

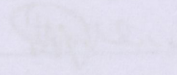
**THE EXPERIENCES OF TEENAGE PREGNANCY BY TEENAGE MOTHERS IN
THE THULAMELA MUNICIPALITY OF THE VHEMBE DISTRICT IN LIMPOPO
PROVINCE**

DECLARATION

I, Virginia Mulelu, hereby declare that the dissertation for the Master's degree at the University of Venda, hereby submitted by me, has not been submitted previously for a degree at this or any other university, that it is my own work in design and in execution, and that all reference material contained therein has been duly acknowledged.

By

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Signature:  Date: 2010-05-24

**SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE
DEGREE OF**

MAGISTER CURATIONIS (MCUR)

In the

Department of Advanced Nursing Sciences

At the

UNIVERSITY OF VENDA

**SUPERVISOR: PROF. L.B. KHOZA
CO-SUPERVISOR: MS L.H. NEMATHAGA**

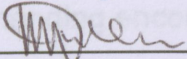
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Signature:  Date: 2010-05-24

- Prof L.B Khoza and Ms L.H Nomathaga my supervisors at UNIVEN, for all you taught me.
- Mr Tshkotshi, UNIVEN Librarian for the many literature sources you helped find for me.
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EXPERIENCES OF TEENAGE PREGNANCY BY TEENAGE MOTHERS IN THE THULAMELA MUNICIPALITY OF THE VHEMBE DISTRICT IN THE LIMPOPO PROVINCE

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ABSTRACT

Study background and purpose: Teenage pregnancy is a significant problem in today's society as it interferes with teenagers achieving success in life. Teenage pregnancy tends to prevent teenage mothers from completing their studies and places additional financial burdens on their parents. In developed countries, teenage pregnancy usually occurs outside marriage and in many communities and cultures carries a social stigma. However, teenage pregnancy may also be the result of sexual abuse or incest, both of which leave emotional scars. The teenage mother may still be a scholar, with plans for the future and unresolved relationships. Still being a child herself, she is not sufficiently emotionally mature to take care of another child. This may lead to denial, parental rejection and the procurement of an unsafe abortion. Despite the health department services available, like family planning and the termination of pregnancies, the incidence of teenage pregnancy continues to rise. The purpose of this study was to understand the experience of pregnancy by teenage mothers in the Thulamela municipal of the Vhembe district, Limpopo Province.

Study objectives: To explore and describe the experiences of teenage pregnancy and to identify and describe the factors that led to the pregnancy, as experienced by the teenage mothers.

Methods: The study used a qualitative design to explore and describe the perceptions and experiences of teenage mothers. The study population comprised

teenage mothers between 13 and 17 years of age, residing in the Thulamela Municipality of the Vhembe District in Limpopo province. A non-probability purposive sampling technique was used to obtain a sample of teenage mothers from each of the five villages, and then a snowballing sampling technique was used to identify the 30 participants who met the criteria of the study. A different number of participants was identified in each village, as this depended on their availability. Data was collected through in-depth individual unstructured interviews, using two broad questions, “How did you experience teenage pregnancy? and, “What were the factors that contributed to your becoming pregnant?” During interviews, data was tape recorded and field notes were taken. Tesch’ model for data analysis was used as guideline. The trustworthiness of the study (its credibility, dependability, confirmability and transferability strategies) was ensured, and all recommended ethical considerations were observed.

1.3. PURPOSE OF STUDY

Study Findings: Five major themes and sub-themes emerged. The findings of the study are discussed around the perceptions of the experience of pregnancy by the teenage mothers and their parents and male partners; abortion and the use of services to terminate pregnancy; knowledge of contraceptives, sexually transmitted infections and HIV and AIDS; factors that contribute to teenage pregnancy; and their perception of the consequences of pregnancy.

1.10. MEASURES TO ENSURE TRUSTWORTHINESS

Implications and recommendations: The study showed that the teenage mothers sampled experienced psychosocial, physiological, and economical problems. Various persons and institutions namely parents, teachers, health care providers, community and the government, failed to empower the teenage mothers with the knowledge and skills they required to make informed choices about their future. The study highlights the importance of coordinating multidisciplinary and intersectoral teams, involving parties such as school governors, School Health Services, Department of Education, communities and families, in order to find solutions to issues surrounding teenage pregnancies.

2.2.2. Descriptive research design

2.2.3. Explorative design

	Page no
TABLE OF CONTENTS	
2.2.4. Phenomenological	24
2.3. STUDY AREA	25
2.4. POPULATION AND SAMPLING	26
2.4.1. Population	27
Declaration	ii
Acknowledgements	iii
Abstract	iv
2.5. DATA COLLECTION	28
2.5.1. Data collection approach	29
CHAPTER 1	30
AN OVERVIEW OF THE STUDY	30
1.1. INTRODUCTION AND BACKGROUND OF THE STUDY	1
1.1.1. Problems associated with teenage pregnancy	5
1.2. PROBLEM STATEMENT	12
1.3. PURPOSE OF STUDY	13
1.4. OBJECTIVES OF THE STUDY	13
1.5. RESEARCH QUESTION	13
1.6. SIGNIFICANCE OF THE STUDY	14
1.7. DEFINITION OF TERMS	15
1.8. THEORETICAL FOUNDATION OF THE RESEARCH STUDY	16
1.9. RESEARCH METHODOLOGY	19
1.10. MEASURES TO ENSURE TRUSTWORTHINESS	20
1.11. ETHICAL CONSIDERATIONS	20
1.12. DELIMITATION OF THE STUDY	21
1.13. ORGANISATION OF THE STUDY	21
3.2. FINDINGS	42
3.2.1. Biographical	45
CHAPTER 2	45
RESEARCH METHODOLOGY	45
2.1. INTRODUCTION	22
2.2. RESEARCH DESIGN	22
2.2.1. Qualitative research design	22
2.2.2. Descriptive research design	23
2.2.3. Explorative design	24

2.2.4.1.	Phenomenological approach	24
2.3.	STUDY AREA	26
2.4.	POPULATION AND SAMPLING	27
2.4.1.	Population	27
2.4.2.	Sampling	27
2.4.2.1.	Sampling method	27
2.4.2.2.	Sample	29
2.5.	DATA COLLECTION	29
2.5.1.	Data collection techniques	30
2.5.2.	Plan for collecting the unstructured data	30
2.5.2.1.	Gaining entry to the research site	30
2.5.2.2.	Initiation phase	31
2.5.2.3.	Working phase	32
2.5.2.4.	Termination phase	33
2.6.	PILOT STUDY	33
2.7.	DATA ANALYSIS	34
2.8.	MEASURES TO ENSURE TRUSTWORTHINESS	36
2.9.	ETHICAL CONSIDERATIONS	37
2.10.	DELIMITATION OF THE STUDY	40
2.11.	CONCLUSION	41
	CHAPTER 3	
	PRESENTATION AND DISCUSSION OF THE RESEACH FINDINGS	
3.1.	INTRODUCTION	42
3.2.	FINDINGS	42
3.2.1.	Biographical information	45
3.2.1.1.	Teenage mothers' ages	45
3.2.1.2.	Teenage mothers' age of menarche and onset of sexual activity	46
3.2.1.3.	The age of male partners	48
3.2.1.4.	Teenage mothers' level of education	49
3.2.2.	Experience related to perceptions of pregnancy by significant others	50

3.2.2.1.	<i>Acceptance of pregnancy by teenage mother</i>	50
3.2.2.2.	<i>Reaction of the parents towards pregnancy</i>	52
3.2.2.3.	<i>Reaction of the male partner towards pregnancy</i>	53
3.2.3.	Experience related to abortion and use of termination of pregnancy services	55
3.2.3.1.	<i>Attitudes towards abortion</i>	55
3.2.3.2.	<i>Knowledge and utilisation of TOP services</i>	56
3.2.4.	Knowledge and perception of contraceptives, sexually transmitted infections, HIV and AIDS	57
3.2.4.1.	<i>Use of contraceptives including abstinence</i>	58
3.2.4.2.	<i>Knowledge of sexual transmitted infections, HIV and AIDS</i>	61
3.2.5.	Factors contributed to teenage pregnancy	64
3.2.5.1.	<i>Coercion by male partners</i>	64
3.2.5.2.	<i>Ignorance</i>	67
3.2.5.3.	<i>Peer group pressure</i>	68
3.2.5.4.	<i>Poor parental guidance</i>	70
3.2.5.5.	<i>Poor sex education</i>	71
3.2.6.	Perception of consequences of pregnancy by teenage mothers	73
3.2.6.1.	<i>Early responsibilities and forced marriages</i>	73
3.2.6.2.	<i>Low socio economic status</i>	74
3.2.6.3.	<i>Physiological pain</i>	76
3.2.6.4.	<i>School drop out</i>	77
3.3.	CONCLUSION	80

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1.	INTRODUCTION	82
4.2.	CONCLUSIONS	82
4.3.	LIMITATIONS OF THE RESEARCH STUDY	85
4.4.	RECOMMENDATIONS	85
4.4.1.	Health education for teenage mothers	85

4.4.2.	The role of the teachers	86
4.4.3.	The role of the parents	86
4.4.4.	The role of the health care providers	87
4.4.5.	The role of the community	88
4.4.6.	The role of the government	88
4.5.	SUMMARY	89

REFERENCES	90
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ANNEXURE A	98
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ANNEXURE B	102
------------	-----

LIST OF TABLES

Table 1.2 Teenage (13-17) and adult pregnancies in 2007 in the Thulamela Municipality	13
Table 2.7 Tesch's eight steps of data analysis	34
Table 3.2 Themes and sub-themes	44
Table 3.3 Summary of themes and sub- themes	80

CHAPTER 1

AN OVERVIEW OF THE STUDY

1.1. INTRODUCTION AND BACKGROUND OF THE STUDY

Teenage pregnancy is a worldwide problem that affects the future of teenage mothers, and raises concerns for all those interested in the health and wellbeing of young people and their children. One of the most significant aspects of teenage pregnancy is the prevalence of teenage pregnancies among those who themselves were children of teenage mothers (Barnett & Kartz, 2000:03; Whitehead, 2009:148). In 1994 the world wide figure for teenage pregnancies in the group 15 to 19 years of age was 30.2 per 100. It is an area of great concern because of the significant impact on communities. The strain that teenage pregnancies place on the health care and social services is enormous. There is also social concern over the lost potential of young parents. When pregnancy occurs, teenagers generally become academically and economically disadvantaged (Omolola, Irinoye, Oyelene, Adeyemi, & Tope-Oje, 2004:290; Skinner, Smith, Fenwick, Hendricks, Fyfe & Kendall, 2009:51).

In South Africa and many Sub-Saharan African countries the average age of first-time mothers is about 18 years. The increase in pregnancies in very young teenagers (under 16 years) in these countries represents a disturbing trend (Molatlhegi, 2007:56). As a significant problem in today's society, not only do teenage pregnancies interfere with the success in life that these girls might ultimately achieve, teen mothers require more public assistance than adult counterparts. However, children born from teenage mothers tend to be both socially and economically disadvantaged (Smit, Beksinka, Kunene & Penn-Kekana, 2005:75).

Early pregnancy prevents teenage mothers from completing their studies, placing additional financial burden on their parents. It is associated with a high

costs, involving direct monetary expenditure for public assistance from welfare and child health care costs in terms of child abuse, neglect and poverty. United States of America data indicates that the teenage pregnancy rate in 15-19 year old in 1999 was 86.7 per 1000 (Franzcog, Luehr & Evans, 2004:274). From the earliest years children watch television shows and movies that imply that sex appeal is a personal quality that people should develop to the fullest, and this contributes to promoting adolescent sexual activities and pregnancies (Lebelle, 1999:11; Whitehead, 2009:153).

Data supporting teenage pregnancy as a social issue in developed countries includes reports of lower educational levels, higher rates of poverty and other poorer "life outcomes" for children of teenage mothers. Teenage pregnancy in developed countries usually occurs outside marriage and carries a social stigma in many communities and cultures. A report by Save the Children found that 13 million children are born annually to women under the age of 20 worldwide in more than 90% in developing countries (Franzcog et al., 2004:274).

According to the findings of studies conducted in Bristol, USA, it was indicated that adolescents from disadvantaged backgrounds thought that ideal age for starting a family is between 17 and 25 years, whereas those from an advantaged background wanted to wait until their late 20's or early 30's, emphasising their plans for a career, university, money and personal development (Jewell, Tacchi & Donovan, 2001:522).

Teenage pregnancy appears to be encouraged by lack of access to sex education. Some parents are reluctant to make sex education and contraceptives available to their teenagers as they are afraid that their teenagers may interpret this as permission to engage in sexual activities. Teenage mothers are reluctant to visit clinics for contraceptives and thus do not make use of available health services. Teenagers also often lack knowledge about contraception and the physiology of pregnancy (Richter & Mlambo, 2005:65). Despite the introduction of "Baby think it over" pregnancy prevention

mothers said that they were unhappy about being pregnant as there was a stigma attached to it, and their babies were given names that indicated their illegitimacy (Richter & Mlambo, 2005:64).

In South Africa, the department of Health and Population Development report that the highest rate of teenage pregnancy is among women of low socio economic status. Teenagers often become pregnant as they are ignorant about their sexuality and have little sense of control over their lives and their future. African children traditionally learn about sexuality and sexual responsibility at initiation schools (Ehlers, 2003:13). The steady increase in the numbers of teenage pregnancies in South Africa is causing great concern and becoming a critical issue today. This situation requires the urgent attention of every society in order to prevent family life from disintegrating completely. Young girls of 13-17 years of age are biologically immature for successful child bearing, as they have not yet reached the physical, intellectual and social level required for heterosexual love and developing a satisfactory body image. In teenage pregnancies, the mother is usually unmarried, conception is a mistake and in most instances the babies are unwanted (Richter & Mlambo, 2005:65). In 1994, the Health Science Research Council reported that 48% of black women, 17% of coloured women, 30% of Indian women and 17% of white women gave birth before the age of 20 (National Youth Policy 1998). It is believed that the increased problem of teenage pregnancy is the result of introducing a child support grant by the government in 1999. The survey done at Tswane indicated that adolescents aged 14-19 were scholars or domestic workers and lacked financial support (Ehlers 2003:18).

For the past twenty years, teenagers in the USA have led and continued to lead the world in rates of pregnancy, abortions, and births. In nations with comparable economic backgrounds and cultures, the highest teenage pregnancy rates are one half of the USA. For example, although the rate varied substantially among Canadian provinces and territories, from a low rate of 31.5 per 1000 in Prince Edward to 136.7 per 1000 in the North West territories, the

rate of Canadian teenage births trends were towards a steady decline for both younger than 15-17 and older. In the Indian subcontinent, early marriages sometimes mean adolescent pregnancy, particularly in rural regions where the rate is higher than it is in urbanised areas (Somers & Fahlman, 2001:188; Dlamini, Van der Merwe & Ehlers, 2003:75).

The highest rate of teenage pregnancy in Sub-Saharan Africa is among women who marry at an early age. In Niger, 87% of women surveyed were married and had given birth to a child before the age of 18. In Nigeria, many adolescents are noted to be sexually active, engage in unsafe sexual practices and do not make use of contraceptives. These activities may result in sexually transmitted infections, unwanted pregnancy, unsafe abortion and early child bearing which always come with additional health and social problems. However adolescents identified causes of teenage pregnancy as lack of parental guidance, lack of appropriate sex education and lack of necessary material resources to meet their needs as a result of poor socio-economic status of parents and influence of peer groups (Omolola, Irinoye, Oyeleye, Adiyemi & Tope-Ojo, 2004:26).

In Swaziland in the region of southern Hho-ho, a study indicated that teenage mothers experience multiple problems: educational problems, financial problems, social and cultural problems (Dlamini, Van der Merwe & Ehlers, 2003:78).

The study conducted in Guinea, Cote d' Ivoire findings indicate that an unplanned teenage pregnancy could mean shame for the family, and the mother of the teenager could also be expelled from the family together with her pregnant daughter, meaning an end to education and rejection by her friends (Barnett & Kartz, 2000:02).

1.1.1. Problems associated with teenage pregnancy

Teenage pregnancy affects the life of a young girl negatively. These effects include physical effects, economic issues, social issues, psychological issues

and perinatal outcomes (Molatlhegi, 2007:56). The discussion below highlights some of these problems.

- **Teenage pregnancy and literacy**

Teenage pregnancy results in interruption of adolescent education, as they drop out of school. Worldwide two-thirds of teenage mothers have their first child before the age of fifteen and do not complete high school. Teenage mothers are also less likely to complete high school, seek further education or obtain employment (Trad, 1999:29; Franzcog et al., 2004:273). Recent studies indicate that teenage mothers who had already dropped out of school prior to becoming pregnant and those at school at the time of pregnancy are less likely to graduate than their peers. It is estimated that one in every eight young women has been forced out of the education system as a result of pregnancy (National Youth Policy, 1998; Barnet, Arroyo, Devoe and Duggan, 2004:263). Teenagers with higher levels of education are less likely to fall pregnant (Smit et al., 2005:75).

Youth frequently lack access to the information, education and services that could help them make sound choices about their needs (Barnett & Kartz, 2000:03). Mothers present sex as a dangerous activity to their daughters and this contributes towards a mutual understanding that sex should be kept secret (Lesch & Kruger, 2003:1078). African children traditionally learned about sexuality and sexual responsibility at initiation schools (Ehlers, 2003:19), however, now teenagers have access to media and the internet which provide unlimited access to information on sex and pornography and they feel anonymous while looking at it (Lebelle, 1999:02). Some teenage mothers indicate that they learned about birth control at school, while others learned from their parents (Dixon, Schoonader & Philliber, 2000:427).

In Swaziland teenage mothers report that they had lost faith in their own abilities to complete their education and to find a good job. Teenage mothers who did not attend school claimed to be happier about being pregnant, as they had nothing to

do at home. However, they also said that they had insufficient funds to pay for school fees and that they had opted to substitute schooling with pregnancy. Other researchers say that educational institutions do not provide teenagers with sex education and that they were expected to leave school even if they would like to finish their education (Dlamini et al., 2003:80; Stevens, 2009:42).

In UK Bristol, researchers found that teenage mothers said that sex education was provided too late. No explanation was provided about contraception and the emotional aspects of sex and pregnancy (Jewell, Tacchi & Donovan, 2000:523). They indicated that although they had some knowledge of how to prevent unwanted pregnancies (apart from the total abstinence) they could not use the different methods properly. Some took a pill when meeting a boyfriend or after. Others had misconceptions that contraceptives would make them gain weight or that condoms would make sex unenjoyable (Richter & Mlambo, 2005:65).

In Tswane, teenage mothers knew about emergency contraceptives and Termination of Pregnancy Services but did not utilise them as they believed that they were potentially harmful or were afraid that their parents would find out (Ehlers, 2003:19). Introduction of the "Baby Think It Over" programme at school made the teenagers to realise that teen parenting is time consuming and a lot of responsibility and that it might prevent them from fulfilling future life goals (Somers & Fahlman, 2003:193; Herrman, 2008:44).

- **Teenage pregnancy and socio-economic status**

Young people have different views of adolescent pregnancy and motherhood: some feel that pregnancy will prove their fertility and extend the family line, while others see motherhood as an important way of gaining respect and status in their families and their larger communities (Barnett & Kartz, 2000:20). The majority of teenage mothers had a low or destitute socio-economic status, were homeless or had experienced domestic violence. Pregnant teenagers report that they require emotional assistance and that promised financial support is not

forthcoming. (Franzcoog et al, 2004:278; Chen, Wen, Fleming, Yang & Walker, 2008:690).

Since most pregnant teenagers are still attending school, whether primary and secondary, they are still being cared for by their parents and have nothing, financially or materially, to provide for the unborn child. This places a lot of financial strain on the family concerned and the teenager herself. Pregnancy is expensive. Additional food and clothing are required, as the pregnant teenager's appetite increases and her shape changes and she does not fit into her old clothes. A new born baby also needs new clothes, baby food, fees for a paediatrician and a gynaecologist (Molatlhegi, 2007:56). Child bearing in the very young teens is not approved of, even in populations where this is coupled with social expectation that a network of peers and elders will actively support young mothers and their children (Geronimus, 2003:881). Teenagers who live with both of their parents until the age of fifteen are less likely to become pregnant during their first sexual relationship than young women raised in another structure (Zavodney, 2001:200; Deptula, Henry, Shoery and Slavic, 2006:38).

Young motherhood in developing countries such as South Africa affects employment prospects and less than one third of teenage mothers receive any form of child support, increasing the likelihood of their turning to the government for assistance (National Youth Policy, 1998). For instance, in Swaziland teenage mothers are generally from poor families, but their motherhood status aggravates their financial problems. They cannot rely on financial support from the fathers of their babies and their families (their parents and mostly their mothers) have to carry the financial burden for them and their babies (Dlamini et al., 2003:82). In Tswane, Gauteng Province, most teenage mothers are scholars; some are domestic workers, so they either have no income or earn very little, meaning that they are unable to care for themselves and their babies (Ehlers, 2003:18). The majority have a low and destitute socio economic status, are homeless and experience domestic violence. Their main source of support

is their own mother, followed by the father of their unborn child (Franzcoog, Luehr & Evans, 2004:278). Other teenage mothers are able to buy expensive children clothing and strollers (Richter & Mlambo, 2005:64; Jewell et al., 2000:522).

- **Teenage pregnancy and physiological impact.**

As it was indicated in the introduction of this study that teenage mothers aged 13-17 are physically immature for effective for child bearing, and the incidence of premature births and low birth weight is higher among adolescent mothers. Complications of pregnancy result in the death of an estimated 70,000 teen girls in developing countries each year. Girls aged 14 years and younger are at greatest risk, with underdeveloped pelvises which lead to difficulty in childbirth, caesarean sections and eclampsia (Franzcoog et al., 2004:274; Chen, Wen, Yang, & Walker, 2008:690).

The increased maternal mortality and morbidity in teenage mothers is partially due to an increased risk and severity of gestational proteinuric hypertension. In very young teenagers, under 16 years, an incompletely developed pelvis may be responsible for higher rates of cephalopelvic disproportion, which may results in failed labour and an increased caesarean section rate. In addition very young girls often do not attend antenatal clinics, which may result in undetected problems such as hypertension and anaemia (Molatlhegi, 2007:56). Teenagers who decide to continue with their pregnancy face a multitude of complications, like low birth weight, preterm birth and pre-eclampsia. Furthermore, postpartum depressive symptoms in adolescent mothers may be exacerbated by disillusionment after previous idealisation of pregnancy and parenthood. (Franzcoog, 2004:275). However teenage mothers in Swaziland indicated that they had no serious health problems during pregnancy, during labour and pueperium (Dlamini et al, 2003:82).

- **Teenage pregnancy and psychological impact**

Teenage pregnancy in developed countries such as USA countries is usually outside marriage and carries a social stigma in many communities and cultures (Barnett & Kartz, 2000:289). In Swaziland, the teenage mothers felt guilty because they let their parents down. They felt alone in their own predicament and felt that nobody really understood what they were going through (Dlamini et al., 2003: 82).

The stress and anxiety of coping with the diagnosis and consequences of an unwanted pregnancy can result in subsequent psychological morbidity, such as stress disorders and depression. Pregnancy at this early stage of life severely restricts the choices for a girl's future. Termination of pregnancy is also associated with negative psychological symptoms. For example, the post-abortion syndrome is characterised by depressions, nightmares, fits and crying and many other disturbing effects. Persistent guilt and feelings that the person has robbed herself of living life to the fullest and spoiled many good chances are also often prevalent (Molatlhegi, 2007:56).

In Bushbuckridge, teenage mothers said their relationships with their partners were put under strain by the pregnancy, and this led to unhappiness and an accumulation of blame between themselves and their boyfriends (Richter & Mlambo, 2005:82). Some of the teenage mothers did not communicate with their partners at all after the baby was born, although they had been in good communication with their partners before the birth (Franzco et al., 2004:279).

According to Richter and Mlambo (2005:65) and Whitehead (2009:150), in most teenage pregnancies, the mother is unmarried, conception is a mistake and the babies are unwanted. They may have been forced into early marriages by their parents or to terminate the pregnancy, as it was regarded as a disgrace. Teenagers without fathers at home are at greater risk of early sexual activity and teenage pregnancy. Other teenagers fall pregnant as a result of coercion

by their male partners, through rape and dating violence (Dillard, 2002:02; Quigley, 2003:02).

- **Teenage pregnancy and STI infections including HIV and AIDS**

There are number of issues affecting young women and men in South Africa, these include sexual health and the spread of sexually transmissible disease. Young people are currently at the most risk of contracting Human Immune Deficiency Virus infection and Acquired Immune Deficiency syndrome. It is estimated that young people will account for 72% of the new cases of HIV infection. The prevalence of problems like HIV and AIDS and unplanned pregnancy among South African female adolescents warrants urgent attention & (National Youth Policy, 1998; Stevens, 2008:32).

Although the global fight against HIV and AIDS is making significant progress, the global epidemic is far from over. The reported estimate is that there are 33.2 million people living with HIV worldwide as of December 2007. AIDS remain the leading cause of death in Africa and the overall rate of infection among women is rising very rapidly (Medical Chronicle, 2008:14). Statistics indicate that HIV and AIDS and teenage pregnancies are prevalent among young South Africa women, and a recent survey also shows that the substantial numbers of young South Africans continue to participate in unprotected sexual activity (Lesch & Kruger, 2005:1073).

Despite public health, media and educational campaigns to prevent the spread of HIV, a significant proportion of preadolescence and early adolescents, (particularly those who live in the inner cities) engage in sexual behaviour that places them at high risk for HIV and sexually transmitted infections (Lieberman, Gray, Wier, Florentino & Maloney, 2000:237; Kendall, Afafe-Munsuz, Speizer, Avery, Schmidt and Santelli, 2005:298). Teenage mothers believe that if they are involved in a steady relationship, they are not at risk of contracting HIV and AIDS (Dlamini et al., 2003:79).

According to a study done in three Ghanaian towns, the youth of Ghana seemed less concerned with protecting themselves from STIs than from pregnancies. Some use condoms to prevent STIs while others do not use contraceptives and fall pregnant, which leads to attempted abortions (Glover, Bannerman, Pence, Jones, Miller, Weiss & Nerquaye-Tetteth, 2003:29).

- **Teenage pregnancy and substance abuse**

Adolescence is a period of vulnerability for substance use and substance disorders. According to a study conducted in USA, most teenage mothers are persistent users of tobacco. White teenage mothers start smoking at a significant younger age than black teenage mother (De Genna, Cornelius & Donovan, 2009:465). Alcohol consumption is often linked to instances of unprotected sexual intercourse. This is evident from teenage mothers who indicated that they were too drunk to care, and that contraception was the last thing that came to mind (Skinner et al., 2009:54).

Based on the research report, it is hoped that this study will provide valuable information on the experiences of teenage pregnancy as experienced by teenage mothers. This information will illustrate the practical implications of teenage pregnancy in the life of teenagers.

1.2. PROBLEM STATEMENT

Despite available services like family planning and Choice on Termination of Pregnancy Act, 1996 (Act No 92 of 1996) which repeals the restrictive and inaccessible provision of the Abortion and Sterilisation act, 1975(Act no. 2 of 1975) and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs, the incidence of pregnancy among teenagers in the Thulamela Municipality continues to rise. The statistics of teenage pregnancy obtained from one particular hospital records these as follows; 1071 in the year 2001, 1011 in 2002, 935 in 2003, 956 in 2004, 1022 in 2005, 1036 in 2006, and 1042 in 2007. Given these statistics,

the researcher found it imperative to explore and describe the experiences of pregnancy as experienced by the teenage mothers in the Thulamela Municipality.

Table 1.2 Teenage (13-17 years) and adult pregnancies in 2007 in the Thulamela Municipality

Month	Jan	Feb.	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Teenagers (13-17)	67	55	51	55	48	48	66	72	64	46	48	43
Adults (18 or older)	89	89	125	121	121	103	121	121	59	98	66	90

The table above shows the high incidence of teenage pregnancy compared with the number of adult pregnancies for the same months of the year. In some instances the number of teenage pregnant mothers is even higher than those of adults. (The age of teenage mothers indicated above is from 13 to 17 years; older teenagers from the age of 18 to 19 were included in the total number of adults.)

1.3. THE PURPOSE OF THE STUDY

The purpose of this study was to understand the experiences of pregnancy by teenage mothers in the Thulamela Municipality of Vhembe District in the Limpopo Province.

1.4. OBJECTIVES OF THE STUDY

The objectives of this study were

- To explore and describe the experiences of pregnancy by teenage mothers.
- Identify and describe the factors that contributed to their falling pregnant, as experienced by the teenage mothers.

1.5. RESEARCH QUESTIONS

The following research questions were used to guide this study

- How did teenage mothers experience pregnancy?
- What factors contributed to their teenage pregnancy?

1.6. SIGNIFICANCE OF THE STUDY

The study should provide valuable information about the experiences of pregnancy, as experienced by teenage mothers, which would be useful to the community, health care providers, school organisations and the government.

1.7. Benefits to teenage mothers

Teenage mothers who participated in the study could gain knowledge and information that might better help them cope and deal with the problems brought by teenage pregnancy. They would be given a chance to express their perception and attitudes towards pregnancy. Their morale could be boosted during interaction with the researcher because they would have been able to discuss their problems with the researcher. The research report could influence the teenage mothers to change their attitude towards their lives.

• Benefit to the community

The research report may reveal the practical implications of how pregnancy affects the life of teenage mothers in the community. The community could change their attitudes towards teenage pregnancy and give them more support. The community could develop strategies to prevent teenage pregnancies, for example, by reinforcing cultural norms for the youth and encouraging them to practice safer sex.

• Benefits to health care providers

The research report may influence the attitudes of health care providers and encourage them to adopt a holistic approach when rendering their services to young mothers. This could result in improved input when planning health care strategies for the youth, and could encourage teenagers to obtain information and assistance from health care facilities.

- Benefits to schools

The research report may influence school establishments to change their attitude towards teenage pregnancy. It could lead to the development of programmes that could assist teenage mothers to continue their education.

- The benefit to the government

The recommendations based on the results of this study may increase awareness of the problems created by teenage pregnancy and this may lead to the amendment of some of government policies.

1.7. DEFINITION OF TERMS

The following terms are defined as follows:-

- Experiences

An experience is defined as a process of gaining knowledge or skills by doing or seeing things (Hornsby, 2009:98). In this study it refers to the experiences of teenage pregnancy by teenage mothers.

- Teenage pregnancy

Teenage pregnancy refers to pregnancy in a woman under the age of 20 years.

In the United States of America it is defined as pregnancy in an under-age female. In the United Kingdom the legal definition of teenage pregnancy is a woman becoming pregnant before her 18th birthday. In everyday speech it refers to women who have not reached legal adulthood, the exact age of which varies across the world (Lebelle, 1999:11). In South Africa this age is eighteen.

- Teenage mother

The general definition of a teenage mother is any woman who is nineteen years old or younger at the time of giving birth, irrespective of the outcome of the pregnancy and her marital status (Ehlers, 2003:15). However, for this study, a teenage mother is a woman between the ages of thirteen and seventeen years who was pregnant and has delivered an alive or dead baby. The researcher chose this age group because they were deemed the most vulnerable group.

- Pregnancy

Pregnancy is defined as a woman who has a baby developing in her womb (Hornsby, 2009:1142). Furthermore, it is defined as long and very special

journey for a woman. It is a journey of dramatic physiological, psychological and social change, through which one becomes a mother. It redefines family relationships and involves taking on the long-term responsibility of caring for and cherishing a newborn (Myles, 2004:28).

1.8. THEORETICAL FRAMEWORK

The assumption of this study is that teenage mothers experience unique problems because they are not physically, socially, culturally, emotionally, spiritually, economically and educationally ready to deal with motherhood. In the Thulamela Municipality of Vhembe District in the Limpopo Province, teenage mothers frequently do not have the necessary support or they do not make use of the available support systems to help them deal with their problems. Knowledge obtained from this study could be used to improve the services offered to the teenage mothers by the health care system, and help to meet their unique needs more realistically.

The conceptual framework of this study uses Betty Neuman's theory as a point of departure (Basford & Slein, 2003:256; Chinn & Kramer, 1999:222). Neuman describes her model as a comprehensive and dynamic, multi-dimensional view of individuals, group (family) and communities who are in constant interaction with environmental stressors. Essentially the model focuses on a client's reaction to stress and the factors of reconstitution and adaptation. The basic assumptions underlying Neuman's conceptual framework that were particularly useful to the researcher when outlining this study were that though each individual client, or group as a client system, is unique. Each system is a composite of common known factors or innate characteristics within a normal given range of response contained within a basic structure (George, 1990:261; Basford & Slein, 2003:256).

Many known, unknown, and universal environmental stressors exist. Each differs in its potential for disturbing a client's usual level of stability or normal line of defence. The particular interrelationships of client variables (that is,

physiological, psychological, socio-cultural, developmental and spiritual) at any point in time, can affect the degree to which a client is protected by the flexible line of defence against a possible reaction to a single stressor or a combination of stressors. Each individual teenage mother's system has evolved a normal range of response to the environment over time, which is referred to as a line of defence, or usual state of stability (Chinn & Kramer, 1999:222).

Based on Neuman's systems model, the researcher found it imperative to outline that the teenage mother, as an individual person, experiences unique problems as a result of pregnancy. Although many known and unknown universal environmental stressors exist around them, they are potentially different. Each different stressor can have a different effect on the teenage mother's stability level and their normal line of defence. The stressors can be extra-personal.

The particular stressors that may affect teenage mothers may be physiological, for example, pain due to injury incurred during the delivery of the baby, or an operation (caesarean section) performed on the abdomen for the passage of the baby as the body of teenage mother is often not yet fully developed. Stressors may also be psychological, characterised by depression due to feelings of guilt, fear of her parents, social rejection, anger and loneliness.

Other stressors may be socio-cultural, for example, a forced marriage and heavy responsibilities at an early age, as cultural values dictate that a pregnant girl should be sent to her boyfriend's home. A teenage mother may experience socio-economic problems as she needs clothes to fit her fast-growing pregnant body, or special food as she may experience cravings. She also needs nutritious food for the growing baby inside her.

The stressors may be developmental. She may be unable to continue with her education because there is nobody able to look after her child while she is at school. Or they could be spiritual, where the teenage mother's spirit is

dehumanised as she feels shunned by her community, without support from significant others (for example, her partner, her parents, the community and at school).

Each teenage mother is an individual system, but over time certain stressors may become unbearable, and she finds herself unable to cope alone in her situation. There needs to be some intervention in her life, starting with the primary level, followed by the tertiary and rehabilitative levels. At the primary level, an assessment of needs must be done by conducting phenomenological interviews where the teenage mother can articulate her experiences of pregnancy and health education.

If necessary, provision of treatment at tertiary level can be done through referral to the health professionals, such as reproductive health specialists and clinical psychologists. If possible, a childminder should also be provided, so that the teenage mother can return to school.

1.9. RESEARCH METHODOLOGY

This section provides an overview of how the study was conducted and describes the different methods used to conduct the study. Detailed information on the research methodology is given in chapter 2.

Research design

A research design is a well-thought out, systematic and controlled plan for finding answers to research questions. It is a blue print of how a study is organised, from the first step right up to methods used for data analysis. As this study investigated the experiences of teenage pregnancies by teenage mothers in the Thulamela municipality, it adopted the qualitative paradigm, to gain insight and discovering meaning, exploring the depth, richness and complexity inherent in the daily lives of teenage mothers (Burns & Grove, 2001:61).

This research was descriptive, as detailed pictures of the experiences of pregnancy were described as experienced by the teenage mothers themselves (Burns and Grove, 2001:30). It was also explorative, as the study explored the experiences of teenage mothers, a relatively hidden aspect of life in the Thulamela Municipality of Vhembe District (Uys & Basson, 2000:30).

and then the researcher planned to continue with the study.

The population of this study comprised teenage mothers aged 13-17 years residing in the Thulamela Municipality of Vhembe District in Limpopo Province. The sample comprised teenagers who met the criteria and who were willing to be interviewed. The selection criteria for inclusion in the purposive sample specified that participants were females residing in the Thulamela Municipality, between the ages of 13-17 years, irrespective of their marital status, and who were willing to participate (Brink, 2003:141).

the findings cannot therefore be generalised to other communities throughout the Limpopo Province. However, it

The researcher used non-probability purposive sampling to sample five villages for participants in the study. The snowballing sampling technique was used to identify participants who met the criteria, starting with those known to the researcher and then to reach those who were unknown to the researcher. As the study was qualitative, the number of participants was determined by data saturation (Burns & Grove, 2001:376). The researcher ended up interviewing thirty participants.

participants were concealed by providing a code number to each participant. Confidentiality was thus ensured so that it would not be

The researcher used a structured interview to obtain the individual participants' biographical data, followed by an unstructured interview. Two broad questions were formulated to commence the study. In-depth individual interviews were conducted face-to-face with the teenage mothers to obtain in-depth knowledge and dense descriptions that would enhance the researcher's understanding of each participant (Brink, 2003:142). The duration of interviews varied. Data was collected using audio tape recorder, taking field notes and observational notes.

refuse to participate or to withdraw from the study any time should they wish to.

A pilot study was first conducted, in which the researcher interviewed two teenage mothers from a village that was not included in the sample, to detect

possible flaws and the feasibility of the study. The researcher used the eight steps of the Tesch method for analysing the collected data from the interviews. The interviews were conducted in Tshivenda and then transcribed into English. Similar questions were used to all participants. On evaluation the researcher found that the participants responded more or less in a similar manner and then the researcher planned to continue with the study.

The study was limited to teenage mothers aged 13-17 years residing at

1.10. MEASURES TO ENSURE TRUSTWORTHINESS

The truth value of the research was in discovering the lived experiences of pregnancy as experienced and reported by teenage mothers in the Thulamela Municipality. The interviews of each participant were recorded and transcribed and translated adequately. The findings of this study would not be applicable to other communities and settings, and the findings cannot therefore be generalised to other communities throughout the Limpopo Province. However, it is possible that similar findings would result if the study was replicated with other teenage mothers in a similar context.

the objectives and the significance of the study

1.11. ETHICAL CONSIDERATIONS

The following ethical considerations were adhered to: It includes the research methods, such as the research design, details of the population under study,

The names of the participants were concealed by providing a code number to each participant. Confidentiality was thus ensured so that it would not be possible for the reader to link the participant to the data collected. Privacy was maintained to allow the participants to express themselves freely.

Chapter three covers the presentation and discussion of the findings. Three

Permission to conduct the study was obtained from the local authority, the civic structure in the village. The researcher obtained informed consent from the participants, after explaining the purpose of the study. Participation in the study was voluntary and participants were made aware that they would be allowed to refuse to participate or to withdraw from the study any time should they wish to, without coercion.

As the study was for a degree requirement, no sponsorship was available and so participants were told that they should not expect any material or financial benefits from participating. The participants were asked to give their verbal consent only, as the study would not involve physical status of the participants.

1.12. LIMITATION OF THE STUDY

The study was limited to teenage mothers aged 13-17 years residing at Thulamela Municipality area only, in the Vhembe District of the Limpopo Province.

1.13. ORGANISATION OF THE STUDY

The research report is organised as follows:

Chapter one serves as an introduction and provides background to the study. In this chapter the problem to be studied is highlighted globally, nationally and locally. The effects of pregnancy as experienced by teenage mothers are outlined, as are the purpose of the study, the objectives and the significance of the study.

Chapter two describes how the study was conducted. It includes the research methods, such as the research design, details of the population under study, sampling methods used, the data collection methods, how data was analysed, measures taken to ensure trustworthiness, ethical considerations and the limitation of the study.

Chapter three covers the presentation and discussion of the findings. Three main categories emerged from the findings and these are presented and discussed by themes and sub themes.

Chapter four presents the conclusions, and an outline of the scope of limitations of the study. Finally, recommendations are made based on the research findings.

CHAPTER 2

RESEARCH METHODOLOGY

2.1. INTRODUCTION

Research methodology refers to controlled investigations to obtain, organise and analyse data. Furthermore, it includes the planning, structuring and execution of research, emphasising the actual research process. It includes the research design, strategies and techniques that are chosen for a specific methodological method, (Uys & Basson, 2000:8).

2.2. RESEARCH DESIGN

Research design is a logical, systemic and controlled plan for finding answers to research questions. It offers a road map or blueprint for planning a research project, in a way that maximizes control over factors that could interfere with the findings. It also guides the researcher in planning and implementing the study in such a way that will achieve the intended goal (Uys & Basson, 2000:38; Burns & Grove, 2001:223). In this study the researcher intended to explore and describe the experiences of pregnancy as perceived by teenage mothers and discover the factors that contributed to their teenage pregnancies. Therefore the research study followed a qualitative, descriptive and explorative design, based on the phenomenological approach.

2.2.1. Qualitative research design

Qualitative research is a systematic, interactive, subjective approach used to describe lived experiences and give them meaning. It is a way of gaining insight through discovering meanings and exploring the depth, richness and complexity inherent in the phenomenon. Furthermore, it involves using broadly-stated questions about human experiences and realities studied, through sustained contact with persons in the natural environment. It produces rich, descriptive data that helps us to understand others' personal experiences (Burns & Grove, 2001:65).

The reason for choosing a qualitative design was that the study seeks to describe and promote an understanding of teenagers' experiences of pregnancy, the milestones of being a young mother, and their emotional responses. The researcher wanted to get first-hand information about teenage pregnancy through the observations and descriptions of the teenage mothers' experiences and other related factors.

The main characteristic of qualitative design that made it suitable for this study is that it is placed within the behavioural and social sciences as a method of understanding the unique, dynamic, holistic nature of human beings. Its philosophical base is interpretative, humanistic or naturalistic and is concerned with understanding the meaning of social interactions by those involved. Qualitative researchers believe that truth is complex and dynamic and that it can be found only by studying persons as they interact with and within their socio historic setting (Brink, 2003:11; Burns & Grove, 2001:27).

The qualitative researcher plays an active part in the study and findings from the study are influenced by researcher's values and perceptions. The approach is subjective, but it is assumed that the subjectivity is essential for the understanding of teenage mothers. The study used unstructured observation and communication as means of gathering data. The data included the shared interpretations of the researcher and the participants, and no attempts were made to control interactions (Burns & Grove 2001:28; Brink 2003:13).

2.2.2. Descriptive design

Descriptive design is a method by which the researcher selects a specific event, conditions and behaviour, makes observations of the phenomenon and record them (Burns & Groove, 2001:34). In this study the researcher selected the specific events and characteristics of teenage pregnancy as experienced by teenage mothers and recorded them. This design was chosen to obtain complete and accurate information. The researcher depended on the characteristics of descriptive design that made it suitable to describe those

experiences accurately, thoroughly and completely. The researcher had an opportunity to confirm and validate what may become an exploratory study.

2.2.3. Explorative design

The approach may lead to the development of It aims at a phenomenon of interest and pursues factors affecting or relating to the phenomenon (Oman, Krugman & Fink, 2003:151). In this study the researcher intended to explore the depths, richness and complexity of the experiences of pregnancy by teenage mothers in the Thulamela Municipality. The reason for choosing this design was to gain new insight into the experiences of teenage mothers and to extend a preliminary investigation into a more structured study, to elucidate central concepts and constructs, and to determine the priorities for further research. The characteristics of explorative design that made it suitable for use in this study are that it explains a phenomenon and answers the question “why”; it attempts to offer an understanding of underlying causes of the phenomenon, or in other words, to provide an explanation for it, and is directed towards determining a specific sequence of cause and effect.

2.2.4. Phenomenological approach

The phenomenological approach refers to studies that examine human experience through descriptions provided by the people involved, and these experiences are called lived experiences (Brink, 2003:119).

The study followed phenomenological approach in order to obtain complete and accurate information about the experiences of pregnancy as perceived by teenage mothers, through observation, description and classification. The goal was to explore the dimensions of teenage pregnancy, the manner in which it is manifested and other related factors, and to provide insight into the experiences of teenage mothers and their interpretation of their experiences. Characteristics of the qualitative phenomenological approach that are evident in this study are that it examines human experience through descriptions provided by the people involved, called the lived experiences. It is an approach that concentrates on a

participant's experience rather than on the participants. In attempting to describe the lived experience, the researcher focuses on what is happening in the life of the individual, what is important about the experiences and what alterations can be made. The approach may lead to the development of concepts and themes, which in turn can be applied to practice. The approach consists of steps or stages which guide researchers in their study of the phenomena. It has certain typical basic actions which the researcher uses during enquiry process, namely bracketing, intuiting, analysing and describing (Brink, 2003:49).

Bracketing is the process of identifying and setting aside any preconceived belief and opinions one might have about a phenomenon under investigation. The researcher must first identify what they expect to discover and then deliberately set aside this idea (Brink, 2003:119). Accordingly, in this study the researcher put aside her own opinions when entering the world of the teenage mothers.

Intuiting occurs when the researcher tries to develop awareness of the lived experience, but without imposing any prior expectations or knowledge. It requires the researcher to become totally immersed in the phenomenon under investigation and is the process where by the researcher begins to understand what the participants are experiencing. The researcher reviews the data again and again until there is a common understanding (Brink, 2003: 119). In this study the researcher was fully immersed in the research data. In order to interpret the data, the data was reviewed repeatedly by the researcher so that she could understand the meaning of the experiences.

Analysing involves the task of contrasting and comparing the final data to determine what patterns, themes or threads emerge. If the knowledge is to be relevant to other researchers, it must be understandable and clear, detailing any relationships that exist. The techniques of data collection include participant observation in the natural environment, in-depth or unstructured interviews and

diary recording (Brink, 2003: 119; Polit & Beck, 2004:253). In this study the researcher analysed the unstructured data using the Tesch method and three categories emerged.

2.3. STUDY AREA

The study was conducted in the Thulamela municipality of the Vhembe district in the Limpopo Province. The Limpopo Province is situated in the far northern part of the Republic of South Africa. The province is divided into six districts namely; Capricorn, Mopani, Sekhukhune, Vhembe, Bothlabela, and Waterberg. Vhembe district is divided into five municipalities, namely, Thulamela, Mutale, Nzhelele, Makhado and Musina. Thulamela Municipality is the largest of the four situated in the south-eastern part of Vhembe district, with the Luvuvhu River running in the south and the Nzhelele River on the west. The Thulamela Municipality is about 170 km from Polokwane, the capital of the Limpopo Province and about fifty kilometres away from the Kruger National Park.

The Thulamela Municipality, where the study was conducted, comprises two towns: Thohoyandou and Malamulele, and several villages, such as Maungani, Itsani, Muledane, Maniini, Tswinga and Ngovhela. Population of Thulamela Municipality is educated so that most of them are employed in the government departments, including the hospitals, universities and colleges, army, police station hotels and shops in town. House holdings also provide employments opportunities. Some of the people are employed in the farms where as others survive by selling fruits and vegetables collected from their homes and neighbouring farms. The staple food for the people of Thulamela Municipality is maize-meal, mashonzha, several vegetables and meat. People in the villages plough mealies for food purposes.

The population of Thulamela Municipality comprises men, women, youth and elderly people speaking different languages, but dominated by Tshivenda, Xitsonga and Sepedi. Most of the refugees from the neighbouring countries like Mozambique, Zimbabwe are harboured by this municipality. The youth of

Thulamela Municipality are scholar self employed and employed as professionals. Those who are unemployed survive by selling fruits and vegetables and washing cars. They also participate in different sports such as soccer, netball and tennis.

2.4. POPULATION AND SAMPLING

2.4.1. Population

The population, sometimes referred as target or study population, is the entire group of persons that is of interest to the researcher, and who meet the criteria the researcher is interested in studying (Brink, 2003:132). In this study the target population comprised teenage mothers aged 13-17 years, residing in the Thulamela Municipality of Vhembe District in the Limpopo Province.

2.4.2. Sampling

Sampling is the process by which the study subjects are chosen from the larger population (Brink, 2003:133).

2.4.2.1. Sampling method

In this study the researcher's approach was non-probability sampling because the study design was qualitative, explorative, and descriptive (Brink, 2003:135). The reason for choosing non-probability sampling was to gain insight through discovering the meanings of the participants' experiences, in order to explore the depth, richness and complexity inherent in the phenomenon.

The strength of non-probability sampling is that it is convenient, less complicated and less expensive. Five villages considered to have high incidences of teenage pregnancy were identified by the researcher's co-workers, which saved time, as the total population was unknown to the researcher.

The limitations of using non-probability sampling was that it placed a much greater burden of judgement on the researcher, since the extent of sampling

error could not be estimated, and avoiding bias was critical. The researcher attempted to overcome the bias of the study by developing a form to keep track of all the people who were recruited and to document their status at each stage of the research study. The information recorded included the code number assigned to participants, any reasons given for refusing to participate, the demographic characteristics of those who did not wish to participate, and decisions to drop out of the study, together with the reasons and time. In this study two sampling methods were used, namely purposive and snowballing because the researcher had limited knowledge of the population of Thulamela Municipality. The sample was selected from the Thulamela Municipality using these two methods:

- Purposive sampling

Purposive sampling is referred to as judgemental sampling and involves the researcher hand-picking individuals, based on certain pre-defined criteria (Crookes & Davies, 2004:120). In this study the researcher purposively selected five villages based on her interest and knowledge of them, having witnessed repeated incidences of teenagers delivering babies in the researcher's place of work.

- Snowballing method

Snowballing is described as a non-probability sampling technique in qualitative studies. The method involves approaching a single case within in the phenomenon to be investigated in order to gain information of other similar people. In turn, this person is requested to identify further people who could make up the sample (Oman et al., 2003:172). Thus this method was used to handpick teenage mothers in the Thulamela Municipality. The researcher approached a village knowing only that someone there had experienced a teenage pregnancy. She then also contacted a civic member who helped her to contact the teenage mother. Thereafter, the teenage mother referred the researcher to others she knew. The researcher used this method to identify participants who met the criteria for the study until a sample of about thirty

teenage mothers was obtained. The number of participants from each village varied. The sampling criteria used to select participants were inclusion criteria, which are essential characteristics required for membership of the target population (Burns & Grove, 2001:294; Polit & Beck, 2004:290). These were:

- Teenage mothers or teenage expectant mothers (i.e. pregnant)
- Between 13-17 years old
- Resident of the Thulamela Municipality
- Voluntary participation
- Able to use Tshivenda language.

2.4.2. Sample

A sample is a part, fraction of a whole, subject of a larger set, selected by the researcher to participate in a research study, and consists of a selected group of the elements or units from a defined population (Brink, 2003:133). In this study the sample size was thirty teenage mothers, drawn from the five villages of Thulamela Municipality of the Vhembe District of the Limpopo province.

2.5. DATA COLLECTION

Data collection is a step by step process of gathering information from specified samples of participants about the phenomenon of interest in the research study (Oman et al, 2003: 171).

2.5.1. Data collection techniques

The researcher used a structured interview to obtain individual participants' biographical data and an unstructured interview to explore the experiences of the pregnancy as perceived by teenage mothers residing in the Thulamela Municipality.

Unstructured interviews

An unstructured interview is free-flowing conversation between the researcher and participant, with its structure limited only by the focus of the research (Polit & Beck, 2004:351). Unstructured interviews leave the wording and organisation

of questions, and sometimes even the topic, to the discretion of the interviewer. The interviews were thus conducted more like normal conversations, but with a purpose, and are appropriate for explorative or qualitative research studies, particularly where a researcher does not possess enough knowledge about the topic to structure the questions in advance.

The researcher commenced the interviews with a broad opening statement, in order to elicit more in-depth information on subjects, beliefs and attitudes. The response to this approach was good during the face-to-face interviews as some participants were illiterate or blind. Answers could be clarified as the interviewer and interviewee interacted face-to-face. The depth of questioning was intense because unstructured interviews use open-ended, probing questions to obtain rich and complex data. Missing information was obtained from personal notes and supplementary data was added from observations. There was good sample control (Polit & Beck, 2004:351).

Characteristics of unstructured interviews that are related to the study are as follows: unstructured interviews allow for deeper and more thoughtful responses, but may pose difficulties for people who were good at expressing themselves verbally. Such interviews yield data that are considerably more difficult to analyse. When using unstructured interviews no formal instrument is needed, and so the researcher used probing questions to elicit information about the experiences raised by the participants.

2.5.2. Plan for collecting the unstructured data.

Prior to data collection, the researcher planned to gather information about their experiences, attitudes and behaviour from the teenage mothers in order to answer the research questions. The researcher was personally responsible for collecting the data. The setting for the data collection was the participant's home, a natural setting, chosen as the nature of the interview environment influences the behaviour of the participants. The time for collecting the data was chosen by the teenage mothers: during a weekend when they were out of

school and free from household chores. The length of interviews ranged from 30 to 90 minutes each.

2.5.2.1. Gaining entry to the research site

This involves negotiating with the 'gate-keeper', whoever has the authority to permit the researcher entry into the world of the participants. This requires strong interpersonal skills, some familiarity with the customs and language of the proposed research site (Polit & Beck, 2004:56). The researcher obtained verbal consent to conduct the research study from the local authority and civic structure. The researcher outlined that the purpose of the study was to explore and describe the experience of teenage pregnancy by teenage mothers. Other information about the research project, such as, the selection criteria and data collection method such as interviews, audio-taping, observation and the period of data collection, was also provided. The community at large would be informed of the results verbally by their local authority and civic structure. The researcher indicated that there would be no monetary benefits to participants, as the purpose of the study was for degree purposes. The benefit to participants would be in the information they gained through sharing their experiences of teenage pregnancy.

2.5.2.2. Initiation phase

In this phase, the researcher approached one village knowing one person who had experienced teenage pregnancy. At the other site, she contacted the civic member who then connected her to a particular person, who in turn helped by networking with other people whom she knew or those who were reluctant to make their identities publicly known. The researcher then approached each participant in their homes individually, showing them respect, courtesy and politeness. The researcher presented the information in a clear, unhurried and neutral way, being formal and understanding each individual, adapted the information to the learning needs of each participant (Oman et al., 2003:158).

The researcher introduced herself to the participant to build up rapport. The participant was briefed about the purpose of the study and what activities would be involved, like interviews with the aid of audio-tapes. The researcher ensured that the participants' privacy and confidentiality would be maintained and that, at any stage, they would be allowed to drop out or refuse to participate further in the study. Verbal informed consent was asked from the voluntary participants and they were told about the interview, tape-recording and behaviour observational notes.

2.5.2.3. Working Phase

In this phase, the researcher commenced interviewing the participants, using the two broad questions which were developed from the research questions: "What was your experience of teenage pregnancy?" and, "What were the factors that contributed to your pregnancy?" Depending on how the participant responded to these questions, the researcher invited them to add further information or to clarify the initial response. The researcher used additional probing, follow-up questions to enhance the detailed exploration, such as, "What do you mean by...?"; "Can you describe...?"; "Could you explain a bit more?"; and "How did you feel then?". These interviews produced in-depth information on their experiences, beliefs and attitudes. The interview was conducted until the data was saturated, evident in repeated themes. The researcher used an audio-tape recorder to record the participants' replies while narrating their experiences. The researcher also took notes for back-ups, to prevent lost information, should anything happen to the tapes. When entering into the participant's world during the interview, the researcher put aside her preconceived ideas and immersed herself totally in the teenage mothers' experiences, in order to understand more about their lived experiences. Interviews were conducted in the Tshivenda language, the home language of the participants, so that they could express themselves, as the participants were not professionals.

2.5.2.4. Termination phase

The researcher informed the participants about the termination phase after relationships were well established. They were made aware of the follow-up visits by the researcher. Tentative dates were given, and times and venues agreed upon by the participants. The contact numbers of the researcher were given to the participants, so that the researcher could be contacted in case of changes to the arrangements. The participants were informed about the end of the interview and their role as participants. This was introduced gradually. They were encouraged to ask questions on any issue that required clarity. Debriefing was done.

The researcher used an open coding system provided by Tesch to analyse the

During interviews data was tape-recorded to ensure that no information got lost.

As soon as possible after the completion of a tape-recorded interview, the tape-

recorded information was replayed with the researcher listening carefully to the

content as well as to the question asked and to the participant's response. The

tape-recorded information was duplicated on to another cassette and kept safe,

so that if the tape was damaged or accidentally erased in the process of

transcribing, a back up would be available. The recorded data was transcribed

manually within twenty-four hours to ensure that no information got lost.

Step 1 Get sense of a whole. As the study was a qualitative, descriptive

and explorative research design, the data

2.6. PILOT STUDY

A pilot study is a small scale study conducted before a main study, using a limited number of similar participants from the same population using the same setting, treatment and data collection method and data analysis technique (Brink, 2003: 174; Burns & Grove, 2001:53). The purpose of this study was to understand the experiences of pregnancy by teenage mothers. In this study the researcher conducted a pilot study intending to determine the feasibility of the study, to detect the possible flaws in the data collection techniques (like ambiguous instruction, wording or inadequate time) and to determine whether the sampling techniques were effective. The researcher nominated two participants for the pilot study and used similar questions. On evaluation, the

researcher found that the two participants responded more or less in a similar manner.

2.7. DATA ANALYSIS

Data analysis entails categorising, ordering, manipulating and describing data in meaningful terms (Brink 2003:178). Data analysis is done to reduce, organise and give the meaning to the data. The process of data analysis started when the data collection began. The researcher identified categories by sorting and organising the data. The findings were unique to the study and it was not the intention of the researcher to generalise the findings to the larger population. The researcher used an open coding system provided by Tesch to analyse the data, following these eight steps (Creswell, 2003:155; Schneider, Elliot, Lobiondo-Wood & Haber, 2004:198). The table below illustrate the eight steps of Tesch's method of data analysis

Table 2.7. Represent the Tesch eight steps of data analysis

STEP	DESCRIPTION	ACTION
Step 1	Get sense of a whole	As this study was a qualitative, descriptive and explorative research design, the data was divided into two categories. Firstly, the data collected was written down as notes as the participants were talking. The second analysis was of the audiotape transcriptions which were transcribed verbatim and translated by a language expert. The transcripts were then put together into ideas. After transcribing the data, it was then translated into English.
Step 2	Pick one document	The researcher chose one document from the pile and read it through and wrote key

Step 2	Make a list of topics	words in the margin that explained or described the lived experiences of teenage mothers (for example, fear, anger and guilty, disappointment and shock) and looked at them and then developed them into themes.
Step 3	Abbreviate topics as codes	Once the researcher had completed Step 2 for several participants, she made a list of all the topics, and then grouped similar topics and turned them into sub-themes (for example, fear of parents' reaction, acceptance of pregnancy, and the reaction of their male partner). These topics were listed in columns that were then arranged as major themes (for example, perceptions and attitudes towards pregnancy).
Step 4	Find the most descriptive wording	The researcher took this list and went back to the data. She abbreviated the topics as codes and wrote them next to the appropriate segments of the text. She tried this preliminary organising scheme to see whether the new categories and codes merged.
Step 5	Make a list of topics	The researcher found the most descriptive wording for the topics, such as attitudes and perception of pregnancy by teenage mothers, and turned them into themes. She tried to reduce the total list of categories by grouping topics that related to each other. The researcher drew lines between the themes to show interrelationships.

Step 6	Making final decision	The researcher made a final decision on the abbreviation for each category and listed the categories in alphabetical order. For example, theme one was 'acceptance and attitudes towards pregnancy'. This is clearly indicated in chapter four.
Step 7	Assemble the data and material that belongs together	The researcher assembled the data belonging to each theme and made a preliminary analysis (for example, attitudes towards abortion, and utilisation of TOP services).
Step 8	Recode the existing data	The researcher found it unnecessary to recode the data as the data analysis was finalised.

2.8. MEASURES TO ENSURE TRUSTWORTHINESS

As the study design was qualitative research, the researcher used strategies for establishing the trustworthiness of the data; credibility-, dependability-, confirmability- and transferability strategies.

Credibility

This refers to confidence in the truthfulness of the data and their interpretations (Crookes & Davies, 2004:124). The truth value of this study was the discovery of the lived experiences of pregnancy, as reported by teenage mothers residing in the Thulamela Municipality. To enhance credibility, the researcher spent more time, at least two hours, with each of the participants to identify reappearing patterns and to allow the participants to become accustomed to the researcher. The researcher also used member-checking by continuously testing participants, the data, categories, interpretations and conclusions with research experts (the researcher's supervisors) and with the participants, who recognised their transcribed interview materials.

Dependability

This refers to the stability of data over time and over changing conditions. Findings need to be consistent (Brink, 2003: 125). In this study the researcher described the exact method of data gathering, analysis and interpretation of the findings to an external investigator for auditing. The researcher presented all the documents to the supervisor for review.

Confirmability

This refers to objectivity or neutrality of the data, which is the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning (Polit and Beck, 2004:86). For this study the researcher retained the raw material, the thematic categories, the interpretations and process notes to ensure that auditing is possible.

Transferability

This strategy refers essentially to the generalisability of the data, or the extent to which findings can be transferred to other settings or groups (Polit & Beck, 2004:430; Crookes & Davies, 2004:86; Brink, 2003:124). The data from this study is not transferable to other settings because the study was about the lived experience of the teenage mothers. It is not necessarily applicable to other communities and settings, therefore the findings cannot be generalised to teenage mothers throughout the Thulamela Municipality. However, the same results could be obtained if a similar study was done in the same setting.

2.9. ETHICAL CONSIDERATIONS

Ethics are defined as the aspects of research procedures that adhere to the professional, legal and social obligations of the researcher to the research participants (Polit & Beck 2004:149; Brink 2003:39). In this study humans were used as study participants, and so the researcher exercised care to ensure that the human rights of the participants were protected. These rights are as follows:

The right to protection from harm

The study was conducted by a student researcher under supervision. The researcher was prepared to terminate the study if continuation would result in undue stress for the participants. The researcher strove to avoid inflicting psychological discomfort on them by carefully considering the phrasing of questions, and by providing debriefing sessions. The participants were allowed to ask questions for clarity.

The right to protection from exploitation

The researcher assured the participants that their participation and any information they provided would not be used against them in any way. The researcher adhered to the time limits that were agreed upon before the study and the participants were made aware of the follow-up sessions, where necessary.

The right to benefit from the study

The researcher informed the participants that the study was for degree purposes and the participants were made aware that they would not receive any material benefits. However, they would gain knowledge about teenage pregnancy. The researcher also warned the participants about the risks involved in participation in the study, for example, additional emotional stress.

The right to self-determination

Prior to data collection, the researcher made the participants aware that they had the right to decide not to participate in the study, without the risk of any penalty or prejudicial treatment. The participants were also informed that they were allowed to drop out of the study at any point and could refuse to give any information they felt was too personal. All the participants were volunteers; no coercive treatment was given to people who refused to participate, and neither was incentives given to encourage participation.

The right to full disclosure

The researcher described the nature of the study fully, explained the person's right to refuse to participate, the researcher's responsibilities, the risks and benefits that would be incurred. Before data collection commenced and before participants gave their consent to participate, the researcher explained the following information to ensure that the participants were clear about what would take place.

The purpose of the study was to explore and describe the in-depth experiences of teenage pregnancy. Participation was voluntary and participants were allowed to refuse to participate or to withdraw from the study any time without coercion. The study was for a degree requirement and no sponsorship was available, so participants could not expect any material or financial benefits. Confidentiality and privacy would be maintained throughout the study. The duration of the data collection for each session would be between 30-90 minutes. Data would be collected using a tape recorder. Observations would be recorded as field notes or personal notes. Participants would be expected to give their verbal consent. The voluntary participants were familiarised with the research techniques and procedure for data collection.

Confidentiality

The right to fair treatment

In this study the participants have the right to fair and equitable treatment before and after participating in the study. The researcher ensured that the selection of participants was fair and non-discriminatory, as selection was based on the requirements not vulnerability. The researcher respected the culture of the participants. Participation was voluntary. Participants were given the researcher's contact details so that they had access to her at any point for clarity. Debriefing was done. Where necessary, information that was withheld by the participants before the study was divulged. The researcher treated the participants with courtesy and tact at all times.

The right to privacy

Privacy is the freedom an individual has to determine the extent and general circumstances under which private information will be shared with or withheld from others (Uys & Basson, 2000:98; Brink, 2003:40). This includes attitudes, beliefs, behaviours, opinions and records. In this study the participants were allowed to behave any way they liked, for example, when expressing feelings like crying or laughing. The researcher avoided questions that were irrelevant to the study. Data was collected in a private area where participants felt secure. Anonymity and confidentiality was ensured to maintain privacy.

Anonymity

This refers to act of keeping individuals nameless while participating in the research (Brink, 2003:40). In this study the researcher maintained anonymity by keeping information related to participants away from other people. The researcher ensured that there was no link between the participants and their data by keeping information about their identities separate from the data. The lists of names of people contacted were kept in case the need arose for follow-up interviews.

Confidentiality

This refers to the researcher's responsibility to protect all data gathered within the scope of the study from being divulged or made available to any other person (Brink, 2003:41). In this study the researcher kept the data locked away and informed the participants that she intended to publish the results of the study.

Permission to conduct the study

Ethical clearance was obtained from the Ethics committee of the Department of Advanced Nursing Science at the University of Venda. Verbal permission to conduct the study was granted by the community and civic structures, as the study was conducted in the village. The research proposal was also approved

by the University Health Safety and Ethics Committee. Participants gave their verbal consent to participate in the study.

Informed consent

According to Polit and Beck (2004:149) informed consent means that the participants have adequate information regarding the research, are capable of comprehending the information and have the power of free choice, enabling them to voluntarily consent to participate in the research or to decline. Here the participants were told that the study was being conducted in order to get first-hand information on how they experienced teenage pregnancy. The researcher asked for verbal consent from the teenage mothers to participate in the study.

2.10. LIMITATION OF THE STUDY

The study was limited to five rural villages in the Thulamela Municipality of the Vhembe District in the Limpopo Province because the teenage mothers were considered most vulnerable there. It was not possible for the researcher to cover the whole Thulamela Municipality as qualitative research studies deal with a limited number of participants.

2.11. CONCLUSION

This chapter dealt with the manner in which the study was conducted. The study was a qualitative, descriptive and explorative design, following the phenomenological approach. The population studied was selected following the eligible criterion for inclusion. The selection of the sample followed a non-probability sampling approach, involving the purposive and snowball sampling methods. The data was gathered in unstructured interviews and by records of observation. The data was analysed using the eight steps of Tesch's open coding system. The following measures to ensure trustworthiness of data applied: namely credibility, confirmability, dependability and transferability. Research ethics were observed to ensure that the rights of the participants were protected.

3. PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

3.1. INTRODUCTION

In chapter two the methodology used for conducting this study was discussed. In this chapter the findings will be presented and discussed, according to identified themes and sub-themes, as shown in table 3.1 on page 44.

In the discussion of the findings, relevant data from the literature is incorporated. It should, however, be noted that in reviewing the literature, the literature found focuses on the experiences of teenage pregnancy from a wide variety of settings, not the target population.

The purpose of this study was to understand the experiences of teenage pregnancy by teenage mothers in the Thulamela Municipality of Vhembe District in the Limpopo Province. The study used qualitative research design as a point of departure to explore and describe the teenage pregnancy as experienced by teenage mothers. The study was limited to the Thulamela Municipality only. Data was gathered from 30 participants. The following research questions was used to collect the data, "How did you experience teenage pregnancy?", and, "What causes contributed to your pregnancy?"

3.2. FINDINGS

The findings of the interviews indicate that the experience of pregnancy for teenage mothers in the Thulamela Municipality of Vhembe district in the Limpopo province was pervasive; it affected every area of their lives. It must therefore be noted that it is difficult to describe these experiences separately, as the dimensions are intertwined. Their most important experience relates to the attitudes and perceptions of their parents and their male partners. The teenage mothers indicate that they found it difficult to accept the pregnancy because they were afraid, disappointed with themselves and worried about the reaction of their parents. Their parents were initially furious and some forced the teenage

mothers to marry, but were later supportive when the young mothers were rejected by their male partners.

The next group of experiences were revealed through probing into the teenage mothers' attitudes towards septic abortion and the use of termination of pregnancy services (TOP). Some of them tried to procure backstreet abortions, as they did not know about TOP services.

Another group of experiences relates to their knowledge of contraceptives, sexually-transmitted infections (STIs) and HIV and AIDS. The findings show that the teenage mothers are quite ignorant about safe sex, the use of condoms, the pill and contraceptive injections and are poorly informed about STIs, HIV and AIDS. This is evident when they report that their male partners used condoms for few months only, stopping once they had developed a sense of trust with their partners. However, once they discovered they were pregnant, this resulted in immense emotional problems and left the teenage mothers feeling devastated, fearful, lonely, humiliated, frustrated and unhappy.

The next group of experiences was revealed by probing into the factors that contributed to their becoming pregnant. According to the findings, most of the teenage mothers were coerced into having sex by their male partners and fell pregnant due to their male partners' wishes. Ignorance, indicated by the failure to take contraceptive measures, played a large role. So did peer pressure, as the teenage mothers wanted to join other teenagers who had children. Poor parental guidance, evident from the teenagers being left to act as heads of households when parents were at work, and poor or no sex education, where health care providers and teachers failed to provide sex education, are also contributing factors.

The last set of experiences relates to the consequences of pregnancy, and encompasses the girls having to assume heavy responsibilities early in life, accept forced marriages, a persistent low socio-economic status, physical pain

and dropping out of school. Table 3.1 below summarises the findings according to the themes and sub-themes that emerged from the data analysis.

Table 3.1 Themes and sub-themes

Themes	Sub-themes
Experience related to perception of pregnancy by teenage mothers and significant others	<ul style="list-style-type: none"> - Acceptance of pregnancy by teenage mothers. - Reaction of the parents towards pregnancy. - Reaction of the male partner.
Experience related to abortion and use of termination of pregnancy services	<ul style="list-style-type: none"> - Attitudes towards septic abortion. - Utilisation of TOP services.
Knowledge of contraceptives, sexually-transmitted infections and HIV and AIDS	<ul style="list-style-type: none"> - Knowledge of safe sex. - Use of condoms/the pill or injectable contraceptives. - Knowledge of STIs and HIV and AIDS.
Factors contributing to teenage pregnancy	<ul style="list-style-type: none"> - Coercion by male partner. - Ignorance. - Poor parental guidance. - Poor sex education.
Perceptions of the consequences of teenage pregnancy	<ul style="list-style-type: none"> - Early responsibility and forced marriage. - Persistent low socio-economic status. - Perception of physiological pain. - Dropping out of school.

3.2.1. Biographical information

To obtain biographical data from each participant before asking the central questions, a semi structured interview was used. These questions were used to get general information about the participants, in order to place the rest of the data within the context of the realities of the teenage mothers' lives.

3.2.1.1. Teenage mothers' ages

The age of the teenage mothers who participated in the in-depth individual interviews ranged between 13 and 17 years, as described in chapter 2.7. Most of them were still at school, in grades 7-11, when they became pregnant, as this reply shows: *"I fell pregnant at the age of 15 years after being sexually active for only a month"*.

In a similar study of 61 teenage mothers conducted in Tswane, South Africa, the majority fell pregnant between the ages of 17 and 18. One of them was married; two participants were 14, one was 15 and six were 16 (Ehlers, 2003:18; Arai, 2007:70). In Brazil research findings on teenage pregnancy included adolescents from as young as 11 up to 19, and most of them were multiparous (Padin, Silva, Chalem, Mitsuhiro, Barross, Guinsburg, and Laranjerira, 2009:76). In Canada, study findings reveal that 85% infants born to younger teenage mothers aged 10-15; 3, 02% born to women aged 16-17 years and others were 18-19 (Chen, Wen, Fleming, Yang & Walker, 2008:690).

In South Africa research findings indicate that teenage pregnancy is high among 15-19 year-old sexually active young women. The health goals, objectives, and indicators of teenage pregnancy measure pregnancies among girls aged 15-19 as a proportion of all births. The South African Demographic and Health Survey in 1998 found that 16.4% of all women between 15-19 years of age had been pregnant, although more rural women had been pregnant than urban women in this age range. The target is to reduce the proportion of births among girls aged 15-19 from 16.4% from 1998 to 13% by 2005. Teenage pregnancy rates also varied by province, with rates highest in Mpumalanga

(25.2%) and lowest in Gauteng (9.5%) (Smit, Beksinka, Ramkison, Kunene & Penn-Kekana, 2005: 59).

A report by Save the Children in 2002 found that 13 million children are born annually worldwide to women under the age of 20, of which more than 90% are from developing countries. The highest rate of teenage pregnancy in the world is in Sub-Saharan Africa, where women tend to marry at an early age. In Niger 87% of women surveyed were married and 53% had given birth to a child before the age of 18. By contrast, the Canadian teenage birth rate showed a steady decline for both younger (15-17) and older (18-19) teens between 1992 and 2002. However, in the USA the teenage pregnancy rate has begun to rise as of 2007, reversing a fourteen-year declining trend (Mclean & Hiles, 2005:18 Schwarz, Lohr, Gold and Gerbert, 2007:307).

In Swaziland, research indicates that the majority of adolescent mothers are aged between 13-19 years, with their first sexual intercourse reportedly happening between the ages of 11 and 14 years (Dlamini, Van der Merwe & Ehlers, 2003: 79).

3.2.1.2. The teenage mothers' age of menarche and onset of sexual activity

The average age of the menarche for the participants in this study was between 11 and 13. Their first sexual intercourse reportedly occurred between the ages of 13 and 14 years. Some said that after beginning relationships with their partners they abstained from sex for at least a year, first learning to trust their boyfriends, as the following quotation shows:

"I started to menstruate at the age of 13 and then became sexually active at 14 years old. We didn't have sexual intercourse because I wanted to learn to trust him first. Then we started by using condoms. Thereafter, my boyfriend stopped using them, because he wanted us to have a baby."

Most of the participants reported that they had been sexually active for one or two years before they had become pregnant:

"We had sexual intercourse for one and a half years using condoms. I fell pregnant because the condom burst."

They also reported that they had one sexual partner and did not consider the possibility of contracting HIV and AIDS as they trusted each other:

"I had heard about HIV and AIDS, but my boyfriend and I trusted each other"

Findings from the study conducted in Tswane indicate that the onset of the menarche of those teenage mothers was between the ages of 9 to 17, with a mean age of 14.03% years, and 52,45% of the teenage mothers menstruating by the age fourteen (Ehlers, 2003:18).

Other findings indicate that teenage mothers in Swaziland reported to have had their first sexual intercourse on average between 11 and 14 years, about two years before becoming pregnant. Their partners were generally much older and already working. The teenage mothers insisted that as they had steady relationships, they were not at risk of contracting HIV and AIDS (Dlamini et al., 2003:79).

In the USA, research findings reveal that despite continued efforts to decrease teenage sexual activity, more than half of USA teens have had sexual intercourse, and that almost one in ten (8.3%) experience intercourse prior the age of thirteen (Somers & Fahlman, 2001:188). In Brazil, research findings indicate that teenage mothers generally have their first sexual experience early, at the average age of 14.2 years, and their first pregnancy at an average age of sixteen. (Padin et al., 2009:717).

In North Carolina, a study conducted to determine the effects of a program (featuring an Afrocentric approach to pregnancy prevention among African-American teenage adolescent females) indicates that in 1996 the pregnancy

rate was 178.9 per thousand among African-American females aged 15-19 years, compared with a pregnancy rate of 82.6 per thousand among whites. In 1995, the National Survey of Family Growth reported that African-American females aged 15-17 were more likely to have had their first sexual intercourse without using effective contraception than their white peers. As a result, African-American teenagers are more likely to experience a pregnancy (Dixon, Schoonader & Philliber, 2000:425).

In Bristol, UK, research conducted to determine the attitudes towards teen pregnancy among adolescents from different socio-economic back-grounds, indicates that young women from disadvantaged backgrounds thought that the ideal age of starting a family was between 17 and 25 years, whereas those from more advantaged backgrounds wanted to wait until their late 20's and early 30's, emphasising a career, university, money, and personal development instead (Jewell, Tacchi & Donovan, 2001:02; Deptula, et al., 2006:36).

3.2.1.3. *The age of male partners*

In the study under consideration, the participants' boyfriends are generally much older than them, ranging from 18 to 26 years of age. Most of them are reportedly working, while others are at tertiary education institutions. Very few are still at secondary school. The following quotation illustrates this, reported by a 17 year-old teenage mother, *"My boyfriend's is 26 and he is a security guard"*. Another participant said, *"My boyfriend is still at school in grade 8, while I am in grade 9"*. Although these partners have most probably had prior sexual relationships, the teenage mothers believed that they were in steady and exclusive relationships and therefore were not at risk of contracting HIV or AIDS.

In a Swaziland study, findings indicate that teenage mothers did not know the age of their male partners but that they generally appeared to be much older because most of them were reportedly working (Dlamini et al., 2003: 79). In the USA, research conducted on the effect of partners' characteristics on teenage

pregnancy and its resolution, shows that the age of the male partner did not have a significant effect, unless the age of the women was controlled and compared to that of male partner. However, across studies the likelihood of pregnancy increases with age. Women who are younger than their first partner are not significantly more likely to become pregnant than those who are about the same age, but women who are older than their first partner are significantly more likely to become pregnant than women who are about the same age as their first partner. However, on average, women who became pregnant indicated that the impregnating partner was more than two years older than them (Zavodney, 2001:199).

3.2.1.4. *The teenage mothers' level of education*

Most of the participants in this study were still at school when they fell pregnant and continued to attend school until the pregnancy was in an advanced stage. Most of the teenage mothers reportedly to be in grades 8-11, as the following typical quotation shows:

"I was still at school, doing grade 11, and dropped out when the pregnancy reached seven months".

A research study conducted in Tswane also revealed that most of those teenage mothers were students, and that their age range correlated with their highest school grade passed. Twenty-three adolescent mothers were reported to have passed grade 11 and could have finished their schooling but for their pregnancies. Most participants had received sex education at the ages of 15 and 16, but were already sexually active or pregnant by then (Ehlers, 2003:18).

In Swaziland research findings reveal that teenage mothers are often expelled from school by their teachers and that they usually do not go back to school later on. If not expelled, they are expected to leave school. If they do return to school, they prefer to change schools as they no longer feel accepted by their peers and teachers. Teenage mothers reportedly would like to have a good

education but they lose faith in their own abilities to complete their education and to find good jobs (Dlamini et al., 2003:50).

In Bushbuckridge the teenage mothers under study indicated that they tend to substitute schooling with pregnancy, as they have insufficient funds to pay school fees. Other findings in South Africa indicate that teenagers with higher levels of education are less likely to become pregnant (Richter and Mlambo, 2005:75).

In South Africa, the teenage pregnancy and motherhood percentages measured by education in 1998 was 53.9% in grade 1-5; 31.2% in grade 8-11; 18.0% in grade 10 and 6.0% was in higher grade (Smit et al, 2006:76). In Britain the study findings indicate that the teenage mothers had left school long before becoming pregnant and that the school dropout rate was thus not affected by teenage pregnancy. Teenage mothers in the UK study left school at the average age of 15.9 years, and conceived on average at 16.7 years. Some had higher education while others attended school (Padin et al., 2009:717).

3.2.2. Experiences related to perceptions of pregnancy by teenage mothers and partners

3.2.2.1. Acceptance of pregnancy by teenage mothers

All the participants reported experiencing fear, worry and disappointment when discovering their pregnancy, as the following direct quotations highlight:

"I was very disappointed when I found out that I was pregnant and decided to hide it until my mother discovered it six months later."

"I only accepted that I was pregnant when I was six months along. I was shocked when I went into labour and gave birth to a premature baby".

The majority of the participants indicated that they were afraid of their parents' reactions when they found out about the pregnancy and dropped out of school early.

"I was very disappointed and afraid of my parents' reaction as I was still attending school early in May, too early to drop out of school without explaining to my mother."

The participant had to keep the pregnancy secret until she was six months pregnant, and left it to her parents to discover it through signs and symptoms:

"My mother found out that I was pregnant because I didn't ask for money to buy sanitary pads."

The study conducted in Swaziland revealed similar findings; indicating that teenage mothers there felt lonely, rejected and that nobody understood their experiences. They felt guilty, that they had let their parents down, and that they were failures. They felt that their communities rejected them and that people gossiped about them, and this even caused them to discontinue their church activities, which aggravated their feelings of isolation and alienation. The teenage mothers said that they knew that their churches did not approve of premarital sex and therefore did not want to risk being seen at church. They felt they had sinned, and did not expect forgiveness for their sin of engaging in premarital sex. They felt let down by the very people they trusted (their partners) and felt as if they had lived a lifetime through this experience of motherhood. This made them feel tired and much older than their years (Dlamini et al., 2003: 82).

In Bushbuckridge, in Mpumalanga Province, the research findings indicate that the teenage mothers were unhappy about being pregnant and were not ready to take care of their babies as they felt their pregnancies were mistakes. They felt frustrated, even suicidal. Teenage mothers who had left school claimed to be happier about their pregnancy. They wanted to have babies as they had nothing to do at home. Other participants who were pregnant or who already had babies felt that pregnancy had put a strain on their relationships. This led to unhappiness and they blamed themselves and their boyfriends. Only teenage mothers who had planned their pregnancies were happy and dismissive of the

consequences of having a baby while being young and unemployed (Richter & Mlambo, 2005:66; Herrman, 2008:43).

In California, USA, a survey of 200 pregnant adolescents aged between 13 and 18 years revealed that 17.5% of the women had wanted to become pregnant and another 20% did not mind becoming pregnant. In another study, data collected through interviews with 598 pregnant Australian adolescents at twenty weeks gestation showed that 77% of the teenagers aged 12 to 17 years had planned their pregnancy (Franzco, Luehr & Evans, 2004:278). A Cote d' Ivoire study indicated that young people have different views about teenage pregnancy and motherhood as some of them wanted the pregnancy to prove their fertility and extend their family life. Some saw motherhood as a pertinent way of gaining respect and status in their families and wider communities (Barnett & Kartz, 2000:21; Kendall et al., 2005). In Bristol, UK, studies indicated that young mothers felt they were good mothers, and did so by buying expensive children's clothing and strollers (Jewell, Tacchi & Donovan, 2001:04).

3.2.2.2. Reaction of the parents towards teenage pregnancy

Most of the participants in this study indicated that their parents were very angry and troubled on discovering the pregnancy. Some participants were forced into early marriages, as the following quotations reveal:

"My mother found out about the pregnancy and organised for my family to make enquiries into the pregnancy and for me to be sent to my boyfriend's house. Once there, I ran back home because I had no transport to go to school, but my parents sent me back saying that they could not take care of me, as they were going to work in Gauteng province."

Other participants were required by their parents to abort the baby:

"When my mother discovered my pregnancy she insisted that I had an abortion. Unfortunately, it was already too late as the foetus was six months old"

However, other participants' pregnancies were accepted by their parents and they were offered support, mostly because they were rejected by their boyfriends and were too young for marriage:

"My mother said that she would take care of my baby and that I need not be sent to my boyfriend's house."

Some parents accepted their teens' pregnancy saying that they wanted to see their first grandchild before they died (Richter & Mlambo, 2005:66).

In London, research findings indicate that support offered to young mothers by their own families contributed to their parents' negative attitudes, although their mothers had offered to help them and had promised to stick by them (Arai, 2007:93).

3.2.2.3. Reaction of the male partner towards pregnancy

Most of the participants in this study said that their boyfriends had wanted them to fall pregnant, as the following quotation confirms:

"My boyfriend wanted me to have a baby and decided to stop using condoms."

Other participants indicated that they were rejected by their boyfriends because at some point they were accused of having other boyfriends and the boyfriend started another relationship:

"My boyfriend never came to see our baby, stating that I had many boyfriends, so even his relatives would not accept me."

Another participant found out that she was sharing the same boyfriend with another girl. They were both pregnant, but the first pregnant teenager had already been sent to the boyfriend's house and been accepted. The participant, the second one, was rejected:

"My mother found out that there was another girl whose pregnancy also belonged to my boyfriend and she was already staying with him."

Other participants said:

“My boyfriend promised to take care of me and the baby but never came to see me or answered my calls.”

“My boyfriend indicated that he would not be able to marry me. Instead he said he would support the baby, but has not yet given me any maintenance. I even tried to summon him for maintenance through the magistrate’s court, but this was not successful because he was already in huge debt.”

A few participants indicated that their pregnancies had been accepted by their boyfriends, who had also been very supportive throughout. The following quotations illustrate this:

“My boyfriend accepted me stating that I am his wife and that he would stay with me.”

“My boyfriend came to the hospital to see me and the baby. He bought clothes for the baby as he is working as a security guard.”

In Swaziland research findings indicated that the pregnancy put the participants’ relationships under strain and caused unhappiness. The teenage mothers and their boyfriends blamed each other. In most cases, the inferior status of the teenage mothers in the community had been reinforced, as they had not been able to insist that their partners’ used condoms (Richter & Mlambo, 2005:64).

In contrast, research in the USA shows that the participants there said that their boyfriends were very supportive throughout the pregnancy, buying clothes for their babies. Findings from other studies indicate that teenage parents are frequently in a romantic relationship at the time of the baby’s birth, but that many adolescent fathers do not stay with the mothers over time, and this often disrupts their relationships with the children (Zavodney, 2001:194).

Some men never even find out that their partners have been pregnant, particularly if the pregnancy is terminated or the relationship ends. In Australia the research results indicate that teenage mothers often do not communicate

with their partners while pregnant but that after the delivery of the baby there is a marked change in communication. Most of them were happy about this (Franzcog et al., 2004:278).

The research findings from a study conducted in the USA among Puerto Rican partners of adolescence mothers (to determine what having children meant to them) revealed that 80% of those adolescent mothers were on government transitional assistance. One individual had fathered nine children from four partners; of whom some were married, divorced, single, incarcerated and also involved with the drugs (Foster, 2004:118).

In summary, the findings of this study in the Thulamela Municipality reveal that teenage mothers there generally find it hard to accept their pregnant status because they are afraid of their parents' reactions. Indeed, most of their parents had reacted negatively towards their daughters' pregnancies, indicated in some cases by forced marriages, although others offered support when the teenage mothers were later rejected by their boyfriends. Some of the male partners were supportive; others had rejected them and accused them of having a lot of other boyfriends.

3.2.3. Experience related to septic abortion and use of termination of pregnancy services

3.2.3.1. Attitudes towards septic abortion

The majority of the participants admitted that they knew about backstreet abortions, but that they were also afraid of the risk:

"I knew that I could give myself an abortion using tea or Coca-Cola, and also about termination of pregnancy in hospital, but I didn't want to have an abortion as I was afraid of dying."

Another participant indicated that she was very disappointed in herself and had thought of performing an abortion on herself:

“I thought of abortion because I didn’t know that I could go to hospital for TOP. I tried to abort my baby using black tea and failed.”

Studies conducted in Bristol, UK, indicated that those teenage mothers prefer to have an abortion if they become pregnant during adolescence. Some of the young mothers consider abortion but are then unable to go through with it. Others conceal their pregnancy in the early stages in order to avoid having to consider abortion (Jewell, Tacchi & Donovan, 2001:04). Too late, after 12 weeks of gestation (Ehlers, 2003:21)

In Bushbuckridge, the study revealed that the participants were generally not in favour of abortion, saying that they would rather keep the babies than risk not being able to have babies at a later stage (Richter & Mlambo, 2005:65). Several studies elsewhere showed similar results, with teenage mothers with older partners more likely to carry a baby to term than having an abortion (Zavodney, 2001:192).

and study teenage mothers had no access to services like TOP, as it was illegal to perform abortions there at the time (Damini et al., 2003:31).

3.2.3.2. Knowledge and utilisation of T.O.P services

The South African Choice of Termination of Pregnancy Act (Act No. 92 of 1996) empowers women in the community generally and recognises that backstreet abortion is a widespread practice that causes significant morbidity and mortality. Midwives are now legally able to perform a TOP up to (and including) twelve weeks of gestation. Medical practitioners may perform a TOP up to the twentieth week of gestation (Smit et al., 2005:74).

and study the majority of them did not opt for a TOP as they were already pregnant. Some attempted to procure an

In this study the participants indicated that they knew about TOP services. Most of the participants did not choose it though, as they believed it could lead to future infertility. Others who would have liked to terminate their pregnancy were unable to because their pregnancies were too advanced when they decided to do so, or they did not know how to approach the nurses at the health care services, as the following illustrates:

“I discovered that I was pregnant and was very disappointed. I thought of TOP. At the clinic they said I should come back on a given date, but when I

did, it was only to find that I was too late, as the pregnancy was already too advanced.”

Findings from the study conducted in Tswane to determine adolescent mothers' knowledge and perceptions of contraceptives indicate that of 61 adolescents mothers, 30 (49,18%) knew about termination of pregnancy services (TOP). Although the majority (65, 5%) did not wish to use the service, 8, 5% wanted to have an abortion, and another 9, 8% enquired about it too late, after 12 weeks of gestation (Ehlers, 2003:21).

Similarly, the findings from the study conducted in Bushbuckridge indicate that although the teenage mothers knew about TOP services, most were not willing to use them. Others were too late (Richter & Mlambo, 2005:65).

In the Swaziland study, teenage mothers had no access to services like TOP, as it was illegal to perform abortions there at the time (Dlamini et al., 2003:81).

In London, research findings indicate that teenage mothers are often pressurised by families and friends into having abortions. In one instance reported, a pregnant teenager's mother arranged for her to undergo TOP but the teenager decided to keep the baby instead (Arai, 2007:91).

In conclusion, this study reveals that even though the teenage mothers in the Thulamela Municipality knew about abortion services, the majority of them did not opt for it because they were afraid of dying. Some attempted to procure an abortion but were not successful. They were either ill-informed and decided too late, or did not know how to approach the health care providers for the service.

3.2.4. Knowledge and perception of contraceptives, sexually-transmitted infections, HIV and AIDS

According to the National Youth Policy of South Africa, there are number of health issues that affect young men and women in South Africa, including

sexual health and the spread of sexually-transmissible disease. Young people are currently at risk of HIV infection and teenage pregnancy (National Youth Policy, 1998; Stevens, 2009:43).

3.2.4.1. Use of contraceptives including abstinence

In this study most of the participants had started dating boyfriends at an early age. Their relationships began by abstaining from sex, getting to know each other and trying to build up trust between them, as this quotation says:

“We started seeing each other while I was still 14 years old and didn’t have sexual intercourse for the whole year, although it was very difficult for my boyfriend not to sleep with me.”

Most of the participants said that when they started having sexual intercourse they used condoms for little while, but then stopped and that is when the pregnancy occurred.

Although the majority of the participants indicated that they knew about contraceptives (pills and injections), they had not used contraception as they believed it would cause obesity:

“I knew about family planning, but I resisted using it as it causes obesity”.

Another participant indicated that she used the pill for three months and then discovered that she was pregnant when she returned to the clinic:

“I used family planning for three months, but when I returned to the clinic for another package, I cried, as I found out that I was already pregnant.”

These findings indicate that these teenage mothers were misinformed about the correct use of contraceptives.

A study conducted in the USA to evaluate abstinence-only sex education indicates that the students in the “sex can wait” evidence group were more supportive of abstinence and had greater intentions to remain abstinent. They were less likely to report participation in sexual intercourse even in the last month (Denny & Young, 2006:388). Furthermore, the results indicate that age and differences in educational attainment affected their use of contraceptives.

According to a report from another study conducted in USA to determine the varied circumstances prompting request for emergency contraception at the school-based clinics, the students reported using condoms without any apparent difficulty, but they were worried about the risk of pregnancy as others had told them that condoms could slip off (Mandel, Ebey, Cederbaum, Noll, Hutchison, Jetmott & Blank, 2008:382).

In South Africa, the policy guidelines for adolescent and youth health introduced in 2001 include a recommendation for strategies on contraception, such as improving access to emergency contraception and condoms. It also indicates that younger women reported the highest use of contraceptives among the age of 20-24 (Smit et al., 2005:72).

In Bushbuckridge of Mpumalanga Province, South Africa, the study findings indicate that teenage mothers both knew about and used contraceptive pills and condoms. However, they tended to use contraceptives pills only when they planned sexual intercourse. Some had misconceptions about contraceptives, fearing that the pill would cause weight gain, infertility or a watery discharge. Teenage boys were reluctant to use condoms as a form of contraceptive and a method of infection control, and often refused to use condoms, as they claimed that they made sex unenjoyable (Richter & Mlambo, 2005:65).

Similar findings came from Tswane, where the study revealed that the teenage girls also knew about and used contraceptives - mostly injections, as they did not want their family members to find out that they were using contraceptives. Some used condoms to prevent contracting sexually-transmitted diseases. However, some became pregnant within the first three months of using contraceptives (Ehlers, 2003:19). Findings from other studies also confirm that teenage pregnancy often results from a failure to keep contraceptive ready, with participants saying that they were too embarrassed to ask for or buy birth control pills (Zavodney, 2001:194).

In North Carolina, USA, findings from a study done on the introduction of the program Journey Toward Womanhood in 1998 indicate that 17% of the participants reported having sexual intercourse without using any form of birth control at least for some of the time, and 7% of participants had only learned about birth control through the program (Dixon, Schoonader & Philliber, 2000:47; Bartz, Shew, Ofner and Fortenburry, 2007:273).

In the USA, findings from a study conducted on a program to reduce teen pregnancy, called Baby Think It Over (BTIO) in 1999, indicate that 76% of the participants reported that the doll made them concerned about becoming pregnant and that they were totally afraid of having a child immediately. Seventeen per cent of participants indicated that the doll had persuaded them to use condoms or abstain from sexual activities (Zavodney, 2001:193).

According to a study conducted in USA on the Republic of Marshall Island in 1999, findings indicate that students there had negative attitudes towards condoms use. Girls did not consider it their human right to obtain information and services about childbearing and sexual health, neither did they know where to go with their questions and concerns about sex. They did not feel they had the right to determine when they would like to bear children, but were accepting of sexual acts without love, and exhibited low self esteem (Suzuki, Motohashi & Kaneko, 2006:138).

In USA a study on how religious involvement influences sexual behaviour indicates that youth aged 11 to 25 who were not sexually active scored higher than sexually active youth on the importance of religion in their lives. They also reported more connections to friends whom they considered to be religious (Dillard, 2002:02).

In Bristol, UK, research findings also indicate that young mothers from a disadvantaged group revealed that they became sexually active at an early age and were poorly informed about contraceptives and used them ineffectively,

echoing the results from Bushbuckridge. Furthermore, the teenage mothers also reported that they experienced problems obtaining suitable contraceptive advice and services, describing negative encounters and other obstacles (Jewell et al., 2001:01).

In Bushbuckridge the study findings additionally indicate that teenage mothers did not know how to use contraceptives properly because they took a pill only when they were going to have sexual intercourse or after the activity. Many had misconceptions that contraceptives would make them gain weight or contribute to infertility. Other reasons given for not using contraceptives included that their mothers did not approve, and that they were ignorant about contraceptives. They were afraid to go to the clinic because their mothers might find out. They were also afraid that their boyfriends would be against using contraceptives (Richter & Mlambo, 2005: 65).

3.2.4.2. Knowledge of sexually-transmitted infections, HIV and AIDS

The prevalence of HIV and AIDS and teenage pregnancy among South African female adolescents warrants urgent attention. The HIV AND AIDS household survey done in 2001 also shows that most of young South Africans continue to participate in unprotected sexual activity (Mclean & Hiles, 2005: 18; Lesch & Kruger, 2005:274).

In this study all the participants said that they had been taught about HIV and AIDS at school and through the media. They indicated that they had abstained at first, then used condoms but then still later had stopped using condoms as they felt that they then trusted their partners.

In New York, USA, research study conducted to determine the long-term outcomes of an abstinence-based, small group pregnancy prevention program in the New York city schools in 1998, findings indicate that despite public health, media and educational campaigns to prevent the spread of HIV, a significant proportion of pre-adolescents and early adolescents engage in sexual

behaviours that put them at a high risk of HIV or sexually-transmitted diseases (Lieberman et al., 2000:50).

In Kwazulu-Natal, a province of South Africa, the study findings on understanding high school students' risk behaviours to help reduce the HIV and AIDS, reveal that, in spite of learning about the risks, most of the learners reported having a boyfriend or girlfriend and there was a low rate of condom use (Taylor, Dlamini, Kagoro, Jinabhai & De Vries, 2003:97).

In Ghana, findings from a study conducted in three Ghanaian towns indicate that the participants seemed less concerned with protecting themselves from STIs than from pregnancy. Others who were more sexually experienced used something to prevent transmission of STIs (condoms) while others did not use contraceptives and fell pregnant which led to attempt of abortion (Glover, Bannerman, Pence, Jones, Miller, Weiss & Nerquaye-Tetteth, 2003:29).

In Swaziland research findings indicate that even though the participants had more than one sexual partner, they did not entertain the possibility of contracting HIV and AIDS. Others who were involved in steady relationships also felt they were not at risk of contracting HIV and AIDS (Dlamini et al., 2003:79). According to the findings of a survey done to identify reasons why adolescent mothers failed to utilise contraceptives, emergency or TOP services in Tswane, reveal that only minority adolescents used condoms in spite of the countrywide HIV and AIDS drive to abstain, be faithful to one sex partner and use condoms (Ehlers, 2003:20).

In Turkey, a study on sexual knowledge and risk behaviours of students revealed that students reported having had sexual intercourse with different partners at irregular intervals without ever using condoms (Gökengin, Yamazhan, Ozkaya, Autung, Ertem, Arda & Selter, 2003:259).

In USA the study findings on trends in HIV virus-related behaviour among high school students in the USA, 1999-2005 revealed that there had been a decrease in HIV-related sexually risky behaviour and in gonorrhoea. The same study revealed that the pregnancy and birth rate among adolescents resulted from a combination of factors, contributed to by parents and families, schools, youth service community organisations, health care providers, media and the government, and the availability of effective interventions to address HIV knowledge, skills and behaviours (Brener, Kann, Lowry, Welsher & Romero, 2006: 521).

In the USA findings indicate that of the 60 million-plus people who have been infected with HIV in the past twenty years, about half were infected when they were between the ages of 15 and 24. The USA Centre for Disease Control and Prevention indicate that most sexually active teenagers get sexually-transmitted diseases every year. Sadly, most of the infected teens do not even know they have an STI and thus pass the disease on to unsuspecting partners. When it comes to new HIV infections, each year about 50% of them occur in people under the age of 25 (Lebelle, 1999:04; Stevens, 2008:32).

According to a study conducted in the USA to determine sexually-transmitted diseases among adolescents who receive specialised education, the findings indicate that a high percent of female students between the ages of 10 and 19 are treated annually for STIs, and that in South Africa young mothers and their babies are at greater risk of contracting HIV and AIDS. Young women make up the bulk of HIV infections but the rate of teenage pregnancy is declining (Mandel, Ebey, Cederbaum, Noll, Hutchison, Jetmott & Blank, 2008:385; Molathlegi 2007:56).

In summary, the Thulamela Municipality study findings reveal that the teenage mothers did not have enough information about the use of contraceptives, and harboured misconceptions of becoming fat and losing their libido. They were poorly informed about the transmission of STIs, HIV and AIDS, as indicated by

their practices of abstaining from sex for a while, having sexual intercourse using condoms for few months, and then having unprotected sex which lead to pregnancy.

3.2.5. Factors contributing to teenage pregnancy

In a study conducted in Nigeria, adolescents identified factors that contributed to their pregnancies. These were lack of parental guidance, lack of appropriate sex education, lack of material resources to meet the adolescents' needs as a result of the poor socioeconomic status of parents, and peer-group pressures (Omolola, Irinoye, Oyelene, Adeyemi & Tope-Oje, 2004:26).

In Thulamela Municipality, a similar list of findings emerged. These were coercion by male partners, ignorance, inadequate sex education, and poor parental guidance. Each of these is discussed more below.

3.2.5.1. Coercion by male partner

Most of the participants said that their boyfriends were the ones that wanted to have babies:

"My boyfriend stopped using condoms because he wanted us to have a baby. I didn't like the idea because I was afraid of HIV and AIDS".

Another participant said:

"I used to run away from this boy, but one day he threatened to beat me if I didn't accept him as my boyfriend. He also beat me until I would have sexual intercourse with him."

She then became pregnant.

Some of the participants indicated that they had to submit to their boyfriends' sexual advances, most probably because of the age gap, as most of their boyfriends were working or at tertiary education institutions. A 17 year-old teenage mother told the researcher: *"My boyfriend is 26 years old and works at the grinding mill".*

Findings from the study in Australia at King Edward Memorial Hospital indicated that the age discrepancy between teenage girls and the men who impregnates them plays an important role. Teenage girls with older partners and in particular, adult men, are more likely to become pregnant than those with partners who are closer to their age. They are also more likely to carry the child to term rather than abort the baby. (Franzcog et al., 2004:278).

According to study findings indicate some of several authors that rape is a large contributing factor to pregnancies under age of 15. This is less so for other minors, but it is still significant in teen pregnancies in girls above 15. Two-thirds of babies born to teenage girls in the USA are fathered by adult men of 20 and older. However, it was revealed that between 11 and 20 percent of pregnancies in teenagers are direct results of rape, while about 60 percent of teenage mothers claimed that their pregnancies were the result of unwanted experiences. In girls under the age of 15, the majority reported that their first experience of intercourse was not voluntary. The Guttmacher Institute found that 60 per cent of girls who had sex before 15 were coerced by males of about six years their senior (Mclean & Hiles, 2005:18).

In Bushbuckridge the research findings revealed that teenage pregnancy was often the consequence of coercion into sexual intimacy. Teenage girls were easily influenced by older boyfriends to have sex with them in order to show their love. They tended to accept instructions from these older boyfriends, and said that they fell pregnant because they had been forbidden to use contraceptives (Richter & Mlambo, 2005:66).

In South Africa, the findings from a study conducted in a low-income South African community to determine the sexual agency of mothers and daughters, indicate that the participants did not emphasize their feelings, experiences and pleasures of intercourse, but instead that they were pressurised into sex by male partners who wanted proof of being loved (Lesch & Kruger, 2005:1072).

In a Swaziland study, one participant insisted that her male partner use a condom but she was reminded to remain submissive as she was a female in the community (Dlamini et al, 2003:80). In USA, the study findings indicate that women who are younger than their partners are not significantly more likely to become pregnant than women who are about the same age as the first partner (Zavodney, 2001:200).

In Washington, in a study of over four thousands high school students, just over 30% of females and 9% of males reported a history of sexual abuse. Abused males were four to five times more likely than non-abused males to have multiple partners, engage in substance use and to get someone pregnant. Abused females were twice as likely than non-abused females to report early coitus, multiple partners, and a past pregnancy. Furthermore, study of high school student found a significant relationship for both black and white female students between having been a victim of dating violence and date rape and the number of sexual partners. For males significant association existed between multiple sexual partners and being victims of rape (whites) and being a perpetrator or victim of dating violent (Blacks) (Dillard, 2002:01).

The findings of the study conducted in North Carolina, USA, to introduce the Journey toward womanhood programme indicate that teenagers who participated in the programme were sexually experienced and those inexperienced reported to have had sexual intercourse willingly and not because they were forced, therefore sexual intercourse among adolescents in general is a matter of choice (Dixon et al, 2000:47).

In Hawaii the study findings on dating violence, victimisation associated drinking and sexual behaviours of Asian, native Hawaiian and Caucasian high school students, indicated that participants who had never engaged in sex exhibited a lower rate of violence than those who had initiated sexual intercourse at an average of 13 years (Ramisetty- Miller, Goebert, Nishimura & Caetano, 2006:443).

3.2.5.2. Ignorance

The participants revealed that they engaged in sexual relationships without thinking of the consequences, as the following quotation highlights: *"I didn't think of the consequences because we were in love and trusted each other"*.

Out of 30 participants 20 participants ignored their pregnancies until quite late, about six months. The following quotation highlights this aspect:

"I found out that I was pregnant when I was already six months pregnant and was so shocked that I delivered a premature baby."

They indicated that they didn't want to use contraceptives as they believed they would cause weight gain: *"I knew about family planning but I was afraid I would become fat"*.

Participants had also allowed their boyfriends to stop using condoms because they trusted them and did not think they could contract HIV or AIDS.

The findings of the study conducted in Bushbuckridge reveal that teenagers were reluctant to use contraceptives because of fear of infertility and weight gain. Teenage boys did not visit family planning clinics and were reluctant to use condoms, stating that condoms make sex unenjoyable. The boys also believed in the myth that sexual intercourse in a standing position does not cause pregnancy (Richter & Mlambo, 2005:67).

In California, USA studies conducted to determine the effects of an Afrocentric approach to pregnancy-prevention among African-American adolescents females done in two groups that is participants and non-participants. The research revealed that most participants and non-participants reported to have had sexual intercourse before the graduation willingly and not because they were forced to. Only 15% of the participants and 14% of the non-participants indicated that they had never been forced to have sex. This thus indicates that sex among these adolescents was in general a matter of choice; therefore

intercourse among adolescence in general is a matter of personal choice (Dixon et al., 2000:427; Bartz et al., 2007:274).

In Nigeria many adolescents are noted to be sexually active, engage in unsafe sexual practices and do not use contraceptives. These activities result in sexually-transmitted infections, unwanted pregnancies, unsafe abortions and early childbearing, which always comes with additional health and social problems (Omolola, Irinoye, Oyeleye, Adeyemi & Tope-Ojo, 2004:26). Similar findings were obtained in Swaziland, indicating that teenage mothers there were also ignorant about many issues, including puberty, pregnancy, labour, childcare and contraception. Ignorance was aggravated by cultural taboos, like not talking about sex with one's parents (Dlamini et al., 2003:80). In Australia, study findings indicate that teenage mothers ignored the use of contraceptives, stating that if they were to fall pregnant, it should just happen. Furthermore, immediately after finding out about the pregnancy, they said that they really wanted to be mothers (Skinner et al., 2009:52).

3.2.5.3. Peer-group pressure

The participants revealed that they became sexually active at an early age because they admired others who were already involved. The following quotation confirms this:

"I admired other girls who had boyfriends. I just wanted to share the experience".

Other participants indicated that they wanted to have a reason to leave school:

"Others didn't go to school or ask for permission from the school principal to go and collect the Government child support grant to buy things for their babies. I also needed that money."

Furthermore, they indicated that they no longer felt ashamed at school, as almost every girl had one or two children:

"There was no reason to feel ashamed of my pregnancy, as most of the girls have one or two children."

The pressure on a young person to conform comes from different directions. Teenage mothers not only receive pressure from their peer group, they are exposed to influences from wide range of media, for example, television, cinema, radio, magazines and newspapers. This pressure entices them to experiment with particular lifestyles. However, as teenagers develop, they tend to belong to a group, and become subjected to the sets of norms, values and standards by which they, as group members, are expected to behave. Teenage mothers experience social pressure from both families and friends, for example, if their parents got married because of a teenage pregnancy. Other girls in the neighbourhood and at school have babies (Whitehead, 2009:152; Arai, 2007:87).

According to findings from the study conducted in Bushbuckridge, teenage mothers fell pregnant because they had nothing to do at home and wanted to impress their boyfriends, or were competing for boyfriends. Furthermore, the study findings indicate that the participants sometimes complied out of fear of abandonment. Non-school attending teenage girls thought it was worthwhile to fall pregnant as they had nothing to do at home and felt it would raise their status (Richter & Mlambo, 2005:66). Similar findings from other studies indicate that teenager girls often had sex for the first time because of pressure from their boyfriends (Dillard, 2002:02).

In USA, other study findings indicate that teen boys' also reported being pressurised by their peers to have sex, although the majority felt that waiting was a better idea. Teenagers have misconceptions about sex, including that all other teens are having sex; that having sex makes you an adult; that there is something wrong with an older teen of 17-19 who is not having sex; and that a girl cannot get pregnant when she is menstruating or if it is her first time (Lebelle, 1999:04).

3.2.5.4. Poor parental guidance

Most of the participants indicated that they lived with their grannies or sisters or who were acting as heads of the family while their parents were working far from home, like in Johannesburg. There was no one to guide or protect them. The following quotations confirm this:

"I was staying with my granny when I fell pregnant."

"My mother was at work and my father doesn't stay with us, so there was nobody who could protect me from this guy, who beat me and forced me to sleep with him".

Another participant stated that:

"My mother doesn't know about this pregnancy and I don't want her to know about it or to be informed about my pregnancy. She no longer stays with us. Both of my parents have remarried and we are living with our grandmother."

In South Africa the study findings show that mothers could not talk about sex with their daughters freely. They presented sex as a dangerous activity and daughters therefore preferred to keep their sexual activity secret, which resulted in unwanted pregnancy and HIV and AIDS (Lesch & Kruger, 2004:1075).

In Bushbuckridge, the study findings indicate that ignorance among teenagers is aggravated by reported cultural taboos that prevent teenagers from talking about sex with their parents. Parents hesitated to make sexual education and contraceptives available to their teenagers out of the fear that this would be interpreted as permission to engage in sexual activities (Richter & Mlambo, 2005:66).

In New Zealand, a study conducted to determine whether a father's absence increases a daughter's risk of teenage pregnancy, the findings reveal that fathers who leave their families may increase their daughters' chance of early sexual activity and teenage pregnancy (Quigley, 2003:02). Furthermore, in USA studies reveal that parents who are involved in their children's lives and

confidently transmit their religious and moral values to their children, have the greatest success in preventing risky and immoral behaviour (Lebelle, 1999:6). However, in Atlanta, USA, studies indicate that teenagers who live with both parents until at least the age of 15 are less likely to become pregnant during their first sexual relationship than young women raised in other family structures (Zavodney, 2001:200).

A study conducted in USA shows that parents who value their children also provide consistent emotional and material support for their children; develop, invest in and rely on extended family, including next-of-kin, to ensure that their children have caring adults who are willing and able to supplement and provide substitute parental support at all times. However, the likelihood of becoming pregnant as a teen increased if one had parents who were inattentive, unloving and who failed to instil moral values (Geronimus, 2003:887).

3.2.5.5. Poor sex education

The majority of the participants reported that they had received sex education at school but it seems as if they were poorly informed, because they got involved in sexual relationship very early, from 13 years old, believed that by trusting their partners, they could stop using condoms and ignore the outcome of unprotected sex.

According to the study done in Swaziland, most of the participants blamed their teachers, saying that they failed to empower them to prevent teenage pregnancy (Dlamini, 2003:80). In Tswane, the study findings indicate that the teenage mothers who participated in the study reported that they received sex education at the ages of 15 and 16, by which time most of them were already sexually active and some already pregnant (Ehlers, 2003:18). In Australia, the study findings indicate that how the teenage mothers defined their relationships and the characteristics of their partners influenced the consistency and duration of condom use. These factors help to justify why condom use changes over time (Skinner et al., 2009:54).

In Bushbuckridge, the research findings indicate that the perception of the pregnant participants was that they fell pregnant because they had no sex education at home. They felt that sex education should be presented in schools as a health promotion activity. Furthermore, the study indicated that the participants had a poor knowledge of the physiology of conception, believed that first-time sex could not result in pregnancy and that sexual intercourse in a standing position would prevent pregnancy (Richter & Mlambo, 2005:66).

In Cote d' Ivoire, study findings reveal that the youth frequently lack access to information, education and services that could help them make sound choices about their health needs and informed decisions that could affect their needs (Barnet & Katz, 2000:03).

The study in Bristol, UK, shows similar findings to this study, indicating that both sets of participants revealed that they became sexually active at an early age. They felt that sex education was provided too late and did not explain enough about contraception or the emotional aspects of sexual relationships and pregnancy. They were poorly informed about contraceptives and health and used contraceptives ineffectively (Jewell et al., 2001:125; Bartz et al., 2007:275).

In North Carolina, USA, research findings reveal that the participants reported that they had first learned about birth control at school and from their parents (Dixon et al, 2000:427). Other studies conducted in USA reveal that the guidelines and cultural systems set for childbearing and family behaviour are deeply salient to individual group members and cultural ideals are well-recognized within the group. Parents work actively to enable children to recognize and follow ideals. Cultural ideals are central to the development of personal identity; therefore these cultural influences affect the range of feelings among individuals who deviate from cultural scripts for example guilty or ashamed they feel about specific deviations and compelled to avoid or conceal

them. Child bearing in the early teens is not approved of; even in populations where childbearing in later teens is acceptable (Geronimus, 2003:887).

In USA, research findings indicate that teenagers seemingly have unlimited access to information on sex from the internet and that they feel anonymous while looking for information on sex (Lebelle, 1999:2). In Tswane, the research findings indicate that African children traditionally learned about sexuality and sexual responsibilities at traditional schools (Ehlers, 2003:19).

According to the findings from the study conducted among the teenagers on the programme, "Baby Think It Over", in the USA, most teens said it made them a little concerned about early sexually intercourse, and a doll which was used made them to feel more confident about desirous of teenage child bearing (Somers & Fahlman, 2001:27).

According to the findings of this study, most of the teenage mothers became pregnant as a result of coercion by male partners who wanted to father babies. Furthermore, the teenage mothers experienced peer group pressure to have a child while still attending school, admiring other girls who had boyfriends and others who did not attend school on days when the days that the government support grant were paid out. Other teenagers fell pregnant as a result of lack of guidance from their parents who were working far from home and had to leave their children at home and in the care of their grandmothers.

3.2.6. Perception of consequences of pregnancy by teenage mothers.

3.2.6.1. Early responsibilities and forced marriages

Most of the participants indicated that their parents sent them to their boyfriend's homes to report their pregnancy and to stay with them. Some were accepted while others were rejected as the following highlights show:

"My parents found out about the pregnancy and organised for me to be sent to my boyfriend's home. I ran back home because I had no money to go to school."

Others stayed at home because they were rejected by their boyfriends.

"My boyfriend didn't accept me; he said that I have many boyfriends."

Another participant indicated that she had to go to work in the Indian shops in order to help her mother to support her other children. Other teenage mothers had to stay at home looking after their children instead of attending school because there was no one to help them.

Findings from the study conducted in Swaziland show that the teenage mothers had to mix with older members of the community once they had had their babies, which also contributed to the feeling that motherhood had changed them (Dlamini et al., 2003: 81). In Bushbuckridge the study findings indicated that parents want their girls to be married at a very young age so that they can receive *lobola* (price for a bride), and that they thus encouraged relationships between the two sexes. They discouraged them from attending school after having their babies, as married girls belong to the husband's family and they must work for them. Other studies indicate that in countries like USA the majority of teenage mothers are not married, whereas in India and Greece the majority of teenage births occur within marriage (Richter & Mlambo, 2005: 67).

In USA the findings of the study on the programme, "Baby Think It Over", show that the students felt that being a parent was time consuming, a lot of responsibility and that it would keep them from meeting their future goals (Somers & Fahlman, 2001:187). In Bushbuckridge, the findings indicate that most pregnant mothers are unmarried and that the babies are unwanted (Richter & Mlambo, 2005:65).

3.2.6.2. Low socio- economic status

All the participants indicated that they were still scholars, although most of them had dropped out of school due to lack of money and because they had no one to look after their children, as their parents were working.

"I had to run back to my parent's house because at my boyfriend house they gave me no money to go to school."

Most of the participants indicated that they were of a low- socio economic status:

"We are eight children at home. My father doesn't stay with us but he maintains us. My mother does not earn that much, so I have to work for Indians to help my mother support the other children."

Another participant said:

"I had no maternity garments to put on when I was pregnant. Instead I had to wrap myself in rags. My baby had no clothes to put on when I left the hospital; instead I was given some used clothes from other babies."

Most of the participants revealed that they had not been motivated to fall pregnant in order to get the Government child support grants, although some indicated that they were envious of girls who got permission to go and get this payment to buy babies clothes:

"I fell pregnant because I needed the Government child support grant and some time out of school."

Most of them did not have the identity documents they needed to register for the Government child support grant, so their children could not get the grant. Instead they were supported by their mothers and the fathers of their children.

"I couldn't get a grant because I don't have an identity document."

According to research findings from a study conducted in the USA, teenage mothers cost society much more than those who have delayed childbearing or teenage mothers who have miscarriages. Furthermore, the studies indicate that if they delay childbearing, public funds would have increase as they would contribute to taxes (Geronimus, 2003:885).

In Swaziland similar findings were revealed. Teenage mothers there are generally from poor families but their motherhood status aggravated their financial problems. They could not rely on financial support from the fathers of their babies, and so their parents, mostly their mothers, had to carry the

financial burden of taking care of the teenage mothers and babies (Dlamini et al., 2003:81).

The study conducted in Tswane revealed that most teenage mothers were scholars, while others were domestic cleaners. Some had no income; some earned R500.00 per month; others were unemployed and could not care for themselves and their babies. Furthermore, the findings indicate that most teenage mothers did not receive any form of child support, and turned to the government for assistance for the first five years of their child's life (Ehlers, 2003:18).

According to the study conducted in Australia the majority of participants there had a low socio-economic status, were homeless or destitute, and experienced domestic violence. The pregnant teenagers reported that they required both financial and emotional support that was not forthcoming. The main source of support was from their parents, followed by the father of their children (Franzcoog et al., 2004:278; Chen et al., 2008:691).

3.2.6.3. Physiological pain

The participants indicated that they experienced a lot of pain during delivery of their babies. Some delivered through caesarean section, an abdominal operation, while others delivered low-birth weight babies. The following show this aspect:

"I delivered my twins babies through a caesarean section and suffered burst abdomen. Thereafter, my wound did not heal well and I had to return to the hospital for re-suturing of the wound."

"I felt the most severe pain that I had ever experienced in my life. My baby died after two days, because he couldn't cry after birth, and that was the most painful experience in my life."

Other participants indicated that they suffered emotional shock after discovering they were pregnant as late as six months, and delivered premature babies.

In Canada, the study findings indicate that neonatal mortality is higher in infants born to mothers aged 10-15, 16-17 and 18-19 than to mothers who are between 20 and 24. Teenage pregnancy was associated with increased risk of both neonatal and post neonatal death, as a result of preterm labour (Chen et al., 2008:691).

According to the findings from other studies, no girl should become pregnant before the age of 18 for health reasons. A woman is not ready to begin bearing children until she is about 18 years, and the babies of younger mothers are more likely to be born early and weigh too little at birth. The risks to the teenage mothers' own health is too great. Physical problems experienced by teenage mothers younger than 16 years in South Africa include pregnancy-induced hypertension, premature labour, and anaemia. Pregnancy may remain undetected because pregnant teens only attend prenatal clinics very late during their pregnancy (Sellers, 2004:1717; Ehlers, 2003:13).

In the USA, findings similar to those in this study were noted, indicating that teenagers who decide to continue with their pregnancy face a multitude of problems. These come in the form of medical complications, such as preterm birth, low-birth-weight and pre-eclampsia, in addition to physical problems relating to depression, drug use and social deprivation (Franzcoog et al., 2004:283). In America, babies whose mothers were 15 years old were likely to have a lower birth weight than those of mothers who were 25-35. Other researchers had similar findings, indicating that premature birth and low-birth weight is higher among adolescent mothers worldwide (Geronimus, 2003:884). Only in Swaziland did participants report that they were healthy and had no serious health problems during pregnancy, labour and the puerperium period (Dlamini et al., 2005:82).

3.2.6.4. School drop out

In the Thulamela Municipality the participants indicated that they wanted to go back to school immediately after they had delivered their babies. Some

managed to go back to school because their parents took care of their babies, while others could not return to school because their parents were working, as these quotations illustrate:

"I would like to go back to school and finish tertiary education to become dietician, my grandmother will look after my child."

"My mother promised to look after my child while I attend the classes."

Most of the participants indicated that they dropped out of school because of the pregnancy and they had nobody to look after their babies, although some managed to stay at school until they delivered their babies.

"I would like to go back to school but I had nobody to look after my child, as my mother is working".

"I was still attending school when I was seven months pregnant, right until I delivered my preterm baby. The teachers sent me school work to do while I was in hospital so that I would not be left behind."

In South Africa, the Department of Education allows teenage pregnant mothers to continue attending school while pregnant and after the birth of the newborn baby. The following direct highlights show this aspect:

"I am still attending school and I will go back to school after the delivery of my baby. My mother will look after my child."

"The principal indicated that when I start labour pains my boyfriend would be able to find me under a tree, waiting for him to take me to hospital."

According to the National Youth Policy of South Africa, teenage pregnancy is one of the major reasons why young women leave school. However, other study findings indicate that some teenage mothers had already dropped out of school prior to becoming pregnant, and that those in school at the time of their pregnancy were as likely to graduate as their peers (National Youth Policy, 1998; Barnett, Arroyo, Devoe and Duggan, 2004:264).

According to the findings from another study teenage pregnancy disrupts adolescents' education. In that sample, the teenager mothers dropped out of school; with most of them having their first child before the age of 15. Those who were between 15 and 17 did not complete high school. Adolescent mothers face failure in many aspects of life. They miss out on normal adolescent experiences, fail to remain in school and to become self-supporting (Trad, 1999: 29; Ehlers, 2003:14).

In Swaziland the study findings reveal that education was interrupted negatively and this had a huge impact on the expectations of the teenage mother's futures and that of their babies. Teenage mothers reportedly would like to finish school and would like their children to have a good education, but they have lost faith in their own abilities to complete education and to find good jobs. They envisage problems in achieving educational qualifications because they feel that they are no longer accepted by their peers and their school teachers and they have the extra burden of caring for their babies (Dlamini et al., 2003:74).

In the USA, findings show that teenage mothers are less likely to complete high school, seek further education and obtain employment (Franzcog et al., 2004:275).

In Bushbuckridge, early pregnancy prevented teenage mothers from completing their studies, placing an additional financial burden on their parents. However, the teenage mothers who had dropped out of school said they were happy to substitute schooling with pregnancy because they had insufficient funds for school fees (Richter & Mlambo, 2005:65).

In the Thulamela Municipality teenage mothers were forced into early marriages by their parents, as it is a custom that once a girl falls pregnant, she should be sent to her boyfriend's house. Some of the teenage mothers were rejected by their male partners and accused of having many boyfriends. Some of them experienced poor socioeconomic conditions which forced them to look for jobs.

Some couldn't claim a social grant as they did not have an identification document. The teenage mothers experienced great pain when delivering their babies.

3.3. CONCLUSION

This chapter dealt with the presentation and discussion of the study findings regarding the experiences of teenage pregnancy by teenage mothers in the Thulamela Municipality of Vhembe District in the Limpopo Province as shown in the table 3.3 below.

Table 3.3. Summary of themes and sub-themes

Themes	Sub-themes
Experience related to perception of pregnancy by teenage mothers and significant others	<ul style="list-style-type: none"> - Acceptance of pregnancy by teenage mothers. - Reaction of the parents towards pregnancy. - Reaction of the male partner.
Experience related to abortion and use of termination of pregnancy services	<ul style="list-style-type: none"> - Attitudes towards septic abortion. - Utilisation of TOP services.
Knowledge of contraceptives, sexually-transmitted infections and HIV and AIDS	<ul style="list-style-type: none"> - Knowledge of safe sex. - Use of condoms/the pill or injectable contraceptives. - Knowledge of STIs and HIV and AIDS.
Factors contributing to teenage pregnancy	<ul style="list-style-type: none"> - Coercion by male partner. - Ignorance. - Poor parental guidance. - Poor sex education.

Perceptions of the consequences of teenage pregnancy

- Early responsibility and forced marriage.
- Persistent low socio-economic status.
- Perception of physiological pain.
- Dropping out of school.

4.1. INTRODUCTION

In chapter three the study findings were presented and discussed in detail. This chapter will present the conclusions, implications and recommendations of the study based on the research findings.

4.2. CONCLUSIONS

The research findings of this study reveal that teenage mothers in the Thulamela Municipality of Mankweng district found that pregnancy affected almost all the dimensions of their lives. Most of them had pregnant unintentionally, as they were young and vulnerable. The participants revealed that they had experienced psychological, physiological and economic problems due to their pregnancies, and felt that their parents, teachers at school, health care providers, their community and the government had failed them. Lack of facilities and poor involvement of the health care providers also contributed to the teenage mothers becoming pregnant.

The researcher used the following objective to reach to her conclusions.

- To explore and describe the experiences of pregnancy by teenage mothers.

The findings of this study revealed that teenage mothers found it difficult to accept their pregnancies because they were afraid of their parents' reactions. They felt guilty, which led to them hiding their pregnancies for months until discovered by members of their families. Furthermore, teenage mothers experienced a lack of support and rejection from their parents when their parents reacted negatively, because they blamed them into early marriages or pregnancies. However, some teenage mothers were accepted and supported at home because they were rejected by their male partners. Most of them were forced into early marriages as it is a traditional view that if a girl falls pregnant, irrespective of her age, she should be married to her boyfriend's house so that his

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

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family can help maintain the baby. Some of the teenage mothers experienced rejection by their male partners, and were accused of having multiple partners. However, others were accepted by their male partners and families, because their male partners were the ones who wanted the babies initially.

The study findings reveal that the teenage mothers were poorly informed about using termination of pregnancy services (abortions); many did not know how to access this service, although some did, but tried to do so only after the pregnancy was already viable. However, all the teenage mothers knew about how to procure a septic abortion, but most of them dismissed this, as they were afraid of dying.

The study reveals that teenage mothers were also poorly informed about abstinence and the use of contraceptives. This was evident from their reports of abstaining from sex for few months, starting to use condoms for a little while and then stopping, and ending up falling pregnant. Most of the teenage mothers had never used the pill or contraceptive injections because of misconceptions that contraceptives cause weight gain, a loss of libido and subsequent infertility. They also lacked information about STI and HIV/AIDS. Most of them had heard information about this on the radio or from their teachers. However, the teenage mothers continued to practice unprotected sex as they felt they trusted their partners and stopped to use condoms.

- **To identify and describe factors which contributed to pregnancy, as perceived by teenage mothers**

The research findings reveal that there were several factors that contributed to teenage pregnancy. Firstly, many of the teenage mothers were compelled to have unprotected sexual intercourse by older male partners, who wanted to experiment with having a baby. Some were emotionally abused by their partners, who forced them to have unprotected sexual intercourse but did not want to be responsible for their babies. Still others were ignorant about the

consequences of being sexually active at an early age without using contraceptives, ignoring the possibilities of falling pregnant or contracting HIV/AIDS. This is apparently because they were misinformed about contraceptives, TOP, and sexually-transmitted infections.

The findings revealed that the teenage mothers were vulnerable, had little knowledge about sexual behaviour during adolescence and picked up incorrect information from their peers. They were misguided by their friends who encouraged them to engage in sexual activities, and were pressurised into having sexual relationships by older male partners. They failed to report assaults by male partner when they refused their advances. However, some of the teenage mothers envied their friends who had children and could sometimes miss classes in order to collect their Government child-support grants.

The study indicates that these teenage mothers lacked parental guidance. Their parents had failed to teach them good morals about sexual behaviour and left them as the heads of the household while out working. Other teenage mothers were left in the care of their grandmothers, who could not be firm when guiding them. The study reveals that teenage mothers were poorly informed about sex by their parents, school teachers and health care providers. This was evident from the pattern of becoming sexually active immediately after the menarche; entering a steady relationship; initially abstaining from sex; later engaging in sexual intercourse using condoms; then abandoning the use of condoms because they trust each other; and ending up pregnant.

The teenage mothers experienced lack of emotional and socio-economic support. They had to assume the adult responsibility of becoming a mother and participating in adult life as they were forced into early marriage. Their futures were at stake, as they had to choose between taking care of a baby and attending school. They lacked emotional support from their parents and had to immediately fit in the community role of young adults. The teenage mothers got

little financial support, ending up dependant on their parents or the father of their children. Most could not apply for child-support grants because they were under the age of 18 years and had no identity documents. Although most teenage mothers wanted to go back to school after the delivery of the baby, there was usually no one to look after their children, so unfortunately pregnancy resulted in the permanent interruption of their schooling. A few were fortunate to receive help from grandmothers who took care of their babies while they returned to school.

Many of the teenage mothers experienced severe pain when they gave birth to their babies through caesarean sections. Others stayed for a long time in hospital recovering and waiting for their low birth-weight babies to grow.

4.3. LIMITATIONS OF THE RESEARCH RESULTS

The study findings could not be generalised to the whole population of Thulamela as the study was a phenomenological qualitative research design. The study population was limited to teenage mothers residing in the villages of Thulamela municipality in the Vhembe district of the Limpopo province because they were considered to be the most vulnerable group.

4.4. RECOMMENDATIONS BASED ON THE RESEARCH FINDINGS

Despite the limitations of the study, the following recommendations, based on the research findings could enhance teenage mothers' knowledge and about sex and good parenting.

4.4.1. Health education to teenage mothers

The teenage mothers should be empowered by developing a responsible attitude to sexual behaviour. Such education should include information about contraceptives, in order to ensure that they are able to control their sexual behaviour. This could help reduce casual sex and repeat pregnancies. It would also enable them to retain their status and plan better for their future.

They should be taught about emergency contraceptives and TOP services, and this should include girls who have not yet reached the menarche. These services should be freely accessible to all teenagers. Teenage mothers who are already pregnant should be helped to accept pregnancy and be encouraged to take responsibility for caring for their babies. They need help so that they can return to school after the delivery of the baby, even if it is only for a period of a year in order to finish school. They should receive full information about sexuality and be kept involved in other activities that attract their attention and keep them occupied. They should feel empowered to report things like sexual assault, and to get the necessary help before it is too late.

4.4.2. The role of the teachers

Sex education should be included in the school curriculum because it is a low-cost strategy that could lower the incidence of teenage pregnancy. All young people should be reached before they become sexually active. Sex education programme in schools should be linked to primary health care services to enhance their accessibility and such services should be offered at the venues where teenagers congregate informally. Programme that promotes abstinence should be developed and should aim at building skills and conveying information to all teenagers.

The teachers should incorporate sex education into the daily school activities to empower pupils with information about HIV/AIDS. The health care programmes could be linked to educational programs, for example, to school health programs that assess the health status of pupils. Health care services should be provided on the school premises, so that pupils have individual access to information about how to care for themselves. Pregnant teenagers should be encouraged to attend school until the delivery of their babies and to return to school afterwards.

4.4.3. The role of the parents

The parents should be involved as primary sex educators. Sex education is integral to a person's personal development and has to begin before and

continue during puberty. Parents should be encouraged to guide adolescents about puberty when they are still approaching that stage, and before they get incorrect information from their peers. Parents should not leave teenagers in charge of households, without adult support, while they are working far from home. Mother-daughter friendships should be encouraged so that girls are able to freely report any maltreatment by older boys, and so that mothers can observe other kinds of behaviour during adolescence, when girls are still young and vulnerable. Parents should be encouraged to assign the teenagers other chores at home so that they are kept busy and do not have time to spend outside their homes. They should be encouraged to support teenage mothers emotionally and economically by accepting the teenage pregnancy and not to force their daughters into early marriages, as this is likely to ruin the life of the teenage mother.

4.4.4. The role of the health care provider

Comprehensive health services should be available to all teenagers. Health care providers should promote youth health by empowering them with the information about reproductive health issues, for example, information on sexual development and behaviour, encouraging abstinence, and the use of contraceptives including condoms and emergency contraceptives. Emergency contraceptives should always be advertised and accessible via health care services. Counselling should be offered to teenagers so that they can make informed decisions about the use of Termination of Pregnancy services. TOP should also be easily accessible, and teenagers should not be turned away. This would prevent teenagers from approaching TOP services too late and prevent septic abortions.

The health care services should be planned with the needs of the teenagers in mind, for example to provide separate services for youth, so that they feel at ease about seeking out information. Teenage mothers should be guided during pregnancy and allowed to be accompanied by their spouses or mothers for moral support when attending antenatal clinics or during the delivery of their

babies. The study conducted in UK recommended that young people born to teenage parents should be made a special focus of midwives and colleagues such as health visitors. Educators should work within communities and across all generations in families to promote sexual, maternal and infant health. The risks of post neonatal death could be reduced if there was better medical follow up and supervision at home (Chen et al., 2008:693; Whitehead, 2009:153).

4.4.5. The role of the community

The community as a whole needs to talk to their children about sexual issues before the onset of menarche. The community should encourage the youth to form youth clubs, in order to keep them well informed about new developments on sexual behaviour, for example with the involvement of organisations like LoveLife. The community should be more accommodating of teenage mothers and give them the support they need to face the consequences of teenage pregnancy. Communities should be mandated to develop protocols to deal with truancy from school, and to enforce the consequences.

4.4.6. The role of the Government

The government needs to revise its policies concerning TOP services, so that it could be offered at the primary health care level. Youth centres should be established in rural areas so that all teenagers have access to such services. Entertainment facilities like sports fields, indoor sports centres and community halls should be made available to youth in order to keep them off the streets and to combat boredom. The policy on the Child Support Grant needs to be reviewed, in order to cater for teenage mothers under the age of 17 years, as those who really need it most cannot access it because they are too young and do not yet have identity documents. The researcher recommends that government should focus on measures aimed at managing the impact of teenage pregnancy and motherhood on the lives of girls in low income groups (Padin, Silva, Chalem, Mitsuhiro, Barros, Guinsburg and Laranjerira, 2009:719).

4.5. CONCLUSION

This research study was conducted among teenage mothers aged between 13-17 years residing in the Thulamela Municipality of the Vhembe District in the Limpopo Province. According to the findings of the study, various persons and institutions reportedly failed to provide knowledge and skills to teenagers so that they could make informed choices about their future lives. In order to ameliorate the pervasive effects of pregnancy on the lives of young teenage mothers, a coordinated, multidisciplinary and intersectoral team, such as school governance, school health services, the Departments of Health and Social Development, civic structures, local authorities, and communities and families should be activated. Any initiative or programmes planned need to include teenagers. A multi-disciplinary team approach should be fostered, one that includes all stakeholders and interested parties involved in the well-being of teenage mothers.

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Annexure A

TRANSLATED TRANSCRIBED INFORMATION FROM A FEMALE PARTICIPANT (aged 16 years)

Interviewer: Tell me How did you experience teenage pregnancy?

Participant: I found out that I was pregnant after only one month. I felt very frustrated and was very fearful about my parent's reaction, that they would be really furious because I was still young, only 17 years old and still at school in grade 11. I told my boyfriend and who then told his mother. His mother responded by saying that she knew that his father was very difficult and would be furious about it. I decided to keep quiet about it and keep the baby.

Interviewer: Mm...and....then what was your parents' reaction towards the pregnancy?

Participant: My mother's younger sister suspected that I was pregnant and told my parents and then they insisted that I should be confronted about the pregnancy. They arranged for me to be sent to my boyfriend. They left me there. I decided to run back home, then they sent me back, stating that nobody would be able to take care of me at home because they were working at Gauteng province, leaving nobody at home.

Interviewer: Tell me..... what was your boyfriend's reaction then?

Participant: I was accepted by my boyfriend's parents but couldn't continue to go to school because I had no money for bus

Participant:

fare, as I had moved far away from the school. I phoned my parents, and then they send me money. I continued to go to school because were allowed to attend school while pregnant. One day my cell phone rang. I went outside to answer the phone because there was a noise from the television and I didn't want to distract the attention of family members who were watching. My boyfriend scolded me saying that I was talking to another boyfriend. I felt very angry because it was not true. By that time I was six months pregnant. I was upset.... and....felt labour pains then went into labour and gave birth to a premature baby (her eyes were full of tears). I stopped communicating with him and didn't want to see him near my baby. He sent his mother several times to ask for forgiveness and later I forgave him and continued as normal. It was arranged that I would go home after being discharged from the hospital.

Interviewer:

Participant:

Interviewer:

Participant:

Interviewer:

Seeing that you fell pregnant at the age of 17 years....explain a bit more how you managed not to fall pregnant until then?

Participant:

I started to menstruate at the age of 13 years, then... (smiling looking down) I started a relationship with my boyfriend when I was 14 years old. From there, we used condoms to prevent pregnancy for full two years until I fell pregnant. My boyfriend stopped using condoms for no apparent reason. I was against the idea because I was afraid of HIV/AIDS and pregnancy.

Interviewer:

Err.... I think I heard you mention condoms and HIV/AIDS? Can you explain a bit more?

Participant:

I knew about family planning, I mean, injections and pills. My mother had explained that to me. I resisted using them because others said it causes obesity. About HIV/AIDS - I heard about it from the media and at school the teachers also used to talk to us about it, although it wasn't much.

Participant:

Interviewer:

How did you feel about being pregnant at that age?

Participant:

I was very disturbed. I knew about back street abortions and other abortions that are done at hospital (TOP). I didn't attempt any of those because I was afraid of dying or becoming infertile in the future.

Interviewer:

Interviewer:

How did you experience giving birth.... err...I mean, when you were in labour?

Participant:

Participant:

Eeh.....! It was a terrible experience. It started by water draining from my private parts. Then I told my mother who accompanied me to the clinic. When we reached the clinic, they called an ambulance that took me to the hospital. While waiting for the ambulance, I felt a sharp pain below the umbilicus and in my back. Delivering the baby was the most horrible pain I have ever had in my life. This was made worse by the baby born being prematurely. I had to stay in the hospital until it gained weight. I experienced so much pain during labour, especially because the nurse made a cut to provide a good passage for my baby. The pain was much worse because I had to nurse my tiny baby without the support of the father while we were not on speaking terms.

Interviewer:

Interviewer:

Interviewer:

Participant:

Interviewer:

Interviewer: Hmm.....and then...what were the factors that contributed to your pregnancy....I mean the cause of your pregnancy?

Participant: There was no motive behind it, because I didn't like the idea of stopping condoms. I started the relationship just because others were doing it and I didn't want to appear stupid in front of the other girls. I knew about the child support grant from the government, but that was not my motive. It's true other girls don't attend classes on the day of payment or they duck classes and go to buy things for their babies while others are attending class.

Interviewer: Did you intend to go back to school?

Participant: I went back home and continued to go to school while my mother looked after my baby. I don't want to get married or to have another baby before I finish school.

Interviewer: Hmm.....Who supports you, I mean, financially?

Interviewer: Both my parents and and my boyfriend's parents supported the baby because he was still at school, doing the tertiary education at university.

Interviewer: Is there anything that you would like us to discuss some more?

Participant: No.

Interviewer: Thank you very much for your time; it was nice talking to you.

Annexure B

TRANSCRIBED INFORMATION FROM A PARTICIPANT

Interviewer: mbudzeni vhudipfi hanu musi ni na thumbu


Participant: ndo divha uri ndi na thumbu musi ndi tshe ndo pfukwa nga nwedzi muthihi. Ndo pfa ndo hanganea ndo dala nyofho dza u ofha vhabebi uri vha do ri mini musi vha tshi pfa nga ha thumbu hne ndi khadi vha mutuku ndi na minwaha ya 17 ndi tshi khadi ya tshikoloni kha grade 11. ndo mbodi vhudza muthannga wanga we na ene a vhudza mme awe .vhone vho fhindula uri ni a zwidivha uri khotsianu vha a dina nahone vha do dinalea ngazwo. Nne ndo humbula u tou fhumula ndi sa ambe ngazwo.

Interviewer: vhabebi vhanu vho ri mini musi vha tshi pfa nga ha thumbu?

Participant: murathu wa mmeanga ozwi humbulela uri ndi nga vha ndi na thumbu a vhudza vhabebi vhanga. Vhone vho ri kha ndi vhudziseswe uri ndi mishumo ya nnyi? Vho mbo di langana u mphelekedza ha yani ha muthannga wanga. Ro swika vha ntutshela henengei vhari ndi do shaya muthuwa u nthogomela saizwi vhone vha khou humela mushumoni makhuwani (Johannesburg)

Interviewer: u bva afho muthannga wanu o ri mini ngazwo?

Participant: ndo tangedzwa nga vhabebi vha muthannga fhedzi ndo kundelwa u isa phanda na u ya tshikoloni nge nda shaya masheleni a u namela bisi ya uya tshikoloni vhunga ho vha ho no vha kule. Hafhu muvhuso wo vha wo tri tendela uri ri

dzhene tshikolo  thumbu. Linwe duvha ellphone yanga ya lila, nda bvela nayo nda ngauri nduni hovha hu phosho ya tv nahone ndi tshi khou shavha u vha khakhisa. Interviewer: Muthannga wanga a ntsema ari ndi khou amba na munwe mutukana nne ndopfa ndo dinalea nga maanda ngauri zwovha zwi si zwone lwe nda sa tsha amba nae. Participant: Nga hetsho tshifhinga thumbu yovha ina minwedzi ya 6. Ndo mbodi mufhulela nda sa tsha amba nae. O rumela mme awe lunzhi uri vha nkhubele prarelo nga murahu nda kona u muhangwela ra dovha ra isa phanda. Ndo mbodi lugiselwa uri uri ndi ye hayani musi ndi tshi tshatshiwa.

Interviewer: mathungo anga kha tshaba owa wa tsa hani?

Interviewer: ngauri no vha na thumbu ni na minwaha ya 17. Dzону umbudza uri no zwikonisa hani uri ni sa vhe na thumbu u swika zwino? Participant: Ndo thoma u mensa ndi na minwaha ya 13(a tshi khounwethuwa o sedza fhasi). Ndo thoma vhukonani na muthannga wanga ndina minwaha ya 14 ngeno ene ana minwaha ya 24 e tshikoloni university. Ro shumisa condom u thivhela thumbu lwa minwaha mivhili u swikela ndi tshi vha na thumbu. Muthannga wanga o litsha u shumisa codnom nga khole fhedzi nne a thongo zwifuna nge nda vha ndi tshi khou ofha u vha na thumbu khathihi na Aids.

Interviewer: ndi tshi tshaba tshaba tshabwanga u vha na thumbu?

Interviewer: ndi khou pfa ni khou amba nga ha condom na Aids zwi sumba ni tshi khou divha mushumo wayo. Participant: Muthannga wanga a tshaba u shumisa condom, tshaba nga a thongo

Participant: hmm....ndovha ndi tshi khou divha ngahazwo hafhu ndo vha ndi tshi divha nana vhutea muta nga pill na injection, mmeanga vho ntalutshedza nne nda sa zwi takalele ngauri ha pfi u a vha na muvhili muhulu kana wa kundwa u vha na tshaba wanga tshaba tshaba tshabwanga u vha na thumbu

vhana musi tshifika khou swika. Zwa Hiv na Aids ndo zwipfa tshikoloni mathitshara a tshi ri funza na nga radio.

Interviewer: no di pfa hani musi ni tshi wana uri ni na thumbu ngeno ni tshe mutuku?

Participant: ndo pfa ndo dinalea ngamaanga lwe naho ndi tshi divha zwa untsha thumbu hayani kana sibandela (TOP) nda sa zwi fune ngauri ndi tshi khou shavha ufa kana usa tsha dovha hafhu nda beba.

Interviewer: siani ia mathelani ndi nnyi wa a vha a khou ni thusa?

Interviewer: mafhungo angei kha ubeba one oni fara hani?

Participant: vhasani vhangana na vhamuthanga vho vha vha khou thusa

Participant: ee! Izwo...yovha inyimele i kondaho. Ndo thoma nga u bva

madi nda vhudza mazwale, vha mphelekedza kiliniki. Ndori

Interviewer: uswika manese vhavhidza ambulese uri ndi iswe sibandela,

ri khadi vha ro i lindela nda pfa pain ya vhuhali fhasi ha

Participant: mukombo na khunduni. Ndi swika sibandela nda mbodi beba

nwana wa musidzana mutukutuku hu tshi pfi ndi

prematshuwa. Ndo pfa vhutungu vhuhulu musi ndi tshi

Participant: bebanda dzulesa sibandela ndolindela a tshi aluwa zwa

nana nge khotsi a vha a santoleli ngauri ro lwa

Interviewer: ndi tshini tshe tsha ni tutuwedza uri vhe na thumbu?

Participant: a huna tshe tsha ntutuwedza nga nnga ha uri muthannga

wanga a litshe u shumisa condom, hafhu nne a thongo


zwifuna nge nda ofha thumbu na Aids.zwa funa vhatukana

ndo tutuwedzwa nga vhanwe thanga dzanga ngauri nda

shavha u vha tshidahela. Zwa tshelede ya u uunda vhana

ndo zwidivha fhedzi a si zwone zwe zwa ntutuwedza. Ndi

zwone zwauri vhanwe vha ari tongisela tshelede ya


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mundende avhayi tshikoloni nga divha la mundende wa
vhana.

Interviewer: no pfa ni khadi funa zwa tshikolo naa ngamurahu a u beba?

Participant: ndo humela hayani nda swika nda isa phanda na tshikololo nwana atshi khou lelwa nga mmeanga. Ndo zwipfa athi tsha dovha nda beba uswika ndi tshi fhedza tshikolo.

Interviewer: siani la masheleni ndi nnyi we a vha a khou ni thusa?

Participant: vhabebi vhanga na vhamuthanga vho vha vha khou thusa sa izwi rotthe ro vha ri tshe tshikoloni.

Interviewer: ro swika magumoni a nyambedzano yashu, hutshe huna zwinwe zwine inwi na toda u vhudzisa?

Participant: ndi zwone, ndo livhuwa, zwo vha zwavhudi.