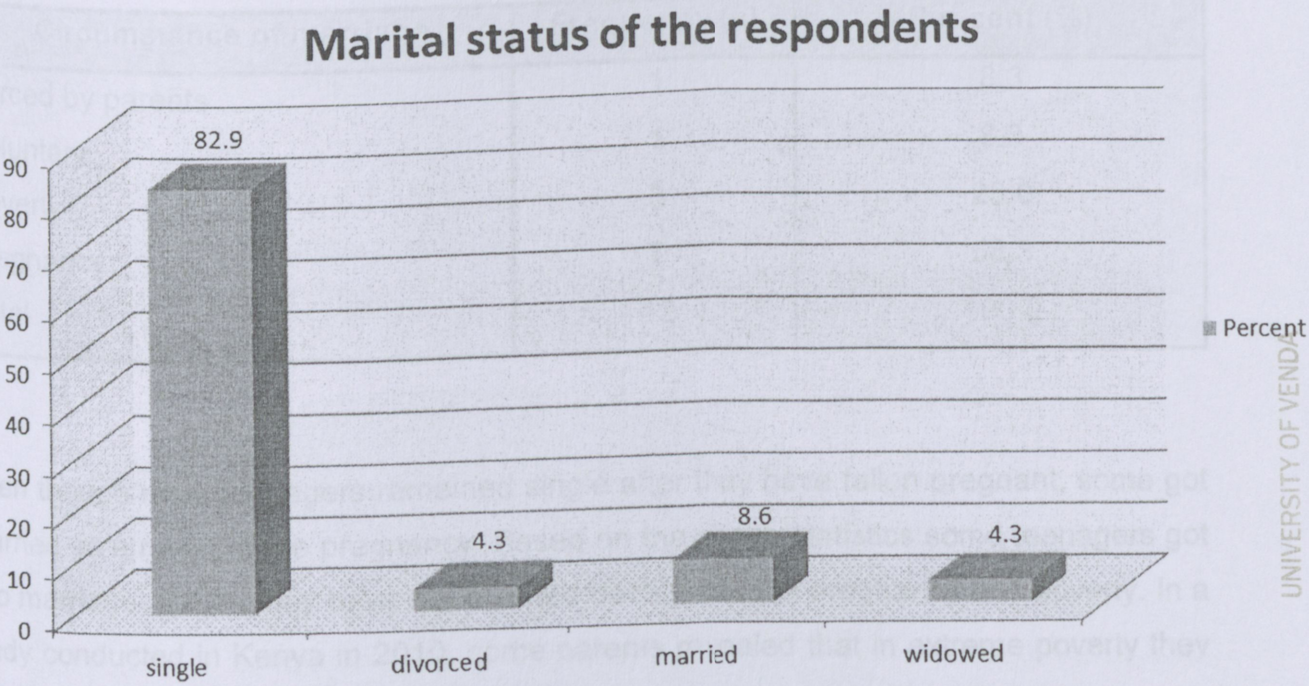


Figure 4.4 Marital status of the respondents (N=70)

Findings revealed that teenage pregnancy have not resulted in early marriage, majority of respondents, remained single after pregnancy. The results of this study differs with that of the study conducted by Were (2007:331) in which majority of teenage mothers were married .In this study it was different, a large number of respondents were single. Oner et al (2012:141) revealed that early marriages and childbearing is encouraged in some communities, especially in developing countries and most girls are married at the age of 18 years.

4.3.1.6.1 Circumstance of marriage of respondents

For those who were married, different circumstances of their marriage were given. Most were married because of pregnancy 7 (58.3%). Other respondents were married because of poverty, 3 (25%). One (8.3%) was married because she wanted to be married and 1(8.3%) was forced by her parents to get married.

Table 4.3 shows the marital circumstances of the respondents (N=12)

Circumstance of marriage	Frequency (n)	Per cent (%)
Forced by parents	1	8.3
Voluntary	1	8.3
Poverty	3	25.0
Pregnancy	7	58.3
Total	12	100.0

Even though most teenagers remained single after they have fallen pregnant, some got married as a result of the pregnancy. Based on the above statistics some teenagers got into marriages which they have not planned because of the pregnancy and poverty. In a study conducted in Kenya in 2010, some parents revealed that in extreme poverty they marry off their teenage daughters as a means to meet the needs of the family.

4.3.1.7 Parents employment status

A large number of respondents' parents were employed 45 (64.3%). Twenty-two (31.4%) of respondents' parents were un-employed. Three (4.3%) of respondents' parents were self- employed. The findings differs with the findings of Ramathuba, Netshikweta and Khoza (2008 :51) reported that Teenagers from low income household are less likely to use contraceptives and view childbearing as a positive desirable choice. who found that women aged 15-19, 60% were sexually experienced, 53% were from low income and 50% from higher income and further reported that poor teenagers use contraceptives less frequently and less successfully, and had higher rates of teenage pregnancies.

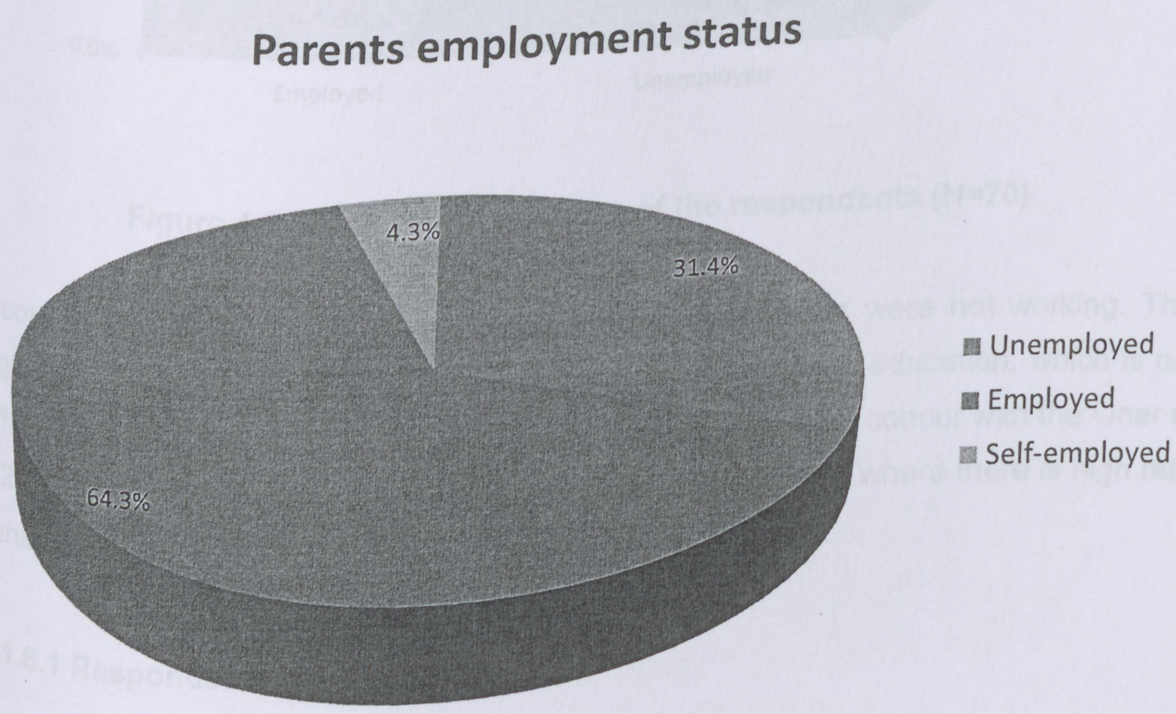


Figure 4.5 Employment statuses of the respondents' parents (N=70)

4.3.1.8 Employment status of respondents

A large number of respondents were not working 64 (91.4%). Six (8.6%) were working.

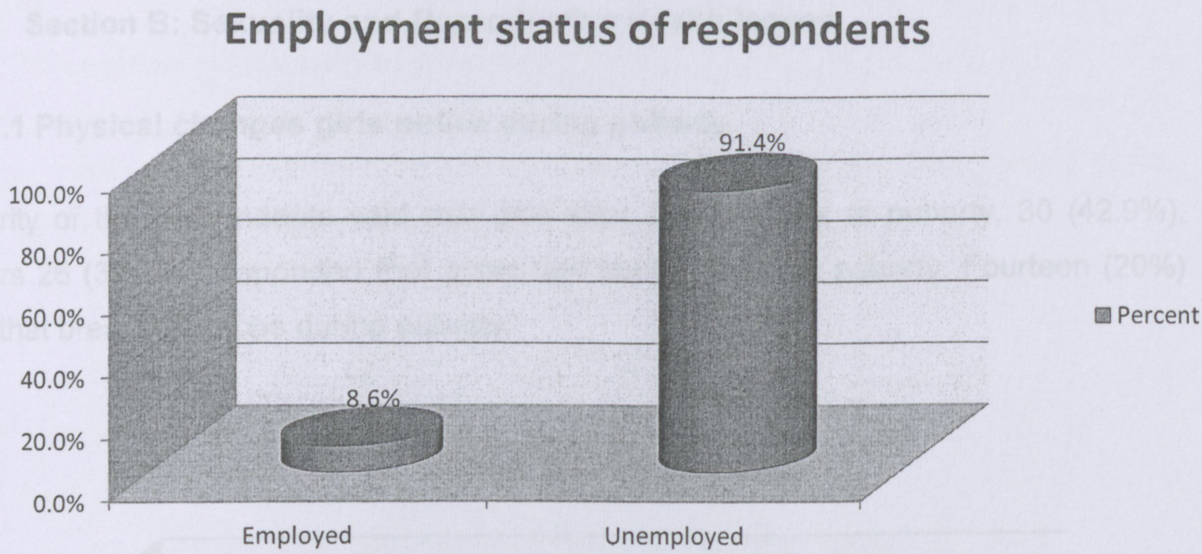


Figure 4.6 Employment statuses of the respondents (N=70)

According to the responses shown above, most respondents were not working. This might be due to the fact that most of them had secondary level education, which is not sufficient for a person to be employed. The findings of this study concur with the Oner et al (2012:141) which indicate that teenage pregnancies increase where there is high rate of unemployment.

4.3.1.8.1 Respondents income

For those who were working, 3 (50%) earn between R3000-3500. Two (33.3%) earn between R1500-2000. One (16.7%) earns R2000-R250. This might be attributed to the fact that they have secondary level of education. High paying jobs require professional qualifications. Ramathuba, Netshikweta & Khoza(2008:) also indicated that Thulamela municipality is a poor municipality where people depend on social grants which is no exception to Makhado municipality as they are both in LP , they further indicated that teen mothers are more likely to live in poverty than women who delay childbearing, and nearly 75% of all unmarried teen mothers go on welfare within the first five years of the birth of their first child

4.3.2 Section B: Sexuality and Reproductive Health Issues

4.3.2.1 Physical changes girls notice during puberty.

Majority of the respondents said that girls start menstruating at puberty, 30 (42.9%). Others 26 (37.1%) responded that pubic hair start to grow at puberty. Fourteen (20%) said that breast develops during puberty.

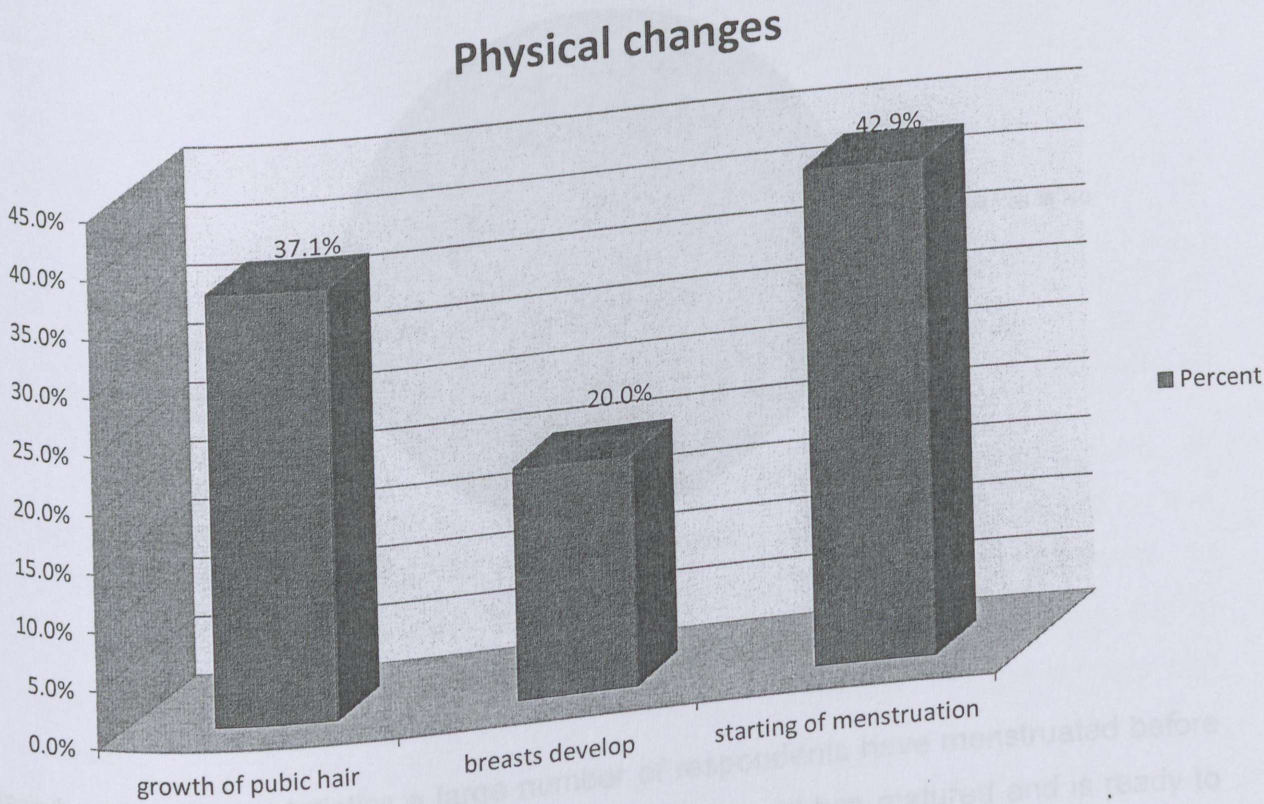


Figure 4.7 Physical changes that girls notice during puberty (N=70)

Respondents are well informed about the physical changes that occur during puberty, majority have indicated that menstruation occurred but they failed to realise that menstruation was an indication that they could fall pregnant.

4.3.2.2 Menstrual status before pregnancy

A large number of respondents had their menstrual period 65(92.9%). Only 5 (7.1%) had their menstrual period before they fell pregnant.

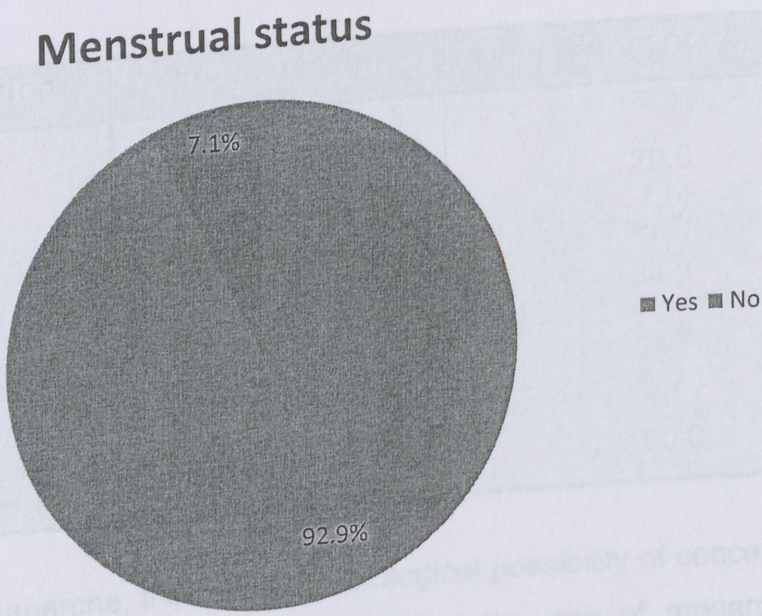


Figure 4.8 Respondents' menstrual status (N=70)

Based on the above statistics a large number of respondents have menstruated before they fall pregnant. Menstruation is an indication that a girl has matured and is ready to have children. Even though respondents menstruated before they become pregnant, they engage in sexual activities without taking preventive measure like using contraceptives. They have showed knowledge of about conception; they failed to relate menstruation with conception. Teenagers are not well informed about sexuality issues

4.3.2.2.1 Age at first menstruation

Most of the respondents 24 (34.3%) started menstruating at the age of 13, followed by 15 (21. 4%) of those who started at the age of 12 years. Fourteen (20%) started at the age of 11 years. Eight (11.4%) started their menstruation at the age of 14 years. Five (7.1%) started their menstrual period at the age of 10 and 4 (5.7%) started menstruation at the age of 15.

Table 4.4 shows the age at which respondents had their first menstruation (N=70)

Age at first menstruation	Frequency (n)	Per cent (%)
10 Years	5	7.1
11 Years	14	20.0
12 Years	15	21.4
13 Years	24	34.3
14 Years	8	11.4
15 Years	4	5.7
Total	70	100.0

The early occurrence of menarche, the earlier the biological possibility of conceiving. In Dar-es-Salaam, Tanzania, Nasoro (2003:25) found that the age of menarche was between 13 and 15 years, and was associated with increased sexual activity, which put teenagers at risk of unwanted pregnancies and STIs. In the Southern Hho-Hho region of Swaziland, Dlamini, Van der Merwe and Ehlers (2003:78) found that the average age of menarche was 11 years, and these girls first sexual intercourse was reported to happen between the ages of 11 and 14. Due to lack of knowledge, advice and emotional support, the youngsters practiced unsafe sex and are not aware that they could be pregnant or contact HIV/AIDS. In this study majority of respondents had their first menstruation early at the ages between 13-14 years. It is also relevant of this study; in our communities it is uncommon to discuss sex issues with teenagers. And these teenagers at the age of 13-14 they had started menstruation without information about sexual and reproductive issues.

4.3.2.3 Information respondents received regarding menstruation

Twenty-three (32.9%) were told that as they had started menstruation they should avoid sexual intercourse. Twenty (28.6%) were told that menstruation is painful. Thirteen (18.6%) were told that they are ready to have a baby. Five (7.1%) were told that they are ready to get married. Five (7.1%) were told about personal hygiene, that they should start taking extra care of themselves. Four (5.7%) were told that it's a curse to menstruate.

Table 4.5 Information respondents received regarding menstruation (N=70)

	Frequency (n)	Per cent (%)
It is a curse	4	5.7
It is painful	20	28.6
You are ready to have a baby	13	18.6
You are ready to get married	5	7.1
About hygiene	5	7.1
Avoiding sexual intercourse	23	32.9
Total	70	100.0

Respondents have been warned to avoid sexual intercourse after they have started menstruating. This is proved by the table above, which shows that majority were warned not to engage in sexual activities, but it was not clearly explained to why they should avoid sexual intercourse. Parents are not precise when talking to their children about sexual issues; they are often shy about talking about sex to their teenagers .Studies revealed that African tradition discourages parents to discuss sexual matters with their children. Teenagers learn about sexuality from friends, which is usually just sex talk resulting in risky sexual behaviour. This indicates that young girls reach maturity at an early age and are in a crucial stage which might complicate their lives if they have limited knowledge of how their bodies function. Lack of knowledge could lead them to be involved in risky sexual practices. Most of the young girls lack correct information about menstruation and at times fail to even tell their parents that they had started having their menstruation, even during their puberty initiation rites they are not taught to relate menstruation with conception because they still fall prey of becoming pregnant after undergoing these rites (Ramathuba 2013:5).

4.3.2.4 Respondents informants about menstruation.

Majority receive the information from their mothers 40 (57.1%). Fourteen (20%) receive information from nurses. Five (7.1%) were informed by friends. Three (4.3%) were informed by their fathers. Three (4.3%) were informed by their grand-parents. Five (7.14%) receive information from books and magazines and 1(1.4%) said she got the information from the magazines.

Table 4.6 The informants of the respondents about menstruation (N=70)

Respondents' informants	Frequency (n)	Per cent (%)
Mother	40	57.1
Father	3	4.3
Nurse	14	20
Friends	5	7.1
Grandparents	3	4.3
Magazines	1	1.4
Books	3	4.3
Total	70	100.0

The statistics above shows that mothers gave information to their teenagers about menstruation, but their information might not have been detailed enough to allow teenagers to make responsible decision about reproductive issues. Mothers often delay talking to their teenagers about sexuality and reproductive matters; the information might have not been detailed enough to enable teenagers to relate the occurrence of menstruation with pregnancy. According to Whitehead (2007:154) talking about sexuality among people of different age is regarded as taboo.

4.3.2.5 Information respondents had about conception or becoming pregnant

Most respondents said that conception occur 4 days before menstruation 31 (44.3%). Fifteen (21.4%) said it occurs 4 days after menstruation. Fourteen (20%) said that conception occurs anytime. Ten (10.3%) said that conception occurs during menstruation.

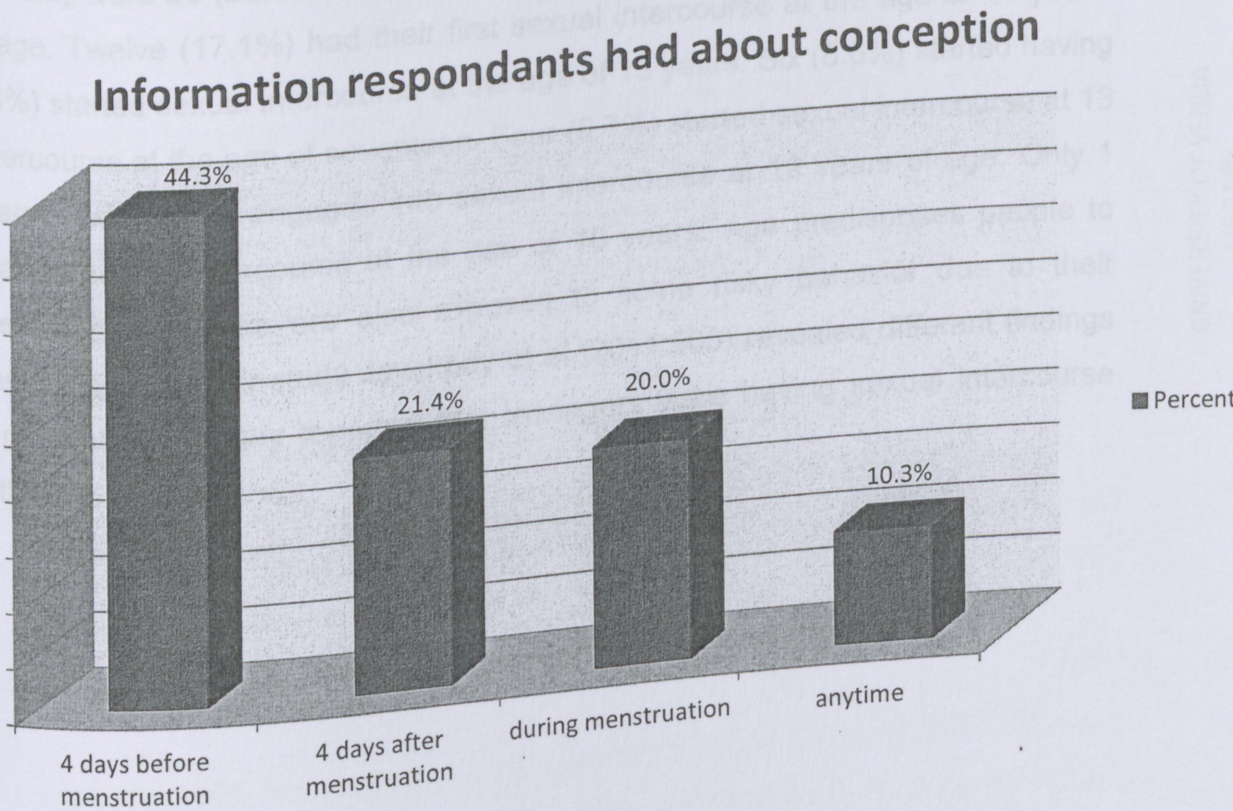


Figure 4.9 Information respondents had about conception (N=70)

The study showed that most respondents were not well informed about conception or becoming pregnant as indicated in Figure 4.9 where 20% of respondents said that conception occurs 4 days after menstruation and 10% who said it occurs during menstruation .These data is supported by Ramathuba (2008:184) that secondary school girls lack information about the menstrual cycle and its implication in relation to conception and contraceptive knowledge because when asked about the sex education received some indicated that their mothers told them to stay away from boys without proper explanation. Teachers at schools do not go into details during their life skill sessions to interpret and integrate conception and contraception so that the learners are able to see the relationships and know when is safe.

4.3.2.6 Respondents age at first sexual intercourse.

The highest number of respondents had their first sexual intercourse at the age of 15 years and they were 20 (28.6%) in number, Followed by the 15 (21.4%) whom were 16 years of age. Twelve (17.1%) had their first sexual intercourse at the age of 14 years. Ten (14.3%) started sexual intercourse at the age of 18 years. Six (8.6%) started having sexual intercourse at the age of seventeen. Four (5.7%) started sexual intercourse at 13 years of age. Two (2.7%) engaged into sexual intercourse at 19 years of age. Only 1 (1.4%) started sexual intercourse at the age of 10 years. Age predisposes people to certain behavior; teenagers are also exposed to some risky behavior due to their developmental age. In their study Jayakody et al (2011:503) revealed different findings from the present study; they reported that teenagers were having sexual intercourse earlier at the age of 13 years.

Table 4.7 Respondents' age at first intercourse (N=70)

Respondents age at first intercourse	Frequency (n)	Per cent (%)
10	1	1.4
13	4	5.7
14	12	17.1
15	20	28.6
16	15	21.4
17	6	8.6
18	10	14.3
19	2	2.9
Total	70	100.0

SA is not excluded from this situation, similar findings were observed by Ramathuba, Khoza and Netshikweta (2012:1) that the mean age for sexual debut was 15years in girls and teen pregnancy was more prevalent among rural girls

4.3.2.7 Respondents reasons for sexual intercourse.

About 26 (37.1%) started sexual intercourse because of peer-pressure. Twenty-three (32.9%) started because of their own desire. Seventeen (24.3%) was pressurised by their partner`s. Three (4.3%) began sexual intercourse because they wanted to get pregnant, but only 1(1.4%) had other reasons. The results of this study indicate that peer pressure can result in risky behaviour such as teenage pregnancy.

This study was in line with the study that was conducted by Whitehead (2007:152) who reported that the value of the peer group lies in their contribution to help construct the social world in which young people find their experiences, cultures, frameworks and beliefs. Peer groups are found at every level in a teenager's life including school, clubs, neighbours, family and friends. The pressure on a young person to conform to the particular traits of a peer group is frequently strong; for some people, this experience can be overwhelming (Whitehead 2007:153).

In her study conducted in Busia district in Kenya about the determinants of teenage pregnancy Were (2007:336) found similar results with that of this study, 50% of teenage mothers concurred that their pregnancy was largely a product of peer pressure to have sex. Additionally, of the girls that admitted having male friends, over 60% reported that major problem they encounter in their relationship was persistent pressure to indulge in premarital sex.

4.3.2.8 Age of respondent's sexual partner at first intercourse

Fifteen (22.4%) of the sexual partners of the respondents' were at the age of 17 were-as another 15 (22.4%) were at the age of 18. Fourteen (20%) of the respondents' partners were 16 years of age at the time of first intercourse. Nine (12.9%) were 19. Seven (10%) were 20. Two (2.9%) were 15. There was an equal number 3 (4.3%) of participants' partners who are aged 21 and 22. One (1.4%) were at the age of 10 and the other 1 (1.4%) were at the age of 14.

Table 4.8 shows the ages of sexual partners at first intercourse (N=70)

Age of partners at first intercourse	Frequency (n)	Per cent (%)
10 Years	1	1.4
14 Years	1	1.4
15 Years	2	2.9
16 Years	14	20
17 Years	15	22.4
18 Years	15	22.4
19 Years	9	12.9
20 Years	7	10
21 Years	3	4.3
22 Years	3	4.3
Total	70	100.0

4.3.2.9 Current number of sexual partners of the respondents

Most respondents 66 (94.3%) were having one sexual partner. Three (4.3%) were having two sexual partners. One (1.4%) was having 3.

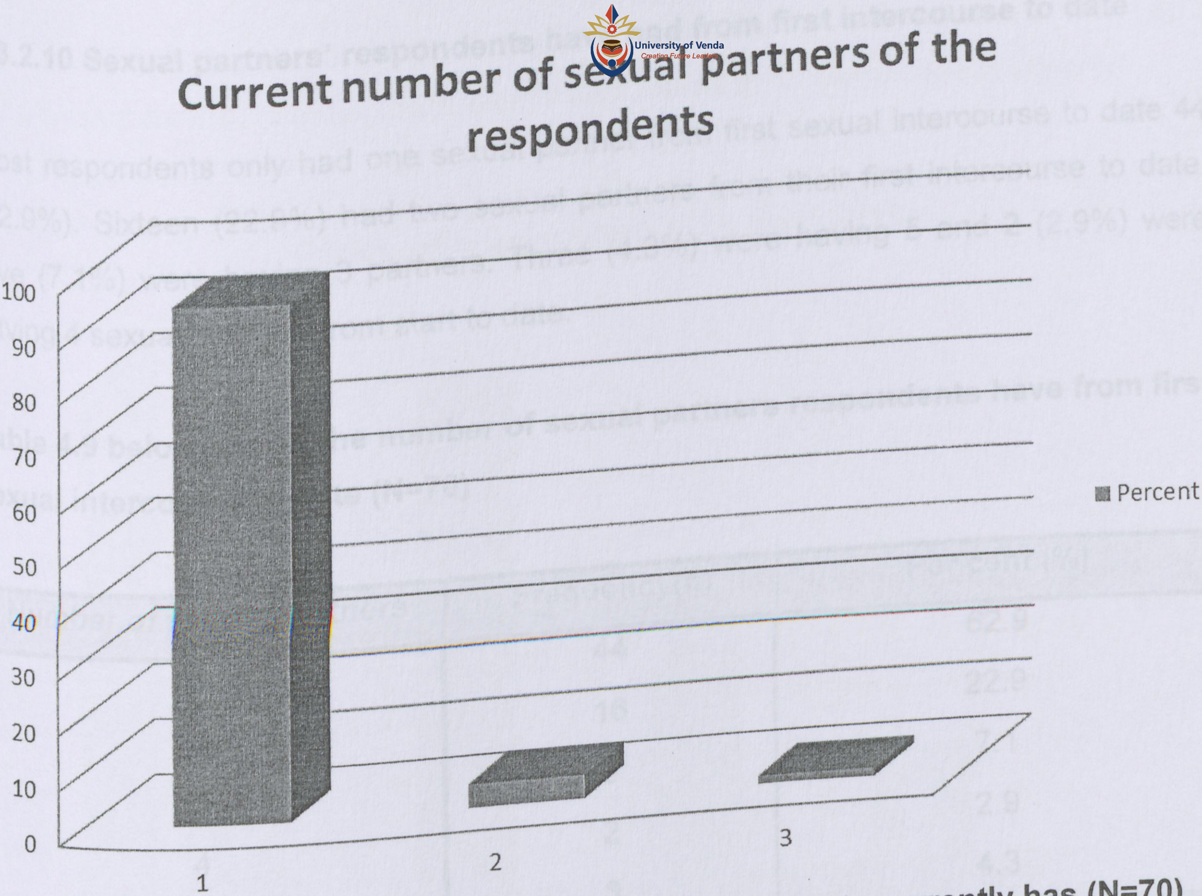


Figure 4.10 Shows number of sexual partners participants currently has (N=70)

Respondents were having one sexual partner 44 (62.9%) . It shows that even though they have engage themselves in sexual matters, they were not to having multiple partners .This reduces their risk of contracting STIs, like HIV/AIDS. The findings may not be a true reflection because teenagers might not want to be associated with promiscuous behaviour, but they do have such partners for monetary gain. Jayakody et al (2011:502) reported that teenagers were more than one partner, multiple partners were common among black teenagers.

4.3.2.10 Sexual partners' respondents have had from first intercourse to date

Most respondents only had one sexual partner from first sexual intercourse to date 44 (62.9%). Sixteen (22.9%) had two sexual partners from their first intercourse to date. Five (7.1%) were having 3 partners. Three (4.3%) were having 5 and 2 (2.9%) were having 4 sexual partners from start to date.

Table 4.9 below shows the number of sexual partners respondents have from first sexual intercourse to date (N=70)

Number of sexual partners	Frequency(n)	Per cent (%)
1	44	62.9
2	16	22.9
3	5	7.1
4	2	2.9
5	3	4.3
Total	70	100.0

Respondents shows that they were having one partner since they have engage themselves in sexual activities, majority of them seem to have been in a stable relationship .The results of this study differs with the findings of Jayakody et al (2011:502),who reported that teenagers were having multiple partners and it was common among black teenagers.

4.3.2.11 Risks of early sexual intercourse

A large number of respondents responded that they are aware that one of the risks of indulging in sexual intercourse at an early stage is teenage pregnancy 33 (47.1%). Fifteen (21.4%) shows that the risk of indulging in sexual intercourse at an early stage is are STI, HIV/AIDS. Another 14 (20%) responded that the risk are *school dropout*. *Eight* (11.4%) said the risk of indulging in sexual intercourse at an early stage is poverty.

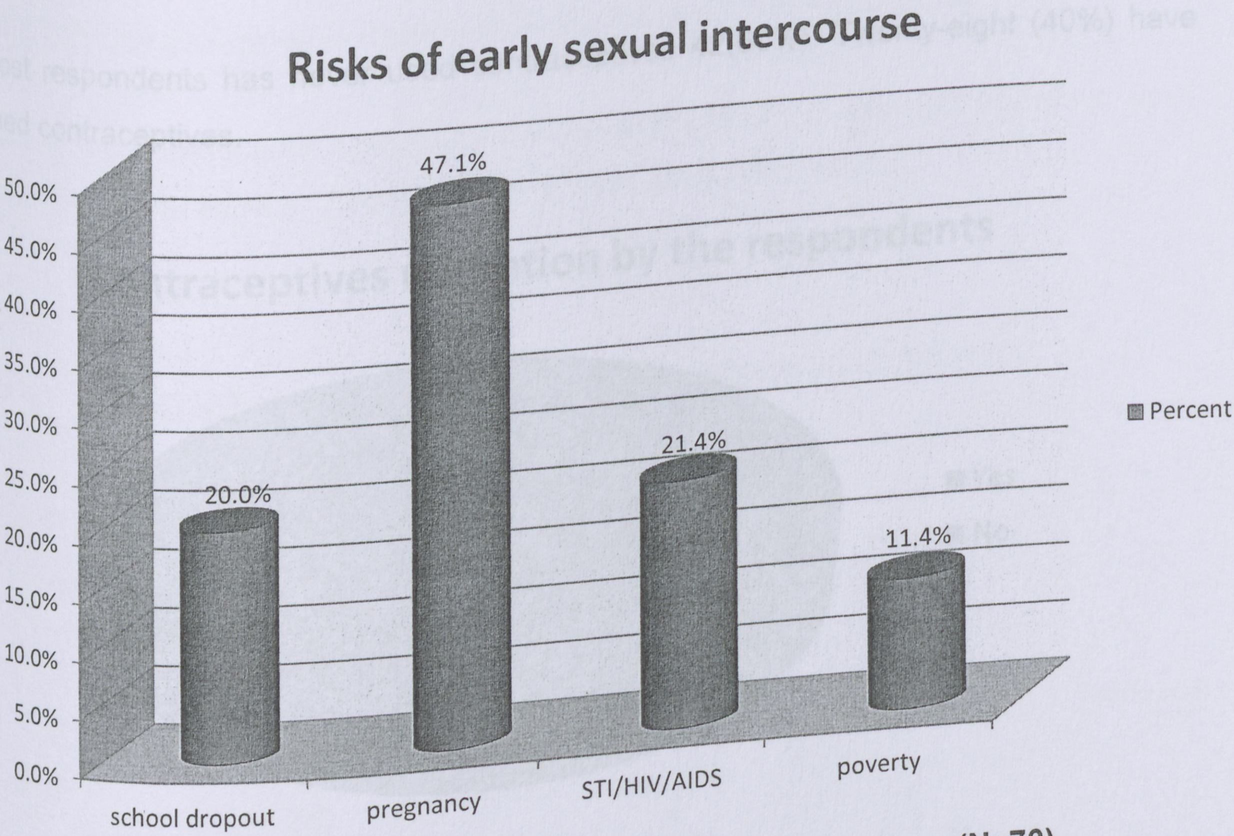


Figure 4.11 Shows the risks of early sexual intercourse (N=70)

Respondents show that the risk of early sexual intercourse is teenage pregnancy. The finding of this study is supported by Jayakody et al (2011:503), they who reported high rate of teenagers in the UK and that the number of STIs infection has doubled in the past 10 years.

4.3.2.12 Contraceptives utilization by the respondents

Most respondents has never used contraceptives 42(60%). Twenty-eight (40%) have used contraceptives.

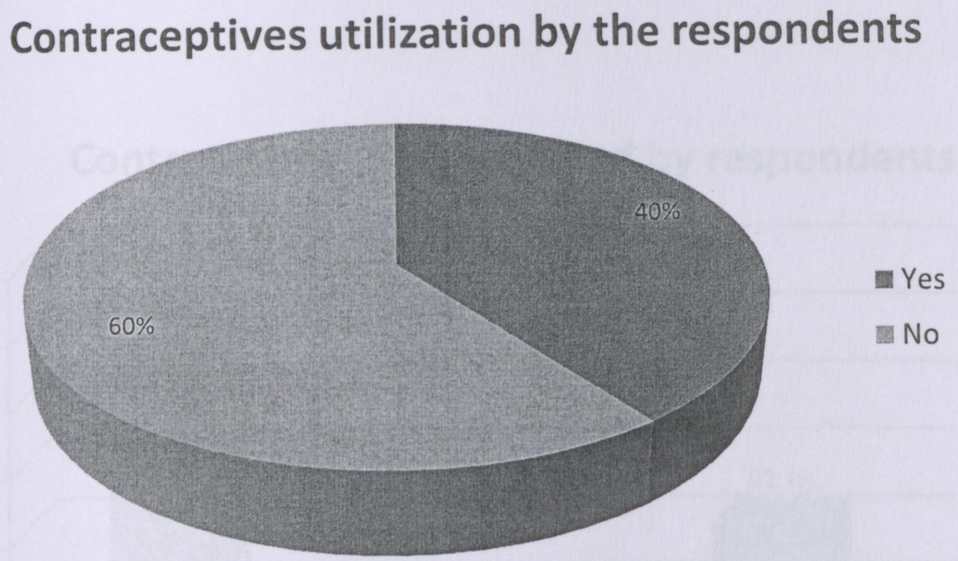


Figure 4.12 Respondents' use of contraceptive (N=70)

Teenagers engage in sexual activities without taking the necessary precaution to prevent themselves from pregnancy, STIs and HIV/AIDS. Contraceptives are freely available in health care facilities. Condoms are also supplied in all public places and usually they are placed where people can take for themselves without consultation .The government have granted sexual rights to teenagers from the age of 12 years and above, to make decisions about their sexuality without permission from their parents or guardian. Teenagers are not making use of all the privileges that government had granted them in order to reduce teenage pregnancy. The findings of this study is relevant with the findings of Were (2007:331) who indicated that majority of teenage mothers reported that they have not used contraceptives due to fear that contraceptives will destroy their fertility.

4.3.2.12.1 Contraceptive method which the respondents were using

Most of the respondents have used condoms 17 (60.7%). Nine (32.1%) have used injectable contraceptives. Two (7.1%) have used contraceptive pills.

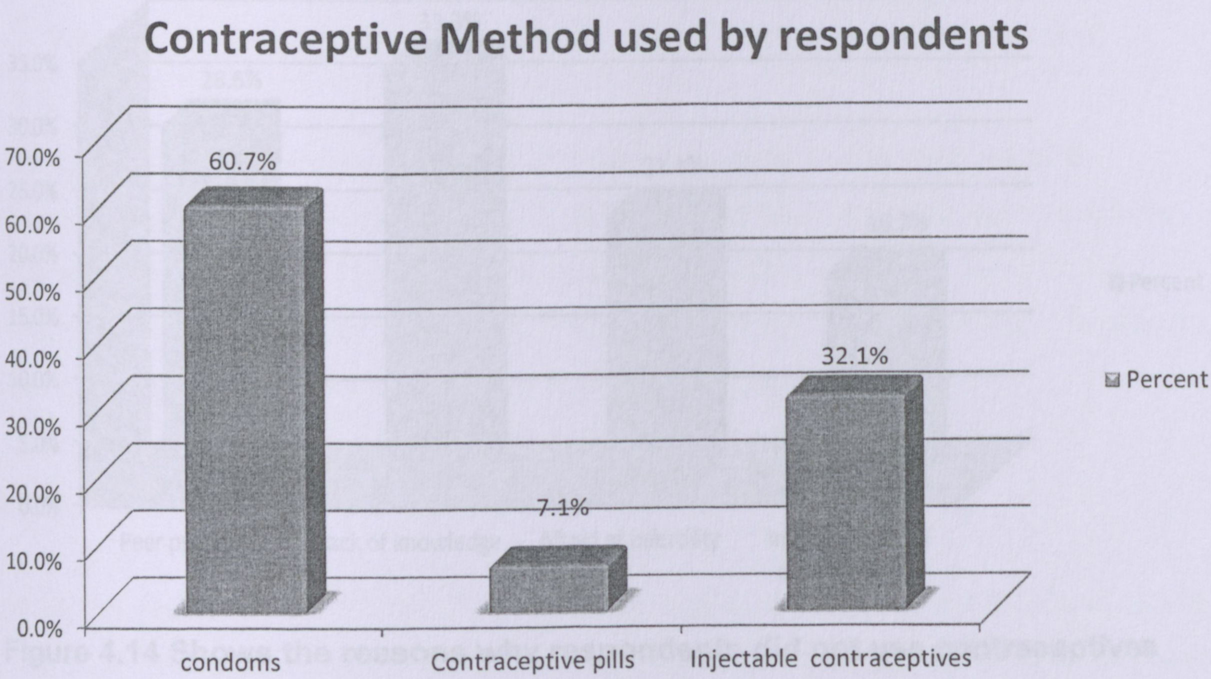


Figure 4.13 shows the methods of contraceptives which respondents were using (N=28)

4.3.2.12.2 Reasons respondents did not use contraceptives

Fourteen (33.3%) of the respondents have not used contraceptives due to lack of knowledge about contraceptives. Twelve (28.6%) did not use contraceptives because of peer pressure. Nine (21.4%) did not use contraceptives because they were afraid they will lose their fertility. Seven (16.7%) did not use contraceptives because of inaccessibility of contraceptives. The findings of this study indicate that teenagers lack information about contraceptives which leads to poor utilization of contraceptives. This results is similar to the results reported by Were (2007:331) in which teenagers were not Using contraceptives due lack of proper information about contraceptives.

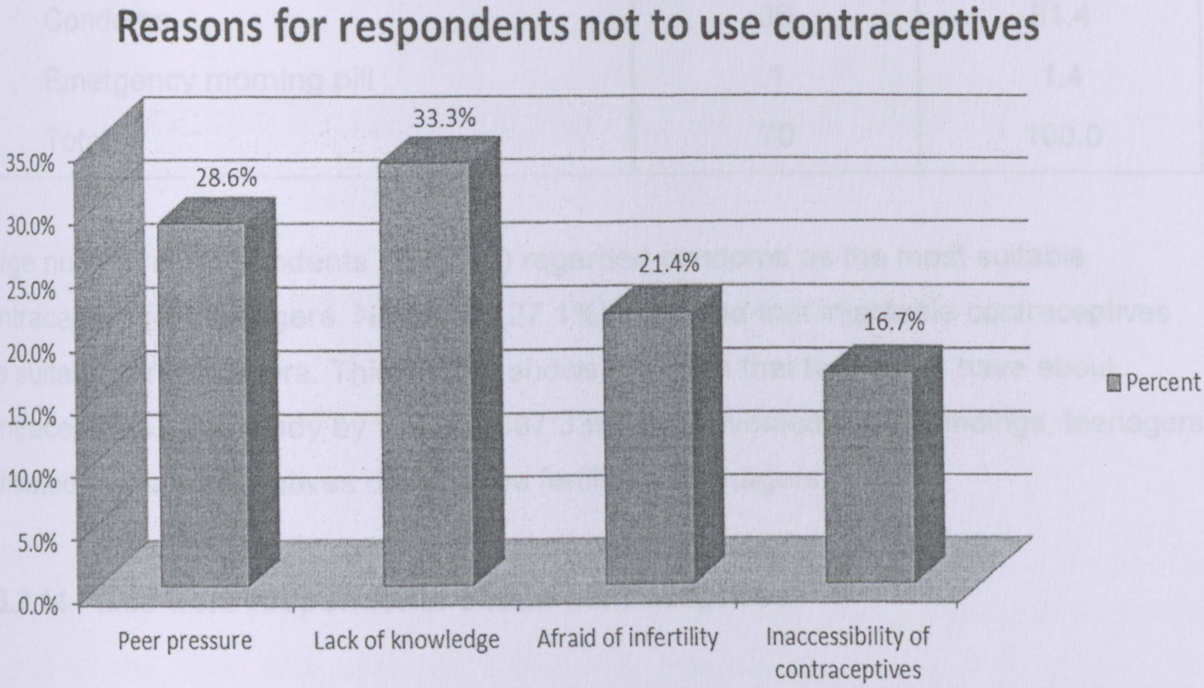


Figure 4.14 Shows the reasons why respondents did not use contraceptives (N=42)

4.3.2.13 Type of contraceptive suitable for teenagers

Slightly more than half the number of respondents 36 (51.4%) reported that condoms are suitable as contraceptive method for teenagers. Nineteen (27.1%) stated that the suitable contraceptive for teenagers is the injectable. Nine (12.9%) reported that suitable method for teenagers is the pill. Five (7.4%) said is the loop. One (1.4%) said that emergency morning pills are suitable contraceptive for teenagers.

Table 4.10 shows type of contraceptives which respondents regard as suitable for teenagers (N=70)

Contraceptives suitable for teenagers	Frequency (n)	Per cent (%)
Loop	5	7.1
Pills	9	12.9
Injectable	19	27.1
Condoms	36	51.4
Emergency morning pill	1	1.4
Total	*70*	*100.0*

Large number of respondents 36 (51%) regarded condoms as the most suitable contraceptive for teenagers. Nineteen (27.1%) indicated that injectable contraceptives are suitable for teenagers. This finding shows the myth that teenagers have about contraceptives. The study by Were (2007:335) also revealed similar findings, teenagers indicated that contraceptives destroy the fertility of teenagers.

4.3.2.14 Place were respondents obtain contraceptives

Most of the respondents 17 (60.7%) reported that they obtain contraceptives at the reproductive and child health clinics. Seven (25%) obtain their contraceptives at public places. 2 (7.1%) obtained contraceptives at school. 1 (3.6%) obtained contraceptives at pharmacy.

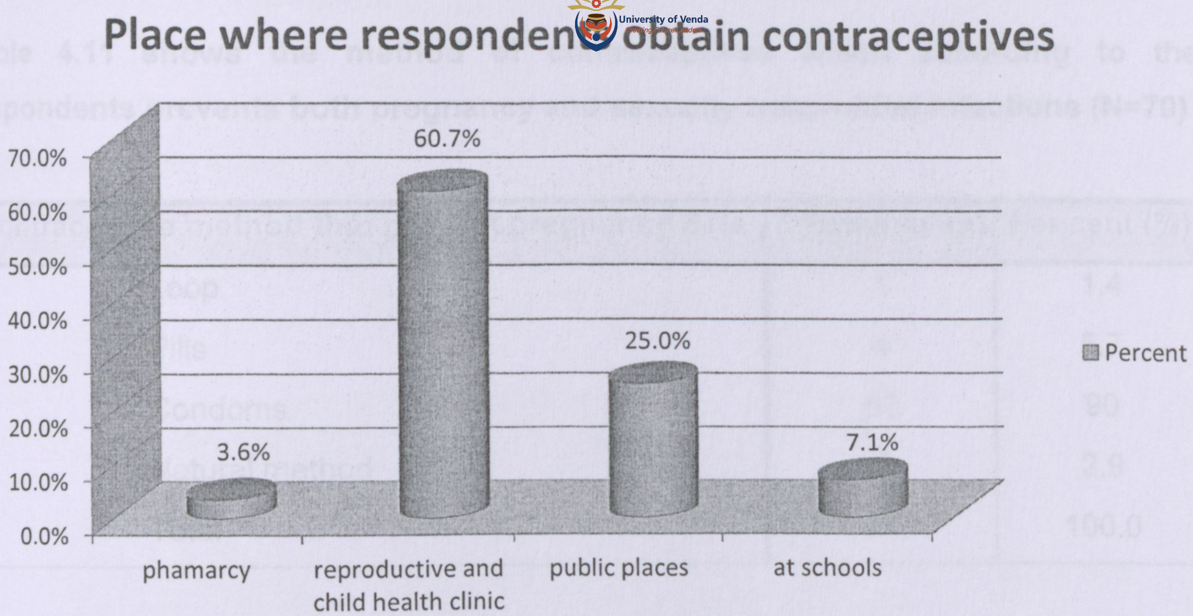


Figure 4.15 Shows place were respondents get their contraceptives (N=28)

4.3.2.15 contraceptive methods that prevents pregnancy and sexually transmitted infections

Majority 63 (90%) stated that condoms prevent both STI's and pregnancy. Four (5.7%) stated *that pills prevent both* STI's and pregnancy. Two (2.9%) stated that natural method is the one that prevents STI's and Pregnancy. *One (1.4%) stated that* pregnancy and STI's is prevented by using a loop.

Table 4.11 shows the method of contraceptives which according to the respondents prevents both pregnancy and sexually transmitted infections (N=70)

Contraceptive method that prevent pregnancy STIs	Frequency (n)	Per cent (%)
Loop	1	1.4
Pills	4	5.7
Condoms	63	90
Natural method	2	2.9
Total	70	100.0

4.3.2.16 Age of respondents at first pregnancy

Eighteen (25.7%) were 17 years old at first pregnancy. Seventeen (24.3%) were 18 years old. Fourteen 20% were 16 years. Eight 11.4% were 15 years old. Seven (10%) were 19 years. Four (5.7%) were 14 years old.

Table 4.12 shows the age of respondents at first pregnancy (N=70)

Age at first pregnancy	Frequency (n)	Per cent (%)
14 years	4	5.7
15 years	8	11.4
16 years	14	20
17 years	19	27.1
18 years	17	24.3
19 years	7	10
20 years	1	1.4
Total	70	100.0

4.3.2.17 Planning of pregnancy

Majority 64 (91.4%) did not plan for the pregnancy. Six (8.6%) reported that their pregnancies were unplanned.

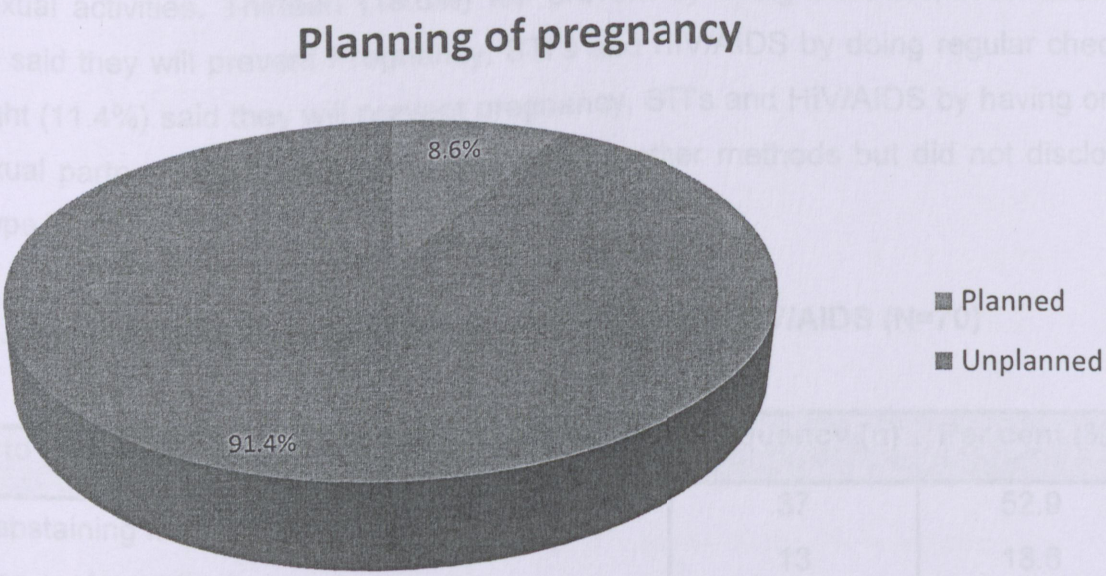


Figure 4.16 Shows whether the pregnancy was planned or not (N=70)

In the survey conducted by Garenne, Talllmn, Kahn, Collins & Ngwenya (2001: 56) respectively of 500 respondents only 141 planned their pregnancy, for the rest pregnancy was unintended. Oner et al (2012:140) also reported that 25-50% of the teenage mothers revealed that their pregnancies were unplanned. This is also evident in this study where only 5 out of 70 respondents planned to have their pregnancies. Teenagers engage themselves in risky behaviours without considering the consequences that are involved.

4.3.2.18 Ways of preventing pregnancy, STI's and HIV/AIDS

Thirty-seven (52.9%) said they prevent pregnancy, STI's and HIV/AIDS by abstaining from sexual activities. Thirteen (18.6%) will prevent by using contraceptives. Eleven (15.7%) said they will prevent Pregnancy, STI's and HIV/AIDS by doing regular check-ups. Eight (11.4%) said they will prevent pregnancy, STI's and HIV/AIDS by having only one sexual partner and 1(1.4%) say they will use other methods but did not disclose which type of method.

Table 4.13 shows how to prevent pregnancy, STI's and HIV/AIDS (N=70)

How to prevent pregnancy, STIs and HIV/AIDS	Frequency (n)	Per cent (%)
By abstaining from sexual activities	37	52.9
Using contraceptives	13	18.6
Having regular medical check-ups	11	15.7
Have only one sexual partner	8	11.4
Other	1	1.4
Total	70	100.0

4.3.2.19 Respondents opinion on the youngest age which they consider risky to fall pregnant

Majority 42 (60%) regard 13 years as the age at which it is risky to fall pregnant. Eight (11.4%) regard it risky to fall pregnant at the age of 14 years. Seven (10%) consider it risky at the age of 15 years. Four (5.7%) consider it risky at the age of 18. Four (5.7%) think the youngest age at which it is risky to fall pregnant is at the age of 19 years. Two (2.9%) consider 16 years the youngest age at which it is risky to fall pregnant. Two (2.9%) consider 17 years as the youngest age at which it is risky to fall pregnant. One (1.4%) regards 12 years as the age at which it is risky to fall pregnant.

Table 4.14 Youngest age which is considered a risk to fall pregnant (N=70)

Youngest age considered risk to fall pregnant	Frequency (n)	Per cent (%)
12 years	1	1.4
13 years	42	60
14 years	8	11.4
15 years	7	10
16 years	2	2.9
17 years	2	2.9
18 years	4	5.7
19 years	4	5.7
Total	70	100.0

4.3.2.20 The age regarded as appropriate to fall pregnant by the respondents

A large number 30 (42.86%) of respondents said the most appropriate age to fall pregnant is 20 years. Seventeen (24.29%) said 18 years is the most appropriate age to fall pregnant. Thirteen (18.57%) said 16 years is the appropriate age to fall pregnant. Four (5.71%) said 15 years is the appropriate age to fall pregnant. Four (5.71%) say 14 years is the appropriate age to fall pregnant. Five (7.14%) said the most appropriate age to fall pregnant is 13 years or younger. Two (2.86%) said at 17 years of age is the most appropriate age to fall pregnant. According to Whitehead (2009:152) being pregnant at an early age poses problems for both the baby and the mother due to the fact that their bodies are not well developed. Miscarriages and anaemia often occurs with teenage pregnancy. In this study a large number of respondents were aware that falling pregnant under the age of 20 years it's risky, they regarded 20years as an appropriate age to fall pregnant .This contradict with the fact that, they have fallen pregnant before the age of 20 years.

Table 4.15 The age which is regarded as appropriate to fall pregnant (N=70)

Age regarded appropriate to fall pregnant	Frequency (n)	Per cent (%)
13 years or younger	5	7.14
14 years	4	5.71
15 years	4	5.71
16 years	13	18.57
17 years	2	2.86
18 years	17	24.29
20 years	30	42.86
Total	70	100.0

4.3.2.21 Expected health problems when teenager falls pregnant

Twenty (28.6%) reported that STI and HIV/AIDS *should be expected when an* adolescent falls pregnant. Sixteen (22.9%) stated that premature labour can occur when a teenager falls pregnant. Fourteen (20%) reported that miscarriage can be expected when an adolescent falls pregnant. Fourteen (20%) stated that high blood pressure can be expected in teenage pregnancy. Four (5.7%) thought that depression can be expected when an adolescent falls pregnant. One (1.4%) state that enemies can be expected when adolescent falls pregnant due to stigmatisation. One (1.4%) did not specify but said that other health problems could be expected when a teenager falls pregnant. Based on the statistics respondents are aware that they may be infected by STI and HIV/AIDS when they fall pregnant. Surprisingly they have fallen pregnant despise the knowledge that they have.

Table 4.16 The problems that could be expected when teenagers falls pregnant (N=70)

Problems that could be expected when teenagers fall pregnant	Frequency	Per cent
High blood pressure	14	20
Miscarriage	14	20
Premature labour	16	22.9
STIs, HIV/AIDS	20	28.6
Depression	4	5.7
Anaemia	1	1.4
Other	1	1.4
Total	70	100.0

4.3.2.22 Social problems prevalent with teenage pregnancy

A large number of respondents 23 (34.3%) reported that lack of money was the prevalent problem that occurs with adolescent pregnancy. Seventeen (25.4%) said that abandonment by parents occurs when an adolescent gets pregnant. Fifteen (22.4%) state that dropping out of school occur in due to teenage pregnancy. Eight (11.9%) stated that shame occurs in adolescent pregnancy. Two (3%) said the fear that their friends might abandon them whereas the other 2 (3%) has other problems than those stated in the table below. This is in line with the study by Whitehead (2007:153), which shows that for mothers between 15 and 19, risks are associated more with socioeconomic factors than with the biological effects of age. Most teenage mothers live in extreme poverty, with no money to support themselves and their babies due to early pregnancy. Teen mothers experience rejection by friends and family members, they live in poverty (Arai 2007:96, James, Van Rooyen & Strumpher (2012:195).

Table 4.17 Social problems which are prevalent with teenage pregnancy (N=70)

Social problems prevalent with teenage pregnancy	Frequency (n)	Per cent (%)
Problems	16	22.9
Lack of money	24	34.3
Parents will abandon me	18	25.7
My friends will abandon me	2	2.9
Shame	8	11.4
Other	2	2.9
Total	70	100.0

4.3.3 Section C: Source of Information

4.3.3.1 Persons who provided respondents with the information about sexuality and reproduction

Twenty-two (31.4%) received information from friends. Nineteen (27.1%) received information from school. Whilst 14 (20%) got information from their parents. Twelve (17.1%) got information from television. Only 2 (2.9%) respondents got most of their information from the newspaper and only 1 (1.4%) got information from the internet.

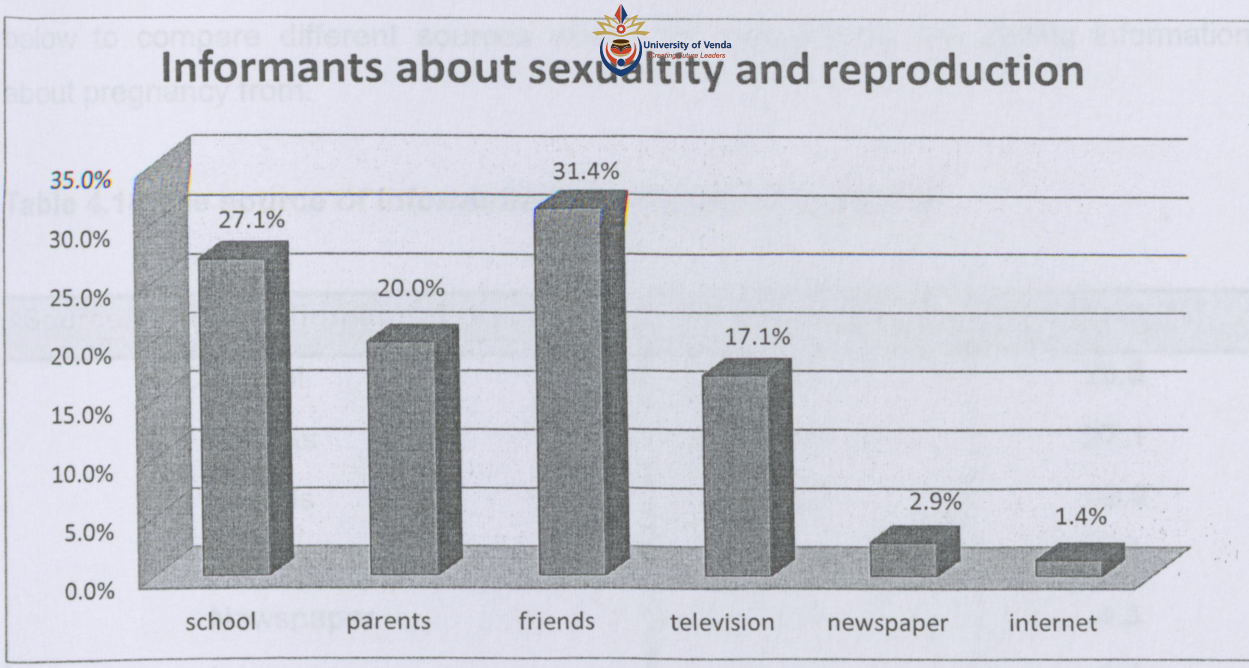


Figure 4.17 shows respondent's informants about sexuality and reproduction (N=70)

In most cultures it is regarded as a taboo for parents to talk about sexual issues with their children this is also evident in this study as the majority of respondents have received information about sexuality from their friends. In Logan, USA, Miller (2002:22-26) revealed in his study about family influences on adolescent sexual and contraceptive behaviour that the cultural practices of socialising adolescent into adult hood range from taboos against discussion of sexual matters between parents and their adolescent to encouragement of premarital sex. Most parents feel uncomfortable discussing sexual matters with their teenagers while teenagers enjoy discussing sex amongst each other.

4.3.3.2 Source of information about pregnancy

Twenty-three (32.9%) got information about pregnancy from their friends. Twenty (28.6%) got information from school. Nineteen (27.1%) got information from parents. Four (5.7%) got information from television. Three (4.3%) got information from the newspaper and only 1 (1.4%) got the information from the internet. Refer to the table below to compare different sources where the respondents are getting information about pregnancy from.

Table 4.18 The source of information about pregnancy (N=70)

Source of information about pregnancy	Frequency (n)	Per cent (%)
School	20	28.6
Parents	19	27.1
Friends	23	32.9
Television	4	5.7
Newspaper	3	4.3
Internet	1	1.4
Total	70	100.0

4.3.3.3 Recommendations regarding the period in which a girl child should receive education about the reproductive information

Whilst 37 (52.9%) recommended girls should receive information about reproductive health at secondary level. Whilst 27 (38.6%) recommended that girls should receive reproductive information at primary level. Whilst 6 (8.6%) recommended that girls should receive reproductive information at tertiary level.

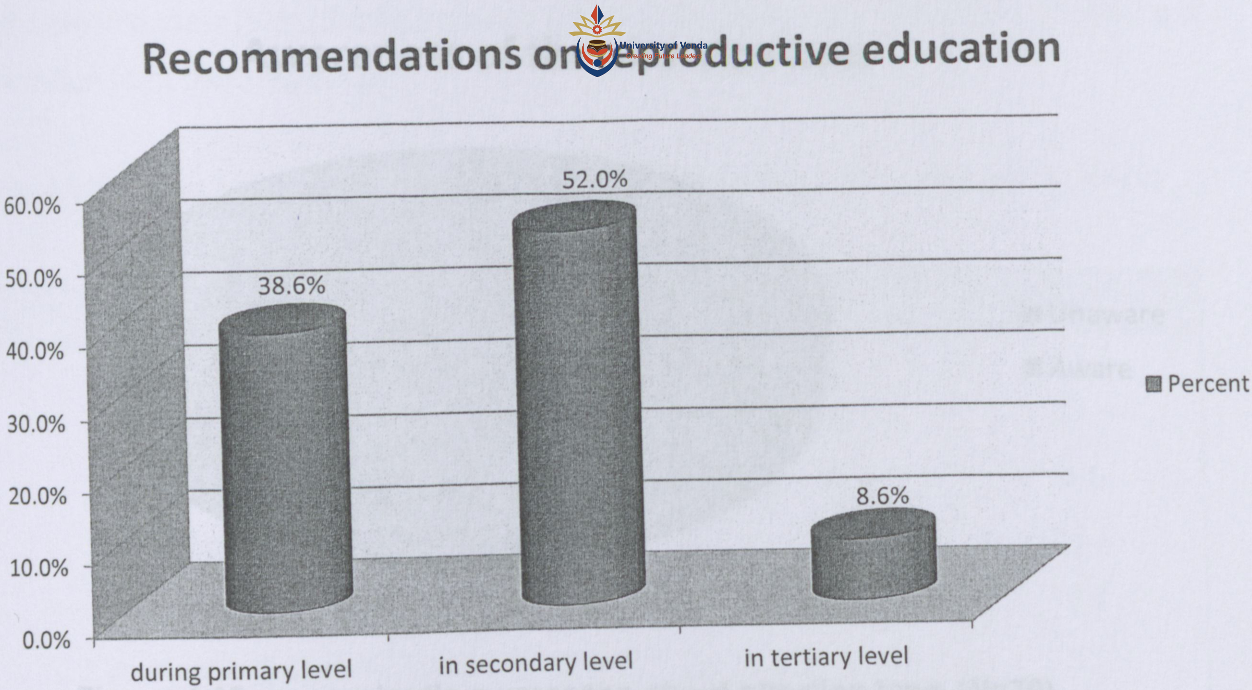


Figure 4.18 respondents recommended age at which a girl should receive information about reproductive health (N=70)

Large number preferred that the girl should receive reproductive health information at a secondary level , this thought is different from Maja (2007:20) who states that sex education should start early in the girl's life at about primary level. Girls who receive sex education at an early age often delay sexual intercourse.

4.3.3.4 Respondents awareness of the abortion laws

Most 44 (62.9%) did not know about abortion laws. Only 26 (37.1%) know about abortion laws.

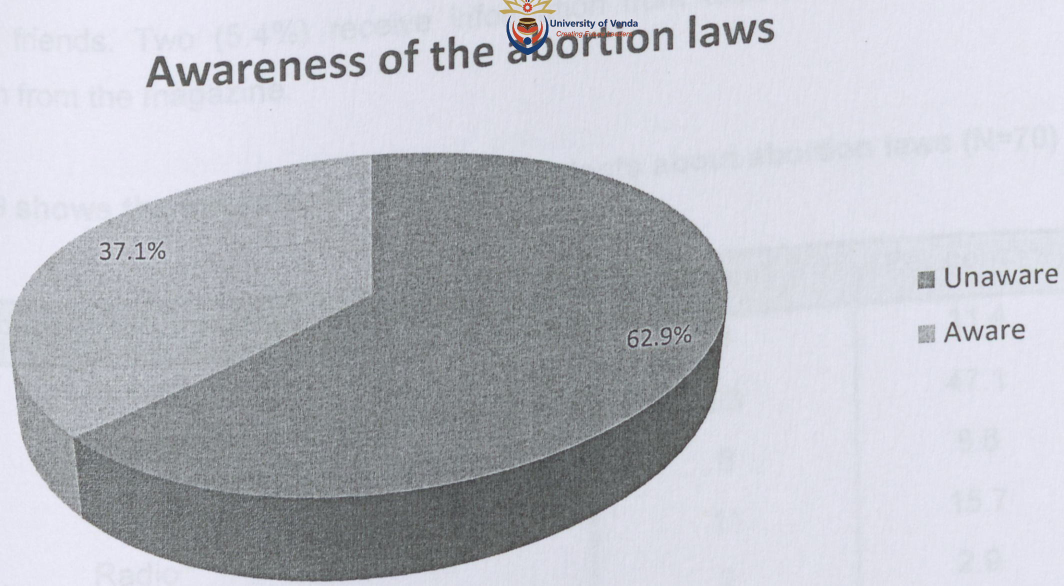


Figure 4.19 respondent's awareness about abortion laws (N=70)

The Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996) is the law governing abortion in South Africa. It allows abortion on demand up to the twelfth week of pregnancy, under broadly specified circumstances from the thirteenth to the twentieth week, and only for serious medical reasons after the twentieth week. Abortion can only be performed with the informed consent of the woman, and no other person's consent may be required. Even in the case where a minor is pregnant, she must be advised to discuss it with her parents, guardian or family, but their consent is not required. According to this Act teenagers have the rights to terminate their pregnancy if they want to, but as it is showed by the study, they are not aware of this Act which allows them to have full control over their bodies .This is supported by Maja (2007:134), who reported that teenagers engage in sexual behaviors without the knowledge of sexual reproductive matters.

4.3.3.4.1 Informants of abortion laws

Eighteen (48.6%) were informed by nurses. Six (16.2%) receive information about abortion by the radio. Four (10.8%) receive information from school. Three (8.1%) were informed by their parents another 3 (8.1%) received information concerning abortion laws from friends. Two (5.4%) receive information from television. One (5.4%) got information from the magazine.

Table 4.19 shows the informants of the respondents about abortion laws (N=70)

Respondents informants about abortion laws	Frequency (n)	Per cent (%)
School	8	11.4
Nurses	33	47.1
Friends	6	8.6
Radio	11	15.7
Magazines	2	2.9
Television	4	5.7
Parents	6	8.6
Total	70	100.0

The Choice on Termination of Pregnancy Amendment Act, 2004 (Act No. 38 of 2004), *which came into force on 11 February* 2005, amended the main act to expand access to abortions. It allowed registered nurses, as well as *registered midwives, to perform* abortions up to the twelfth week of pregnancy. It delegated to the provincial MECs the power to approve and disapprove abortion facilities and the power to make regulations under the act, powers which had previously belonged to the national Minister of Health. It also introduced the provision exempting facilities with a 24-hour maternity service from needing the MEC's approval to perform abortions in the first twelve weeks .The study shows great involvement of nurses in the Top, wherein they were informing teenagers *about the abortion laws.*

4.3.3.5 Respondents' opinions on legal abortion for girls between the age of 14 and 19

Most 47(67.1%) respondents believed that girls aged 14 – 19 years should not have legal abortion. Twenty-three (32.9%) think girls 14 – 19 years *should have legal* abortion.

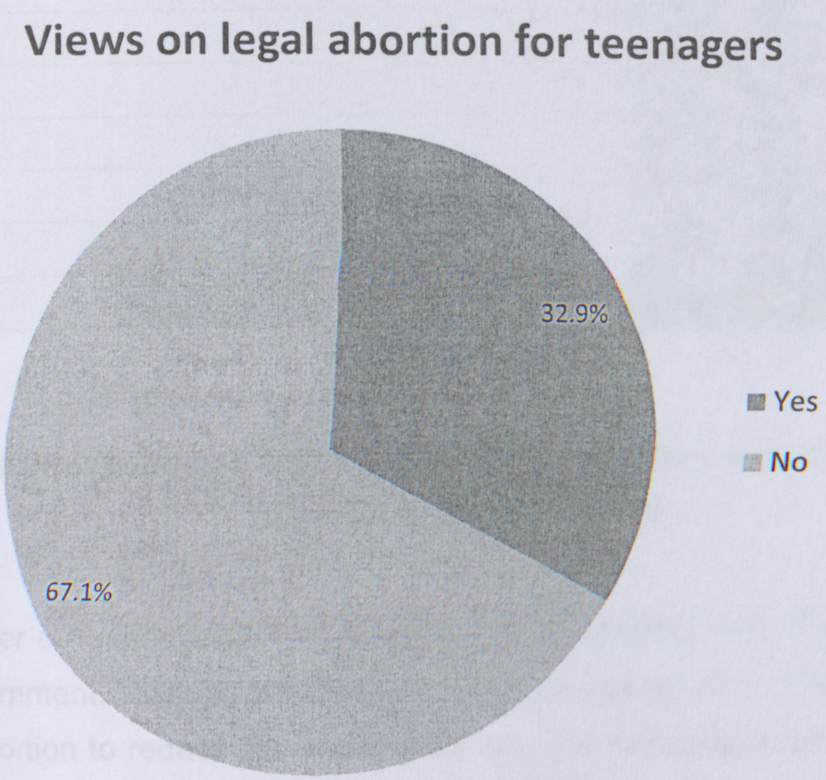


Figure 4.20 Views whether teenagers 14-19 years should have legal abortion (N=70)

4.3.3.6 Respondents' abortion status

A large number of respondents 61 (87.1%) did not undergo abortion. Nine (12.9%) had undergone abortion.

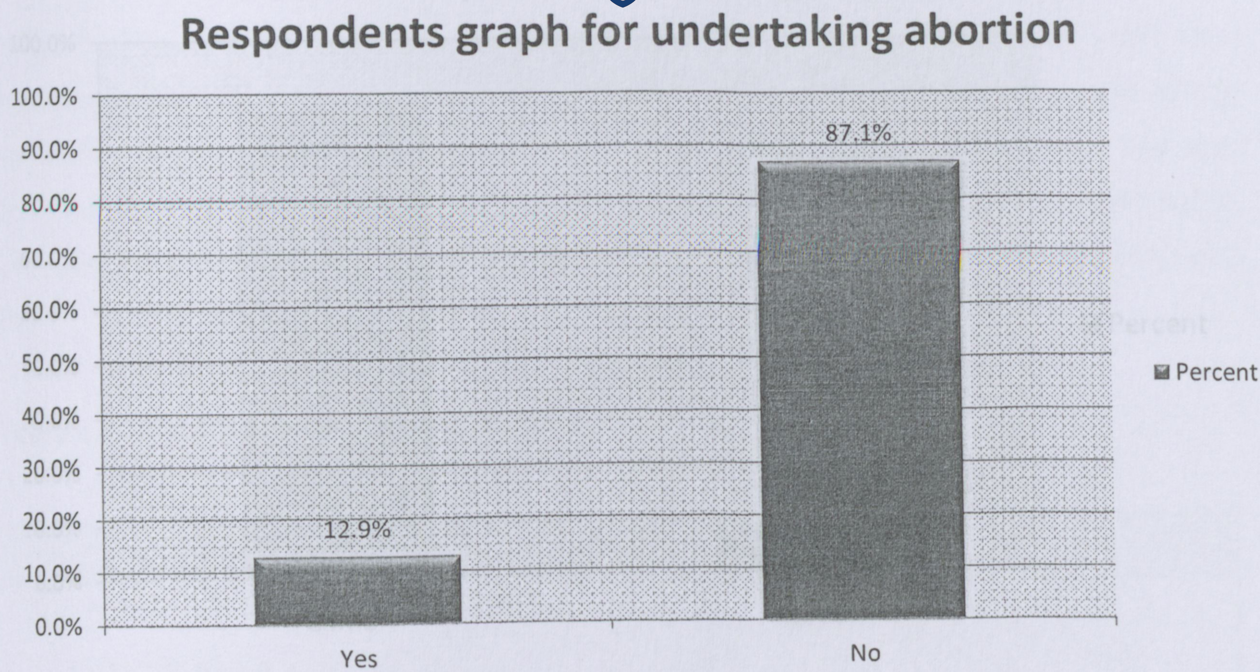


Figure 4.21 Respondents who had undergone abortion and those who had not undergone abortion (N=70).

Large number of respondents had not undergone abortion, even though it is legalised by the government, respondents seem to have no interest in it. The government has legalised abortion to reduce teen pregnancy, but it is not considered by the majority of respondents. Teenage pregnancy is still prevailing as teenagers are not using the services that had been made available to them by the government.

4.3.3.6.1 Place where respondents undergone abortion

Eight (88.9%) had undergone abortion at the clinic. One (11.1%) had an abortion at home.

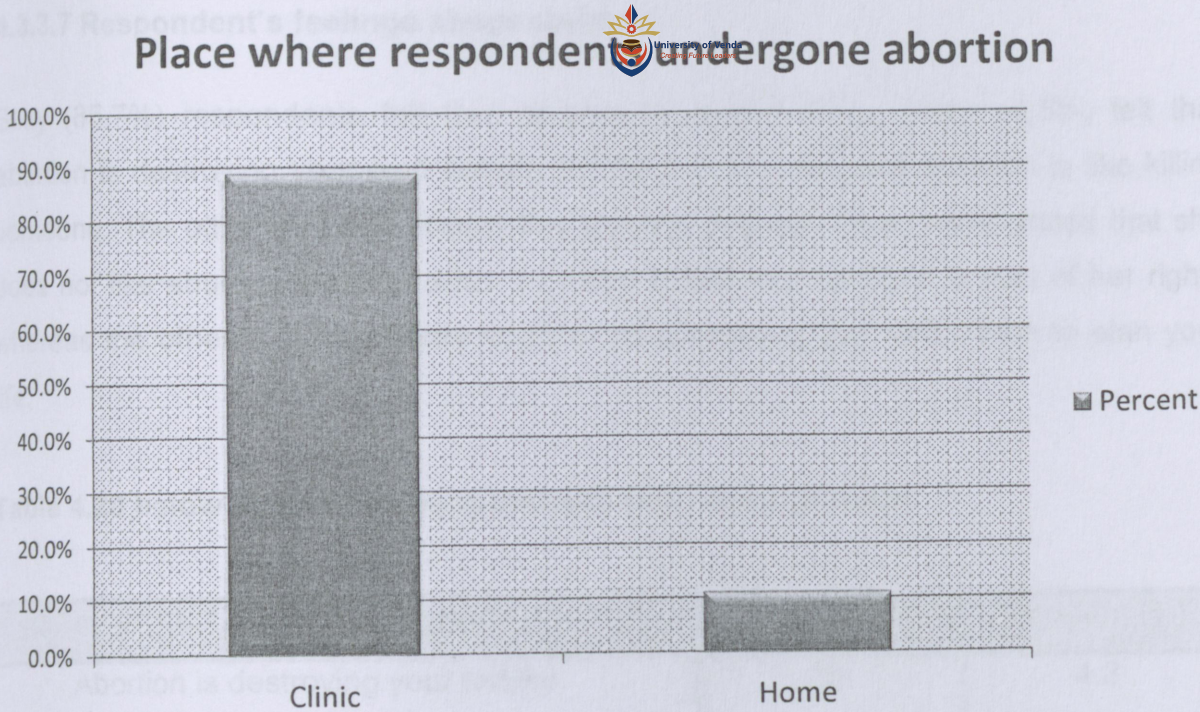


Figure 4.22 places where respondents undergone abortion (N=9).

Respondents were well aware of the place they can have abortion .They have indicated that abortion can be done at the clinic , which is the safe place that the government has designate for performing abortion.

4.3.3.7 Respondent's feelings about abortion

Sixty (85.7%) respondents felt that abortion is a bad thing. Three (4.3%) felt that abortion is destroying your own fertility. Whilst 2 (2.9%) felt that abortion is like killing someone. The other 2 (2.9%) stated that abortion is good. One (1.4%) stated that she does not like abortion and the other 1 (1.4%) stated that abortion is part of her rights whereas the other 1 (1.4%) takes abortion as something that offers time to plan your life.

Table 4.20 below shows how respondents feel about abortion

Feeling about abortion	Frequency (n)	Per cent (%)
Abortion is destroying your fertility	3	4.3
I do not like it	1	1.4
I feel it is a bad thing	60	85.7
Is good	2	2.9
It is their rights	1	1.4
Killing someone	2	2.9
Offer time to plan your life	1	1.4
Total	70	100.0

Statistic on the above table shows how respondents felt about abortion, they felt bad about abortion. They did not considerate abortion even though it would have been a solution to their teen pregnancy. This might be due to the debates that arise during legalisation of abortion. It has brought many controvecial issues within the country.

4.3.3.8 Consequences of unwanted pregnancy

Twenty-three (32.9%) said that unwanted pregnancy causes family problems. Twenty-One (30%) said that unwanted pregnancy or teenage pregnancy causes parents to abandon their pregnant teenagers during unwanted pregnancy. Seventeen (24.3%) stated that teenage pregnancy causes money problems leading to poverty. Six (8.6%) stated that teenage pregnancy caused abandonment by family and friends. Three (4.3%) stated that teenage pregnancy forces pregnant teenagers to dropout from school.

Table 4.21 below shows the consequences of unwanted pregnancy.

Consequences of unwanted pregnancy	Frequency (n)	Per cent (%)
Abandoned by parents	21	30
Abandon families	6	8.6
Dropout of school	3	4.3
Family problems	23	32.9
Money problems	17	24.3
Total	70	100.0

This study shows that teenage pregnancy lead to poverty. Teenage pregnancy changes the teenagers' lives forever and in most instances, in a negative way. They leave school and many never return because of the need to care for their children. Even if they do have the opportunity to continue with their education, many chose not to because of stigmas. The implication of teenage pregnancy is far greater than just having a baby. The young mother misses out on her own development. She can no longer have the experience that other teenagers can, because she has a greater responsibility to her child. Career dreams and goals are shuttered.

Teenage pregnancy culminates in a life that is not allowed to develop into its full potential- a great many opportunities are lost while the girls attend to their babies. Many of these girls are forced into mediocre jobs to earn an income. (http://www.satyagraha.org.za/current/index.php?option=com_content&task=view&id=160&Itemid=41)

4.3.3.9 Preferred methods of preventing unwanted pregnancy

Forty (57.1%) reported that they can prevent unwanted pregnancy by using condoms. Whilst 26 (37.1%) prevent unwanted pregnancy by abstaining from sexual intercourse. Whilst 4(5.7%) reported that they can prevent unwanted pregnancy by using cultural practices.

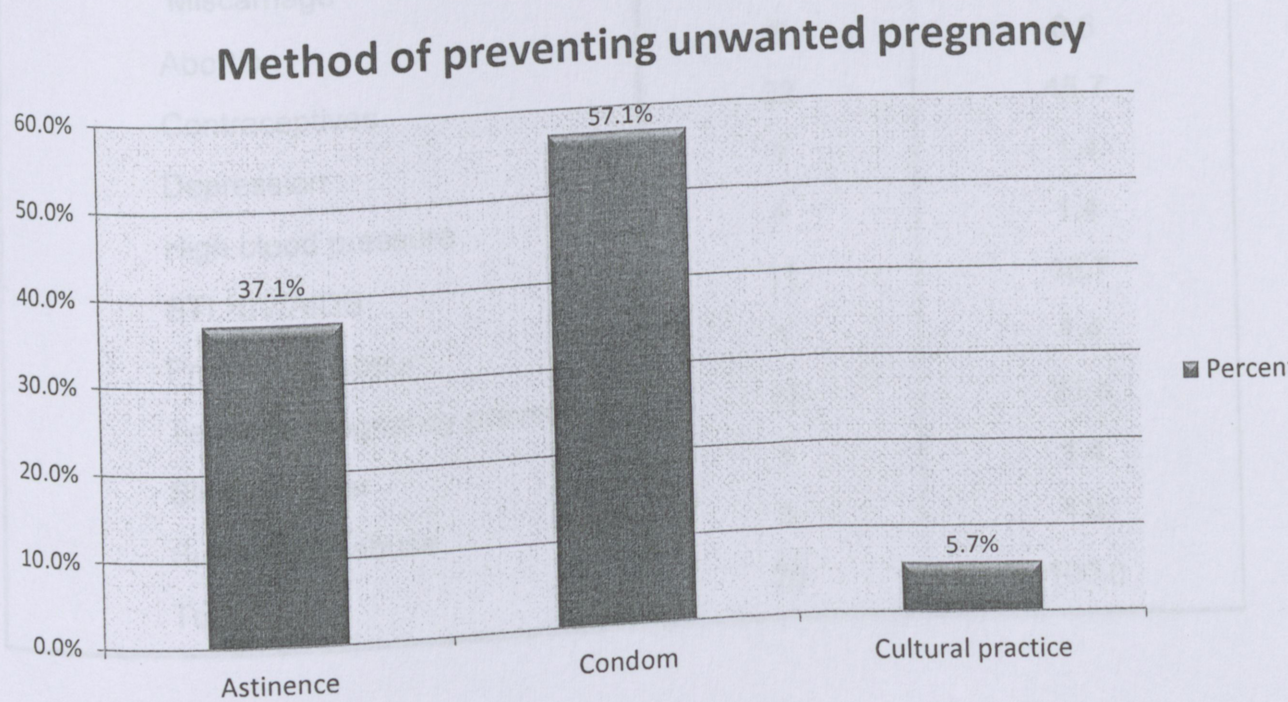


Figure 4.23 Participants' methods of preventing unwanted pregnancy.

The study shows that shows teenagers have knowledge about methods to prevent to prevent unwanted pregnancy but they did not use them. Lack of support from parents hinders teenagers to use the knowledge they had about sexual matters.

4.3.3.10 other information participants want to know more about

Thirty-two (45.7%) participants wanted to know more about contraceptives. Whilst 15 (21.4%) like to know about prevention of teenage pregnancy. Whilst 11 (15.7%) like to know about STI, HIV/AIDS. Whilst 6 (8.6%) like to know more about abortion. Whilst 1 (1.4%) wanted to know about miscarriage. Whilst 1 (1.4%) wanted to more about high blood pressure. Whilst 1 (1.4%) like to know about depression. Whilst 1 (1.4%) likes to know about premature labour. Whilst 1 (1.4%) wants to know about substance abuse. Whilst 1 (1.4%) likes to know about being a single mother.

Table 4.22 below shows what respondents like to know more about.

	Frequency	Per cent
Miscarriage	1	1.4
Abortion	6	8.6
Contraceptives	32	45.7
Depression	1	1.4
High blood pressure	1	1.4
STI,HIV/AIDS	11	15.7
Premature labour	1	1.4
Teenage pregnancy prevention	15	21.4
Single mother	1	1.4
Substances abuse	1	1.4
Total	70	100.0

The findings are indicative of the fact why teenagers are falling pregnant because majority (45.7%) wanted information about contraceptives and teenage pregnancy prevention (21.4%). Therefore contraceptive education and services should be made accessible to teenagers and demystify the myths surrounding contraceptives. Bisika, short, Wontumi & Truong (2007:94) also indicated that access to contraceptives is hampered by provider's lack of training and often times have exaggerated beliefs about the dangers of contraception.

4.4 CONCLUSION

This chapter presented the analysis of data by quantitative method, using tables, bar charts and pie charts. The findings were also discussed. The next chapter deals with the summary and interpretation of results.

CHAPTER 5

RESULTS, LIMITATIONS, RECOMMENDATION AND CONCLUSION OF THE STUDY

5.1 INTRODUCTION

This chapter summarises the findings of the study. This is followed by the conclusion drawn, limitations as well as the recommendations. The purpose of the study was to explore factors contributing to high rate of teenage pregnancies at Makhado local area. Objectives of the study were to:

- Explore factors contributing to high rate of teenage pregnancy at Makhado local area.
- Assess teenager's level of knowledge of reproductive health issues.
- Identify the source of their knowledge for reproductive health issues
- Propose possible intervention or services needed to prevent teen pregnancies.

Research questions that guided the study were:

- What are the factors contributing to high rate of teenage pregnancy at Makhado local area?
- Do teenagers have knowledge of causal factor of pregnancy?
- What strategies to be used to prevent teenage pregnancies?
- Who is responsible for the source of information among teenagers at Makhado local area?

In this chapter the results will be summarised based on the set objectives.

5.2 Objectives

5.2.1. Objective no. 1

This objective was aimed at describing factors contributing to high rate of teenage pregnancy at Makhado local area.

5.2.1.1 AGE

Teenagers aged 14 – 19 years participated in the study. Seventy teenagers participated in the study. A large number of participants were between the ages of 18 – 19 years, 33 (47%). Most respondents started having sexual intercourse at the age of 15 years Majority of respondents` sexual partners were at the age of 17 and 18 years at their first sexual intercourse. This shows that teenagers both male and female engage in sexual activities at young age. Age predispose people to certain behavior due to developmental stage, teenagers due to developmental hormones are attracted to opposite and experiment with sex without taking precaution. In study conducted by Jayakody et al (2011:502), it was reported that majority of teenagers started having sexual intercourse at the age of 13 years and did not use condom or any form of protection. Health education about sexuality and the prevention of teenage pregnancy should be started at early ages.

5.2.1.2 ILLETERACY/SCHOLASTIC ACHIEVEMENT

The results of the study showed the relation between teenage pregnancy and the educational level. Large numbers of respondent's education level were between grades 8 – 12 50 (71.4%). Eleven (15.7%) was between grade 4 – 7. Four (6.4%) were in tertiary level. Those with lower levels of education were the ones who were more vulnerable to teenage pregnancy. This results is in line with the findings of Were (2007; 336) who found high and negative relationship between the level of education and teenage pregnancy, majority of pregnant teenagers were in secondary level. Teenagers with higher level of education have more access to information, including information about sexuality which enables them to make informed decision regarding sex. This might be because most posters used to educate people about sexuality and reproductions are complicated and require high intellectual understanding. Most reproductive and sexual information are printed in foreign languages that require high level of understanding.

5.2.1.3 SOCIO-ECONOMIC STATUS

In most studies that have been conducted teenage pregnancy has been associated with unemployment and poverty. This study concur with those findings, 63 (91.4%) of respondents were unemployed. Twenty-two (31.4%) of respondents parents were unemployed. Forty-five (64.3%) of respondents parents were employed but there were no specification of their employment type. In a study conducted in Kenya Were found that teenage were easily enticed to pre-marital sex with trifles such as soap, dresses, hair-lotion or small amount of money. It was further indicated that in extreme cases some families marry off their teenagers as a way of meeting family needs through dowry.

5.2.1.4 PEER PRESSURE

A large number of respondents attributed their sexual intercourse to peer pressure 26 (37.1%). Teenagers enjoy being part of a group; they like to conform with their group mates who expose them to risky behaviour such as sex and teenage pregnancies. Peer pressure without appropriate guidance and support lead to risky behaviour such as substance abuse and premarital sex which result to teenage pregnancy. The magnitude of peer pressure in teenage pregnancy found in this study correlate to what was found in the study that was conducted in Busia district of Kenya by Were (2007:337), the extent of peer pressure was slightly high 50% of teenagers concurred that their pregnancies was largely a product of peer pressure to have sex. Additionally, of girls that admitted to having male friends, over 60% concurred that major problem they encounter in their friendship was persistent pressure to indulge in pre-marital sex.

5.2.1.5 POOR CONTRACEPTIVE KNOWLEDGE

With regard to contraceptive use, majority of respondents 42 (60%) had not used contraceptive. Whilst 28 (40%) used contraceptives. This shows that the large numbers of respondents were not using contraceptives. Whilst 14 (33.3%) of the respondents did not use contraceptives because they lacked information about contraceptives. Whilst 12 (28.6%) attributed their none-use of contraceptives to peer pressure. Whilst 9 (21.4%) attributed their none-use of contraceptives to fear of becoming infertile. Whilst 7 (16.7%) stated that they did not use contraceptives due to inaccessibility of contraceptives. The reasons that were given for not using contraceptives shows lack of information about sexuality and contraceptive. This explains low use of contraceptive and the resultant teenage pregnancy. Most 64 (91.4%) did not plan their pregnancies; this findings concur with Oner et al (2012:140) in which 25 - 50% of teenagers in the study revealed that their pregnancies were unplanned.

5.2.2 Objective no 2

This objective was aimed at identifying teenager's source of knowledge about reproductive health issues.

5.2.2.1 INFORMANTS ABOUT MENSTRUATION

Large number of respondents got information about menstruation from their mothers 40 (57.1%). Whilst 14 (20%) got information from nurses. Whilst 5 (7.1%) got information from friends. Whilst 5 (7.1%) got information from magazines and books. Whilst 3 (4.3%) got information from their fathers, and another three were informed by their grandparents. Whilst 1 (1.4%) got information from magazines. About menstruation large numbers of respondents were informed by their mothers.

5.2.2.2 INFORMANTS ABOUT SEXUALITY

Twenty-two (31.4%) received most information about sexuality and reproductive issues from friends. Whilst 19 (27.1%) received information from school. Whilst 14 (20%) got information from their parents. Whilst 12 (17.1%) got information from television. Whilst 2 (2.9%) got most of their information from the newspaper and only 1 (1.4%) got her information the internet.

5.2.2.3 INFORMANTS ABOUT PREGNANCY

Twenty-three (32.9%) got information about pregnancy from their friends. Whilst 20 (28.6%) got information from school. Whilst 19 (27.1%) got information from parents, 4 (5.7%) got information from television, 3 (4.3%) got information from the newspaper and only 1 (1.4%) got the information from the internet. Pregnancy is a state in which a person should be well informed about the changes that occurs in the body and the danger signs that require immediate attention. It is important that information should be given by experienced people, but surprisingly in this study large number of respondents got information from friends, 18 (48.6%) were informed by nurses,6 (16.2%) receive information about abortion by the radio, 4 (10.8%) receive information from school. Whilst 3 (8.1%) were informed by their parents another 3 (8.1%) received information concerning abortion laws from friends. Whilst 2 (5.4%) receive information from television, 1 (5.4%) got information from the magazine.

5.2.3. Objective no 3.

This objective was aimed at assessing teenager's level of knowledge of reproductive health issues and causes of pregnancy.

5.2.3.1 PHYSIOLOGICAL CHANGES AT PUBERTY

Majority of the respondents said that girls start menstruating at puberty, 30 (42.9%). Others 26 (37.1%) responded that pubic hair start to grow at puberty. Fourteen (20%) said that breast develops during puberty. Respondents were knowledgeable about changes that occur at puberty.

5.2.3.2 RISK OF SEXUAL BEHAVIOUR

A large number of respondents 32 (47.1%) said that they were aware of the risk of falling pregnant when indulging in sexual intercourse at an early stage,15 (21.4%) said that the risk of indulging in sexual intercourse at an early stage could be that of contacting of STI, HIV/AIDS. Another 14 (20%) responded that early sexual intercourse lead to school dropout if one falls pregnant and 8 (11.4%) said the risk of indulging in sexual intercourse at an early stage is poverty. Surprisingly respondents were aware of the risks that are inherent in early sexual intercourse.

5.2.3.3 KNOWLEDGE OF CONTRACEPTIVES

Fourteen (33.3%) of the respondents have not used contraceptives due to lack of knowledge about contraceptives, 12 (28.6%) did not use contraceptives because of peer pressure. Whilst 9(21.4%) did not use contraceptives because they were afraid they will lose their fertility, 7 (16.7%) did not use contraceptives because of inaccessibility of contraceptives. The findings of this study indicate that teenagers lack information about contraceptives which leads to poor utilization of contraceptives. This results is similar to the results reported by were (2007:331) in which teenagers were not

Using contraceptives due lack of proper information about contraceptives.

5.2.3.4 LACK OF KNOWLEDGE OF CTOP

High number of respondents 44 (62.9%) were not aware of abortion laws. This indicates that most teenagers are going through with their pregnancy due to lack of knowledge about abortion. Most respondents 47 (67.1%) said that girls aged between 14-19 years should not have legal abortion. This clearly shows that respondents are not aware of their sexual right and abortion laws. The Choice on Termination of Pregnancy Act, 2004 (Act No. 38 of 2004), allows for termination of pregnancy from the age of 12 years upwards.

Seventeen (26%) said that teenage pregnancy causes poverty. About 16 (25%) said that teenage pregnancy caused abandonment by family and friends. Fourteen said that teenage pregnancy causes problems within the family. Thirteen (18.6%) said that teenage pregnancy results in poor educational status. Respondents were aware the consequences of teenage pregnancies. Asked to describe in their own words the consequences of unwanted pregnancy, one respondent wrote poverty, family disruption and shame.

Most were aware of the methods for preventing pregnancy, STIs and HIV/AIDS. Asked about their preferred method of preventing pregnancy, STIs and HIV/AIDS, 40 (57.14%) reported that they can prevent unwanted pregnancy by using condoms, about 26 (37.14%) prevent unwanted pregnancy by abstaining from sexual intercourse. Whilst (5.71%) reported that they can prevent unwanted pregnancy by using cultural practice. These contradict with figure 4.16 which indicate that for the majority of the respondents, their pregnancies were not planned.

Most 37(52.9%) recommended that girls should receive information on reproduction at secondary level. This might be the reason for high rate of pregnancy; teenagers are involved in sexual activities before they get more information about sexuality. Some teenagers start to have sexual intercourse before they go to secondary level. Sex education should start early before teenagers engage in sex to ensure informed decision making. These recommendations differ with Maja (2007:20), who reported that sex education should start at primary level.

5.3 LIMITATIONS OF THE STUDY

The study was conducted at Makhado municipality, therefore the results of the study cannot be generalised beyond this area. The response of teenagers from other areas might differ from those at Makhado municipality.

The study focused only on pregnant teenagers and teenage mothers, other teenagers were not included. Therefore the views of other teenagers will not be included. The researcher used a small sample of 70 respondents due to the fact that the respondents' visits to clinics are schedule on different dates.

5.4 RECOMMENDETIONS

5.4.1 Education ministry

- Teachers should be trained to counsel learner s about sexual and reproductive health matters.
- Both boys and girls should receive sexual and reproductive health education at primary level.
- Girls should receive reproductive health education including menstruation, conception, sexual intercourse, contraceptives as well as pregnancy.

5.4.2 Community health support

Community health programmes should be activated to provide information to parents and youth about youth sexual and reproductive issues; to assist them in communicating with their youngsters about reproductive health issues.

5.4.3 Health services

- Reproductive health services should be accessible to teenagers.
- Awareness campaign should be performed to inform teenagers about reproductive health issues.
- Peer education programmes should be strengthened to ensure open communication among teenagers about sexual and reproductive matters.

5.4.4 The country

- The government, NGOs and private sectors should continue to improve the economy of the country, to promote quality life for teenagers.
- Develop partnership with other countries in order to develop new knowledge with regard to teenage reproductive issues.

5.4.5 Further research

- Knowledge and attitude of teenagers about contraceptives.
- Knowledge and attitude of teenagers about the impact of teenage pregnancy.
- Factors that hinders communication about sexual matters between teenagers and their parents.

5.5 CONCLUSION

Teenage pregnancy is a societal concern in SA and other countries. Teenagers are exposed to different health problems including miscarriages, depression, and sexually transmitted infection, such as HIV/AIDS. Although a range of interventions have been implemented in SA to influence teenagers' sexual behaviors, their focus is generally on preventing HIV rather than pregnancies that appear to be epidemic. In addition, the small number in which evaluation studies are conducted limit the extent to which firm conclusions can be reached about their efficacy. Nevertheless, when combined with the larger body of literature available internationally, a number of promising approaches can be identified.

However, many more rigorously evaluated efficacy (to show that programs work) and, in particular, effectiveness (to show how programs can be implemented within existing infrastructure) intervention studies are required. While pregnancy prevention programs should not be separated from HIV programs because of their common antecedents, caution is required to prevent pregnancy from being subsumed and, in some respects, neglected in favor of the overwhelming challenges that HIV presents to young people. Pregnancy prevention needs to be a distinct outcome of reproductive health programs. In addition, a distinct focus of research on second chance programs for reproductive health is required to respond to the large cohort of young people aged 19 years and younger who have, and will continue to experience unintended pregnancies. No doubt a number of community organizations are providing a range of prevention and second chance programs for teenage pregnancy in SA. However, without adequate documentation of the programs or evaluation of its efficacy, it is difficult to make recommendations regarding wide-scale implementation. A mapping exercise should be considered to identify the range and scope of interventions currently being provided in SA. Teenage pregnancy in SA; with a specific focus on school-going learners begin with the lower foundation. This study also found that peer pressure, poor communication between parents and their teenagers, lack of knowledge about contraceptives and low educational level are the main factors contributing to high rate of teenage pregnancy at Makhado local area, Vhembe district of LP.

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ANNEXURE A

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

S305

NAME OF RESEARCHER/INVESTIGATOR:
Miriri TM
Student No: 11530827

PROJECT TITLE: FACTORS CONTRIBUTING TO HIGH RATE OF TEENAGE PREGNANCY AT MAKHADO MUNICIPALITY, LIMPOPO PROVINCE

PROJECT NO: SHS/13/PDC/02/0517

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof ML Netshikweta	University of Venda	Supervisor
Dr DU Ramathuba	University of Venda	Co-supervisor
Mrs TM Miriri	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: May 2013
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: ....
Name of the Chairperson of the Committee: Prof. X.G Mbhenyane

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8484 /8313 FAX (015) 962 8439
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ANNEXURE B

University of Venda
Creating Future Leaders

PO Box 1828
Dzanani
0955
28 May 2013

The Head of Department
Department of Health Limpopo province
Private Bag x 9302
Polokwane
0700

Dear sir/madam

REQUEST TO CONDUCT RESEARCH

I am currently registered in Magister Curationis (Nursing Master's Degree) program at the University of Venda. Part of the requirements for the program is conduction of research of a limited scope. I am thus requesting to conduct research in one of the health districts of Limpopo province, my area of interest is Vhembe district. The topic of the research is:

FACTORS CONTRIBUTING TO HIGH RATE OF TEENAGE PREGNANCY AT MAKHADO MUNICIPALITY IN VHEMBE DISTRICT OF LIMPOPO PROVINCE.

Thank you

Yours faithfully
Mrs MIRIRI TM

ANNEXURE C

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald Ref:4/2/2

Miriri TM
University of Venda
South Africa

Greetings,

Re: Factors contributing to high rate of teenage pregnancy at Makhado municipality, Limpopo province

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
    - Further arrangement should be made with the targeted institutions.
    - In the course of your study there should be no action that disrupts the services.
    - After completion of the study, a copy should be submitted to the Department to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

14/06/2013
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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ANNEXURE D

CONSENT FORM FOR PARTICIPATING IN THE STUDY

I hereby consent to participate in the research study. I understand that my participation is voluntary and that I may refuse to answer any particular question or withdraw from the study at any time without any danger or intimidation and I understand that my responses will be treated confidentially.

NAME OF PARTICIPANT: ______________________________

DATE: ______________________

SIGNATURE: ______________________

ANNEXURE E

QUESTIONNAIRE

Factors contributing to the high rate of teenage pregnancy at Makhado, Vhembe district, Limpopo province South Africa.

Answer each question by placing an "x" in the appropriate box or write down your response in the space provided.

SECTION A: BIOGRAPHIC INFORMATION

1 ***Your age at your last birthday.***

1.1 14 – 15 ☐
1.2 16 – 17 ☐
1.3 18 – 19 ☐

2 **Indicate your religion/faith**

2.1 Christianity ☐
2.2 Protestant ☐
2.3 Catholic ☐
2.4 Other (specify)
....

3 **What is your tribal group**

3.1 Venda ☐
3.2 Tsonga ☐
3.3 Pedi ☐
3.4 Other...

4 **Have you attended School?** Yes ☐ No ☐

4.1 If yes what is your level of education?

4.1.1 Grade R-GRADE 3 ☐
4.1.2 Grade 4-7 ☐
4.1.3 Grade 8-12 ☐
4.1.4 Tertiary ☐
4.1.4 Other ☐

5 **Whom do you live with**
5.1 Both parents ☐
5.2 Father only ☐
5.3 Mother only ☐
5.4 Husband ☐
5.5 Guardian/adoptive parents ☐
5.6 No permanent place (state where)..

6 **Highest level of education of parents/guardian.**

	Father	Mother	Guardian
6.1 No formal education			
6.2 Primary School			
6.3 Secondary School			

6.4 Higher education			

7 **Indicate your marital status**

7.1 Single ☐
7.2 Divorced ☐
7.3 Married ☐
7.4 Widowed ☐
7.5 Co-habiting ☐

8 **If married, state the circumstances**

8.1 Forced by parents ☐
8.2 Voluntary ☐
8.3 Poverty ☐
8.4 Pregnancy ☐
8.5 Other (specify)..................................

9 **What is your Parent's/Guardian's occupational status?**
9.1 Unemployed ☐
9.2 Employed ☐
9.3 Self-employed (Doing business) ☐

10 **Are you working?**
Yes ☐
No ☐

11 If working state your income
11.1 R1500- R2000 ☐
11.2 R2000-R2500.00 ☐
11.3 R3000 and above ☐

SECTION B : SEXUALITY AND REPRODUCTIVE HEALTH ISSUES

12 What physical changes do girls notice during puberty?

12.1 Growth of pubic ☐
12.2 Breasts develop ☐
12.3 Starting of menstruation (menarche) ☐
12.4 Other (please state)....................................

13 Have you had your menstrual period (menarche)?

YES ☐
NO ☐

14 If yes how old were you when you had the first menstrual period?

14.1 19 years ☐
14.2 18 years ☐
14.2 10 years ☐
14.3 11 years ☐
14.4 12 years ☐
14.5 13 years ☐
14.6 Other (please specify)...

15 What information did you receive regarding the menstrual period?

15.1 It is a curse ☐
15.2 It is painful ☐
15.3 You are ready to have a baby ☐
15.4 You are ready to get married ☐
15.5 About hygiene ☐
15.6 Avoiding sexual intercourse ☐
15.7 Other (please state)..

16 Who were your informants?

16.1 Mother ☐
16.2 Father ☐
16.3 Teacher ☐
16.4 Nurse ☐
16.5 Friends ☐
16.6 Grand parents ☐
16.7 Magazines ☐
16.8 Books ☐
16.9 Other (please specify)........................

17 What information do you have regarding conception or becoming pregnant?

17.1 4 days before menstruation ☐
17.2 4 days after menstruation ☐
17.3 during menstruation ☐
17.4 any time ☐

18 What age was your first sexual intercourse?

		Years

19 **What was the reason to have sexual intercourse?**

19.1Desire ☐
19.2Peer pressure ☐
19.3Pressure of partner ☐
19.4Want pregnant ☐
19.5Other (state reasons) ☐
……………………………………………………

20 **What was the age of sexual partner at the first sexual encounter?**

		Years

21 **How many sexual partners do you currently have**

22 **How many sexual partners did you have from first intercourse to date?**

23 **What are the risks/dangers of indulging in sexual intercourse at an early stage?**

23.1School Drop out ☐
23.2Pregnancy ☐
23.3STI/HIV/AIDS ☐
23.4Poverty ☐

24 Have you ever used contraceptives? **Yes** ☐ **No** ☐

24.1 If yes, indicate the method on the following list of methods

method :

24.1.1 Contraceptive pills ☐
24.1.2 Injectable contraceptives ☐
24.1.3 Condoms ☐
24.1.4 Other (please state) ☐
……………………………………………

24.2 **If no, state the reasons**

24.2.1 Peer pressure ☐
24.1.3 Lack of knowledge of contraceptive ☐
24.1.4 Afraid of infertility ☐
24.1.5 Inaccessibility of contraceptive ☐

25 Which type of contraceptive is suitable for teenager

25.1 Loop ☐
25.2 Pills ☐
25.3 Injectable ☐
25.4 Condoms ☐
25.5 Emergency morning pill ☐

26 **Where do you obtain contraceptive?**

26.1 Pharmacy ☐
26.2 Reproductive and child health clinic ☐
26.3 Public places (condoms) ☐
26.4 At schools (condoms) ☐
26.5 Others (specify) ☐
……………………………………………………………………………

27 Which contraceptive method prevents pregnancy and sexually transmitted infections?

27.1 Loop ☐
27.2 Pills ☐
27.3 Condom ☐
27.4 Natural Method/rhythm ☐

28 How old were you at first pregnancy?

		Years

34 **What social problems are prevalent with an adolescent pregnancy?**

- 34.1 Problems ☐
- 34.2 Lack of money ☐
- 34.3 Parents will abandon me ☐
- 34.4 My friends will abandon me ☐
- 34.5 Shame ☐
- 34.6 Other (specify) ☐

....

SECTION C: SOURCE OF INFORMATION

35 **Who provided you with the most information about sexuality and reproduction?**

- **35.1** Schools ☐
- **35.2** Parents ☐
- **35.3** Friends ☐
- **35.4** Television/video ☐
- **35.5** Newspapers/magazines ☐
- **35.6** Internet ☐
- **35.7** Church/mosque ☐
- **35.8** Other (specify) ☐

....

36 **Who / what was the source of information about pregnancy?**

- 36.1 Schools ☐
- 36.2 Parents ☐
- 36.3 Friends ☐
- 36.4 Television/video ☐
- 36.5 Newspapers/magazines ☐
- 36.6 Internet ☐
- 36.7 Church/mosque ☐
- 36.8 Other (specify) ☐

....

37 **What are your recommendations regarding the period in which a girl child should receive education about the reproductive information**

- 37.1 During Primary level ☐
- 37.2 In secondary level ☐
- 37.3 In tertiary education ☐

38 **Are you aware of the abortion laws?**

Yes ☐
No ☐

39 If yes, who informed you?

39.1 School ☐
39.2 Nurses ☐
39.3 Friends ☐
39.4 Radio ☐
39.5 Magazines ☐
39.6 Television ☐
39.7 Parents ☐
39.8 Other (please state) ☐
....

40 Do you think girls 14-19 years should have legal abortion

YES ☐
NO ☐

41 Have you undergone an abortion?

YES ☐
NO ☐

42 If yes, where (please indicate)?

42.1 At home ☐
42.2 At a clinic ☐
42.3 Backstreet ☐
42.4 Other (please specify) ☐
....

43 How do you feel about abortion?

....
....
....
....

SECTION D: EFFECTS OF PREGNANCY ON THE ADOLESCENT

44 In your own words, describe the consequences of an unwanted pregnancy.

....
....
....
....

45 How would you prevent an unwanted pregnancy?

- **45.1** Abstinence ☐
- **45.2** Condom ☐
- **45.3** Cultural practices ☐
- **45.4** Other (please state) ☐

....

46 I would like to have more knowledge about you:

....
....
....
....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE

STEVENS EDITING AND PROOFREADING

~ Editing ~ Proofreading ~ Writing ~

BA: English; Industrial psychology (Unisa)
Sole Proprietor
***Membership*:**
PEG (SA)
IPEd (WA)

18 February 2015

THIS IS TO CERTIFY THAT:

I have language edited a thesis titled: *Factors contributing to the high rate of teenage pregnancy at Makhado local area, Vhembe District of Limpopo province in South Africa,* for Ms Tshilile Mumsy Miriri, a student at the University of Venda, student number 11530827.

The scope of my editing comprised:

- Spelling
- Vocabulary
- Word usage
- Checking of referencing style
- Tense
- Punctuation
- Language and sentence structure

It has been a pleasure working with this student. She has clearly displayed integrity in a well-prepared and timeously delivered paper, keeping communication lines open, as well as prompt payment. My best wishes for successful studies and future career accompany her.

Yours faithfully,

Charlotte Stevens (Ms)
Stevens Editing and Proofreading
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SECTION D: EFFECTS OF PREGNANCY ON THE ADOLESCENT

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....

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....
....
....
....

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE

University of Venda
Creating Future Leaders

29 **Was this a planned pregnancy?**

YES ☐
NO ☐

30 **How would you prevent pregnancy, sexually transmitted infections and HIV/AIDS?**

30.1 By abstaining from sexual activities ☐
30.2 Using contraceptives ☐
30.3 Having regular medical check-ups ☐
30.4 Have only one sexual partner ☐
30.5 Other (please specify) ☐
....

31 **In your opinion, what is the youngest age at which you consider it a risk to fall pregnancy?**

31.1 12 - 13 and younger ☐
31.2 14 years ☐
31.3 15 years ☐
31.4 16 years ☐
31.5 17years ☐
31.6 18years ☐
31.7 19 years ☐

32 **What is the most appropriate age to fall pregnant?**

32.1 13 years and younger ☐
32.2 14 years ☐
32.3 15 years ☐
32.4 16 years ☐
32.5 17 years ☐
32.6 18 years ☐
32.7 20 years ☐

33 **What health problems could be expected when an adolescent falls pregnant?**

33.1.1 High blood pressure ☐
33.1.2 Miscarriage ☐
33.1.3 Premature labour ☐
33.1.4 STI/HIV infection ☐
33.1.5 Depression ☐
33.1.6 Anemia ☐
33.1.7 Other:.......................

implemented in SA to influence teenagers' sexual behaviors, their focus is generally on preventing HIV rather than pregnancies that appear to be epidemic. In addition, the small number in which evaluation studies are conducted limit the extent to which firm conclusions can be reached about their efficacy. Nevertheless, when combined with the larger body of literature available internationally, a number of promising approaches can be identified.

However, many more rigorously evaluated efficacy (to show that programs work) and, in particular, effectiveness (to show how programs can be implemented within existing infrastructure) intervention studies are required. While pregnancy prevention programs should not be separated from HIV programs because of their common antecedents, caution is required to prevent pregnancy from being subsumed and, in some respects, neglected in favor of the overwhelming challenges that HIV presents to young people. Pregnancy prevention needs to be a distinct outcome of reproductive health programs. In addition, a distinct focus of research on second chance programs for reproductive health is required to respond to the large cohort of young people aged 19 years and younger who have, and will continue to experience unintended pregnancies. No doubt a number of community organizations are providing a range of prevention and second chance programs for teenage pregnancy in SA. However, without adequate documentation of the programs or evaluation of its efficacy, it is difficult to make recommendations regarding wide-scale implementation. A mapping exercise should be considered to identify the range and scope of interventions currently being provided in SA. Teenage pregnancy in SA; with a specific focus on school-going learners begin with the lower foundation. This study also found that peer pressure, poor communication between parents and their teenagers, lack of knowledge about contraceptives and low educational level are the main factors contributing to high rate of teenage pregnancy at Makhado local area, Vhembe district of LP.

Table 4.15 The age which is regarded as appropriate to fall pregnant (N=70)

Age regarded appropriate to fall pregnant	Frequency (n)	Per cent (%)
13 years or younger	5	7.14
14 years	4	5.71
15 years	4	5.71
16 years	13	18.57
17 years	2	2.86
18 years	17	24.29
20 years	30	42.86
Total	70	100.0

4.3.2.21 Expected health problems when teenager falls pregnant

Twenty (28.6%) reported that STI and HIV/AIDS should be expected when an adolescent falls pregnant. Sixteen (22.9%) stated that premature labour can occur when a teenager falls pregnant. Fourteen (20%) reported that miscarriage can be expected when an adolescent falls pregnant. Fourteen (20%) stated that high blood pressure can be expected in teenage pregnancy. Four (5.7%) thought that depression can be expected when an adolescent falls pregnant. One (1.4%) state that enemies can be expected when adolescent falls pregnant due to stigmatisation. One (1.4%) did not specify but said that other health problems could be expected when a teenager falls pregnant. Based on the statistics respondents are aware that they may be infected by STI and HIV/AIDS when they fall pregnant. Surprisingly they have fallen pregnant despise the knowledge that they have.