Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa.

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Master of Public Health

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A mini-dissertation submitted in partial fulfilment of the requirements for the degree of Master of Public Health at the School of Health Sciences, University of Venda

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Co-supervisor: Dr S.A. Mulondo

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DECLARATION

I, **Khosa Ntiyiso Vinny**, hereby declare that the mini-dissertation entitled "**Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa** for the Master of Public Health degree at the University of Venda, hereby submitted by me, has not previously been submitted for a degree at this or any other university, and that this is my own work in design and execution and that all reference materials contained therein have been duly acknowledged.

_____ _____

Signature Date

DEDICATION

I would like to dedicate this dissertation to Almighty God for bringing me this far and all my family members for their moral support. My wife Baloyi Dyondzo Tryphinah and my son Ndzlama Jaiden khosa for their unconditional support. Thank you for being there for me. God bless you abundantly. I love you all.

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ABSTRACT

Unplanned pregnancy is a major medical, social and public health problem worldwide. This problem affects learners' performance and leads to a high learner drop-out rate at schools. The purpose of this study was to investigate the factors influencing unplanned pregnancy among high school learners in the Collins Chabane Municipality, Limpopo Province, South Africa. A quantitative study using survey methods was used. A structured questionnaire was used to collect data. The total sample size was 362 female learners ranged between learners whose ages ranged between 16 and 24. Only female learners in the school were recruited to participate in the study. Validity and Reliability were ensured. Data were analyzed using SPSS version 25.0 program. Descriptive and inferential statistics were used to summarize and present the data. Permission to conduct the study was obtained from the Department of Education, Limpopo Province, the Malamulele Circuit and the Principal of the school. Informed consent was obtained from parents on behalf of female learners under 18 years of age. Confidentiality and anonymity was ensured. The study found that about 58.2% of adolescents had used contraceptives, while 64.1% indicated that they needed more information on contraceptive methods and their use. The study also found that about 71.8% of the respondents had abstained from sexual activities in order to avoid unplanned pregnancy. Unplanned pregnancies were found to be associated with ignorance of the consequences of sexual activities, information about sex from their peers and the power imbalance in sexual relationships between male and female adolescents. It is recommended that adolescents be given adequate information about contraceptives, addressing the advantages, disadvantages, side effects and how to manage their side effects. This would help mitigate against the negative attitudes that the adolescents have toward contraceptives owing to misinformation and misconceptions. In addition, school health nurses should use Information Education Communication (IEC) materials on family planning to increase awareness about family planning and to prevent unplanned pregnancies. The IEC materials should be in the most common languages of Limpopo Province, i.e. Sepedi, Xitsonga and Tshivenda for clear understanding of the content.

Key words: Abortion, Adolescents, Factors, Learners, Unplanned Pregnancy

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AYRH	Adolescent and Youth Reproductive Health
CSG	Child Support Grant
CTOP	Choice of Termination of Pregnancy
DHB	District Health Barometer
DoE	Department of Education
DoH	Department of Health
DSD	Department of Social Development
HIV	Human Immunodeficiency Virus
MRC	Medical Research Council
MRDS	Malawi Demographic Health Survey
NCPUP	National Council for Prescription Drug Programs
NPO	Non-Profit Organisation
OC	Oral Contraceptives
POP	Progesterone-only Pill
PHC	Primary Health Care
SASSA	South African Social Security Agency
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1. BACKGROUND OF THE STUDY

Unplanned pregnancy is a major medical, social and public health problem globally (Kang & Moneyham, 2008; World Health Organization (WHO), 2009). According to WHO (2009), every year almost 80 million women and adolescent females have unplanned pregnancies globally, of which 38% can be considered as an epidemic. Glasier, Gülmezoglu, Schmid, Moreno and Van Look (2006) reported that unplanned pregnancies occur among 16 million adolescents aged 15 to 21 years throughout the world every year. In addition, adolescents under the age of 15 had unplanned pregnancies in low and middle income countries and give birth every year.

There is growing acceptance and promotion of emergency contraceptives as a measure to reduce the levels of unplanned pregnancies throughout the world. Mbonye (2000) revealed that unplanned pregnancies have serious health, social, and economic consequences. Adolescents who carry unplanned pregnancies to live births are more likely to experience pregnancy problems, delayed prenatal care, and adverse birth outcomes such as premature births and low birth weights (Orr, Miller, James & Babones, 2000; Mohllajee, Curtis, Morrow & Marchbanks, 2007; Hohmann-Marriott, 2009; Omar, Hasim, Muhammad, Jaffar, Hashim & Siraj, 2010). Raatikainen, Heiskanen and Heinone (2005) also reported that adverse socio-economic consequences, such as psychosocial stress and poor mental health, are associated with unplanned pregnancies.

In Mexico, unplanned pregnancies among adolescents is reported to be the major cause of psychological distress, is associated with dropping out of school, either before or shortly after childbirth (De Villiers, 2004). Adolescent mothers are more likely to present with symptoms of depression when compared with their non-parenting peers and older mothers (Kalil & Kunz, 2000). This is because the transition to motherhood puts adolescents at a greater risk of psychological distress because they are socially, cognitively and emotionally immature to cope with the demands of motherhood.

A study by Compass (2004) revealed that unplanned pregnancy is also linked to other risk factor behaviours, such as alcohol and substance abuse, unprotected sex, and a drop in school achievement. These risk factor behaviours tend to increase dramatically during this period. Adolescents may engage in unprotected sex and other deviant behaviours because of

immaturity, poor assessment and a false sense of invulnerability, as well as personal belief (Hudson & Ineichen, 2012).

Evidence from sub-Saharan Africa indicates that 35% of pregnancies among 15–19 year olds were unplanned and the result of teenage relationships, which were unstable (Mkhwanazi, 2011). In a study conducted in Swaziland, adolescent girls revealed that they were expected to bear children at a young age and were competing for men's love by bearing their children. On the other hand adolescent boys confirmed that men are the leading decision-makers about sexual issues (Ziyane & Ehlers, 2010).

Unplanned pregnancies bring change to the lives of adolescents. In most instances these are negative social consequences, such as dropping out of school and interrupted education. Unplanned pregnancies also contribute to many health problems, as adolescents enter parenthood before they are physically and psycho-socially ready (Godding, 2013; Richter & Mlambo, 2015). Society is negatively affected, as socio-economic factors such as poverty, unemployment and poor literacy are interrelated with adolescent pregnancies (Van Rensburg, 2004).

In 2015, it was reported that 5868 pupils in KwaZulu-Natal, South Africa, approximately 5000 in Limpopo, 2542 in Gauteng and 1748 in the Free State, became pregnant (Dommisse, 2015). According to the report by the Department of Education, as cited by Ramcharan (2015), about 72,000 learners became pregnant and were absent from school in 2015.

A study conducted in Soweto, South Africa, found that 23% of pregnancies carried by 13–16 year old adolescents and 14.9% in the 17–19 year age range ended in abortion, in most cases illegal abortions (Muganyizi, Ishengoma, Kanama, Kikumbih, Mwanga, Killian & McGinn, 2014). According to Pedrosa, Pires, Carvalho, Canavarro and Dattilio (2011), this implies that the predictors of unsafe sexual intercourse during the early years of adolescent were individual, socio-demographic, familial, family patterns of early sexual experience and the lack of school or career goals, as well as relational characteristics.

Adolescent pregnancy interferes with adolescents' educational attainment, resulting in fewer job opportunities for them. Rasch, Silberschmidt, Mchumvu and Mmary (2008) argued that young school girls engage in sexual activities with older partners and have transactional sex, whereby gifts or money are exchanged for sex. Görgen, Maier and Diesfeld (2010) reported on relationships where adolescent girls become involved in sexual activities with older male partners; this results in unplanned pregnancies because they lack the power to insist that their partners use condoms. Furthermore, this may result in their contracting Sexually-Transmitted Infections (STIs), including HIV/AIDS, Human Papillomavirus Syphilis and Gonorrhoea.

A Study conducted in the Greater-Giyani Municipality by Mushwana, Monareng, Richter and Muller (2015) found that (61%) of the respondents did not have adequate knowledge about sexual intercourse and 56.3% of the respondents fell pregnant because of peer pressure.

1.2 PROBLEM STATEMENT

In South Africa unplanned pregnancy was reported to be 26% of all pregnancies in 2016 in the Department of Health's annual report. Adolescents aged between 16 and 24 accounted for the rapidly growing unplanned pregnancy rates. This led teenagers to dropping out of school and to care of their babies. Those who were unlucky not to find someone to look after their babies were likely to leave school forever or dropout (Mushwana et al., 2015).

The present researcher is a member of Mintirho ya Vula-vula Community Empowerment Non-Profit Organisation (NPO), during the awareness campaign initiated by the Mdabula-based Youth Development Program which took place in high schools. The researcher observed that over 60 learners in the schools were pregnant in the first quarter of the year. According to the District Health Barometer (2016), many adolescents (3650) had legal abortions in Vhembe District Health facilities in 2016. Consequently, some experienced complications, such as surgical removal of the uterus and some died, while 2100 delivered babies. Teenage pregnancy also leads to stigmatisation and isolation from their friends, poor performance at school and the abuse of substances. Therefore, this study investigated factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo province, South Africa.

1.3 RATIONALE OF THE STUDY

A number of studies conducted have focused on the factors influencing unplanned pregnancy in Limpopo Province. However, none have investigated this in the Collins Chabane municipality. For instance, Onyensoh (2010) carried out a study on the 'factors influencing unplanned pregnancy among high school students in the Tswaing Sub-district, North West Province. The results revealed that having better educated parents, supportive family relationships, adequate parental supervision, sexually-abstinent friends, as well as attending church frequently, are all related to the later onset of sexual intercourse. Baloyi (2015) investigated the factors contributing to unwanted pregnancy amongst teenagers at the Polokwane Municipality, Limpopo Province South Africa. The findings revealed that about 55% of the teenagers had no knowledge of contraceptives. This is a serious concern. In literature, no known study has investigated the factors influencing unplanned pregnancy among selected high school learners in Collins Chabane Municipality, Limpopo Province, South Africa. Therefore, it is essential to conduct a study on factors influencing unplanned pregnancy among selected high school learners in Collins

Chabane Municipality, Limpopo Province, South Africa, so that recommendations can be made to the Department of Health and other stakeholders, to ensure that there is a reduction in the rate of unplanned pregnancies among adolescents especially high school learners.

1.4 SIGNIFICANCE OF THE STUDY

The findings may assist the Department of Education to collaborate with the Department of Health, so that they can ensure that the Integrated School Health Program, which offers oral or injectable contraceptives among female learners in high school as a method of family planning to prevent unplanned or unwanted pregnancy, is successful.

The study might also assist policy makers to provide guidelines on how to improve the burden of unplanned pregnancy and reproductive health among learners. Policy-makers could therefore ensure that reproductive health care services are available, accessible and comprehensive, and also provide education, counselling and be adolescent-friendly, allowing adolescents to make informed decisions about reproductive health.

1.5 PURPOSE OF THE STUDY

The aim of the study was to investigate the factors influencing unplanned pregnancy among learners in a selected high school in the Collins Chabane Municipality, Limpopo Province, South Africa.

1.6 OBJECTIVES OF THE STUDY

- To assess the knowledge of learners about contraceptives (family planning);
- To determine the personal factors contributing to unplanned pregnancy among high school learners;
- To determine the psychological factors that influence unplanned pregnancy among high school learners;
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

1.7. DEFINITION OF TERMS

1.7.1. Abortion

The WHO defines abortion as the termination of a pregnancy prior toto 20 weeks' gestation or, in the absence of accurate dating, born weighing less than 500 grams. In this study, illegal abortion refers to the action taken by an adolescent without consulting health providers for the termination of the pregnancy.

1.7.2. Adolescence

Adolescence is the age between 13 and 19 years. It is the period of transition from the immaturity of childhood into the maturity of adulthood (Kaplan, 2004). In this study, an adolescent refers to female learners from Grade 8 to 12, in the age bracket of 14 to 23, who are enrolled for the academic year 2017 in all schools under Malamulele West Circuit.

1.7.3. Factors

Simbee (2012) defines factors as the circumstances, fact, or influences that contribute to a result. In this study, factors are individual, school, family and community-related factors that directly and indirectly contribute to the learners' involvement in unplanned pregnancy.

1.7.4. Learner

A learner refers to both male and female pupils who attend a secondary educational institution (Petrie & McGee, 2012). In this study, learners are all female pupils from Grade 8 to Grade 12 registered for the academic year 2017 in the Malamulele West Circuit.

1.7.5. Unplanned pregnancy

An unplanned pregnancy is a pregnancy that occurs sooner than desired and can be wanted or unwanted (Medical Dictionary, 2009). In this study, an unplanned pregnancy refers to the occurrence of pregnancy without the desire of the adolescent to have a child.

1.8. CONCLUSION

This chapter provides the background to the study. It includes the factors influencing unplanned pregnancy internationally, nationally and provincially including the Vhembe District. It also presents the problem, rationale and significance of the study and the definition of concepts. The next chapter presents a review of literature relevant to the study.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

Taylor and Procter (2009) define a literature review as a description of what has been published on a topic by accredited philomaths and researchers. The literature reviewed for this study covers the following areas: knowledge of learners about contraceptives, personal factors that influence unplanned pregnancies, psychological factors that influence unplanned pregnancies and socio-economic factors that influence unplanned pregnancies.

2.2 DATA-BASED LITERATURE

2.2.1 Issues around contraceptives and family planning

For the purpose of this study, *knowledge* refers to the awareness of the adolescent concerning family planning. This is categorised into lack of knowledge, knowledge about the accessibility and affordability of contraceptives, knowledge about the attitudes of health care workers, knowledge of teenagers about contraceptives and types of contraceptives.

2.2.1.1 Lack of knowledge.

According to Senderowitz, Hughes and McCaule (2003), adolescents learn about their emerging sexuality and their development from their friends. Thus, they tend to remain poorly informed or even misinformed about reproductive health matters. In Moshana Village, talking about sex istaboo. Parents do not discuss sex with their children (N'gwalida, 2014). Wang, Wang and Hsu (2003) stated that lack of parental guidance and appropriate sex education contributes to unplanned pregnancy.

Health educators argue that comprehensive sexual awareness would effectively reduce the number of adolescent pregnancies, although opponents of this view argue that such education encourages more and earlier sexual activities (Advocate for Youth, 2015). Even if sexual awareness is provided, adolescents prefer to learn about some sensitive issues on their own through audio-visual materials. This is because they cannot endure their discomfort hence they are unable to retain the information imparted on them face-to-face. Educational materials need to be in the form of leaflets and booklets for adolescents to take home for reference at their own convenience (Senderowitz et al., 2003).

Adolescents who lack general education might also lack knowledge about contraceptives because they might be unable to understand the relationship between menstruation, sexual intercourse, fertility and conception (Mwaba, 2014). Information about sexual and reproductive issues anchored in pamphlets and posters might be read and understood by enlightened adolescents only. Furthermore, poverty, lack of education and inadequate family support could contribute to a lack of adequate prenatal care, which might account for some of the negative health outcomes for adolescent mothers and their children (Greydanus, Patel & Rimsza, 2001).

Lack of information could obstruct adolescents' comprehension of important issues. Health care providers should avail themselves to adolescent clients, to understand and personalise information about reproductive health issues, including contraception (Hatcher, 2012). Adolescent levels of education affect their facility to make informed decisions and could impact negatively on their awareness of their rights, affecting not only their own but their children's future too (Allan Guttmacher Institute, 2010).

Clinics and hospitals are supposed to have methods of preventing pregnancy available. However, adolescents may lack knowledge of these methods. In addition, access to these preventative methods may be difficult because of the associated embarrassment and fear when seeking such information. When contraceptives are used, they are often not used as they should be. For example, adolescents may use condoms incorrectly or forget to take oral contraceptives (Philemon, 2007).

2.2.1.2. Accessibility and affordability of contraceptives.

Access to health care services for adolescents also affects the utilisation of contraceptives. Distances from the most proximate clinics and payment for transport sometimes prevent adolescents from travelling to health care facilities for contraceptives and information. Most adolescent girls are financially dependent on their parents who might be unable to pay for transport to clinics (Kanku & Mash, 2010). Richter (2015) stresses that, according to the principles of primary health care (PHC), health services should be accessible to its users, in this case, adolescent women.

The services should be within a reasonable geographic distance and be functional in terms of adolescents' needs. Accessibility could be improved by rendering services on Saturdays (American Academy of Pediatrics, 2014). Contraceptive services could be located at schools, clinics or community centres accessible to adolescents (Richter, 2015). Reproductive health care services at government institutions are free of charge and in order to improve access to adolescents, the services should be accessed by everyone, irrespective of sex, age, belief, colour, marital status, weakness or any characteristic that puts individuals at a disadvantage

(Bankole & Malarcher, 2010). Services should also be provided in a respectful, non-judgmental and equitable way (Zuilkowski & Jukes, 2011).

2.2.1.3 Attitudes of health care workers

In South Africa, it has been reported that health care providers refuse to give adolescents contraceptives. In a study on adolescents and contraceptive utilisation, Wood, Maepa and Jewkesl (2012) found that adolescents reported that nurses would not give them contraceptives prior to asking about their sexual awareness and lecturing to them on being too young to have sexual intercourse. According to Little (2010), intimidation by staff resulted in under-utilisation of clinics by adolescents.

Theron and Grobler (2001) emphasise how positive attitudes are an important component of any program to improve the quality of health care services. Effective staff attitudes are crucial for improving the quality of care rendered to adolescents. Furthermore, awareness about contraceptives and adolescents' reproductive rights initiate the substructure on which contraceptive service providers should reveal efficacy (American College of Obstetricians and Gynecologists, 2010).

The attitudes of health care providers towards adolescents receiving sexual and reproductive health services are paramount. This is because their attitudes can influence adolescents' to access services that enable them to safely manage their sexual, reproductive health and make informed decisions concerning their reproductive health (Senderowitz et al., 2003).

Senderowitz et al. (2003) further stated that providing sexual reproductive health services to adolescents is a sensitive issue, and that confidentiality, privacy and respect must be maintained all the time. Mmari and Magnani (2003) pointed out that adolescents feel embarrassed about being seen at the clinics and fear that their privacy and confidentiality will be compromised

2.2.1.4 Teenagers' knowledge regarding contraceptives

Dependence on self-management could influence adolescents to be sexually active without knowing about contraception and contraceptive use (Boyce, Doherty-Poirier, & MacKinnon, 2014). In South Africa the proportion of sexually active adolescent girls, that often utilise contraceptives regularly, is relatively small. Numerous factors contribute to this low rate, including difficulties in obtaining contraceptive supplies, limited numbers of contraceptive services, and the value that many cultures attach to contraceptive practices (Campbell, 2012). Anecdotal material suggests that the situation is the same or even worse in developing countries. Adolescents may be ignorant about reproductive physiology and the implications of sexual intercourse. Furthermore, contraception might remain a source of embarrassment for many adolescents (MacPhail, 2015).

According to Ash and Ogakwu (2014), self-consciousness, time spent in health clinics and long waiting times are barriers to adolescents' contraceptive use. In addition, a lack of knowledge about contraceptives and non-use of contraceptives contributed to adolescent unplanned pregnancies. Furthermore, low income among black adolescents had more negative attitudes towards birth control and they used contraceptives less effectively than their white counterparts (Wright, 2013).

2.2.2 Types of contraceptives

Contraceptive methods can be classified as either modern or traditional. Modern contraception includes: hormonal methods that are administered in different ways, the intrauterine device, barrier methods such as condoms, and sterilisation (Biddlecom, 2008). Traditional contraception, also known as conventional or natural methods do not interfere with the reproductive system (Biddlecom, 2008).

There are various distribution methods for hormonal contraception. Synthetic oestrogens and progestin coalescences commonly used include: coalesced oral contraceptives, additionally known as The Pill, the progesterone-only pill (POP or 'minipill), the injectables - Depo Provera and Noristerat as well as contraceptive implants (Babalola, Folda & Babayaro, 2008).

2.2.2.1 Oral contraceptives

Oral contraceptives prevent ovulation i.e. the release of eggs from the ovaries (Theron & Grobler, 2001). With perfect use the failure rate in the first year is 0.3% while that for typical use is 8% (Trussell, 2011). The side effects of oestrogen in oral contraceptives include irregular bleeding, nausea, breast tenderness, changes in libido, bloating, fluid retention and increased blood pressure (Theron & Grobler, 2001). Furthermore, side effects, such as appetite disturbances, weight gain and skin disorders are specific to the progestin (including injectable progestins). Serious side effects are not common but may include blood clots, depression, stroke and gallstones (Hatcher, Rinehart & Blackburn, 2009).

Women have been known to fall pregnant after simultaneously taking Oral Contraceptives and other medications, such as some antibiotics, some anti-fungals and certain anti-tuberculosis drugs. Clients should therefore be encouraged to use a barrier method in addition to oral contraceptives until the completion of the course of medication (Biddlecom, 2008). Oral contraceptives have been proven to be effective in controlling pregnancy when taken correctly and consistently; that is, at the same time every day, and do not interfere with sexual intercourse (Rose, Chrisler & Couture, 2008). According to Bowers (2007), some adolescent mothers preferred using contraceptive pills because they were familiar with pills and they continued to menstruate regularly while using contraceptive pills.

2.2.2.2 Injectable contraceptives

Injectable contraceptives have the same mechanism of action as oral contraceptives but are longer acting. There are two commonly used injectable contraceptives: Depo provera and norethisterone enantate (Foster, Bley, Mikanda, Induni, Arons, Baumrind, Darney & Stewart, 2004).

Depo provera offers protection immediately after each injection if given within the first five days of the period cycle and is reversible within 3 to 18 months. It provides protection for three months. Since Depo provera does not contain oestrogens there are no increased risks of deep vein thrombosis, stroke or myocardial infarction. There is also less drug interaction compared to other hormonal contraceptives, and they are suitable for lactating mothers (Ehlers, 2008). Depo provera may initially cause irregular menstrual bleeding, but (WHO, 2009) thereafter, most women experience amenorrhea.

The main advantages of using injectable contraceptives is that are they are convenient, offer privacy for the user (Milson, 2006) and, since they are injectable, work primarily by preventing ovulation, have a low failure rate (Muhwava, 2003), of 0.3% for perfect use and 3% for typical use (Hatcher, 2012).

2.2.2.3 Intrauterine devices

These are contraceptive devices which are inserted into the uterus. The copper type is effective for five or more years and is used in women older than 35 years (Milson, 2006)

2.2.2.4 Condoms

Condoms are used to reduce both the likelihood of pregnancy and the spread of sexually transmitted diseases (STIs) such as HIV. The male condom blocks semen from entering the body of a sexual partner (Szarewski & Guillebaud, 2008). Furthermore, condoms help prevent both pregnancy and STDs, including HIV/AIDS. Ross (2015) found that 32% of adolescent mothers who participated in their study indicated that they would use condoms because they would protect them against pregnancies and STDs, subsequent to the birth of their babies. However, these adolescent mothers had failed to use condoms effectively to prevent their previous pregnancies.

2.2.2.5 Sterilization

Surgical sterilization is available for women and men. Female sterilization involves the tying of the fallopian tubes and for men, the cutting of the vas deferens (Biddlecom, 2008). Sterilization should be considered permanent. This method has a low failure rate of 0.5% for both typical and perfect use. The disadvantages of using this method are possible operative and post-operative complications, and irreversibility (Szarewski & Guillebaud, 2008).

2.3 PERSONAL FACTORS THAT INFLUENCE UNPLANNED PREGNANCIES

There are several personal factors that influence unplanned pregnancy among learners. For the purpose of this study, these are categorised into gender-power relations in partnerships, physical and sexual abuse and premarital childbearing.

2.3.1 Gender-power relations in partnership

Gender-power imbalance is an important underlying cause for many problems that adolescents experience. The low level of control that adolescents have over their own lives has a critical consequence for their reproductive and sexual health (Zuilkowski & Jukes, 2011). Discrimination against girls and women places them at a disadvantage in decision-making power and choices.

These decisions include sexual intercourse, contraceptive use, child-bearing and how their earnings are spent (Cavazos-Rehg, Krauss, Spitznagel, Schootman, Cottler & Bierut, 2015). Studies have shown that the majority of adolescents are not free to make independent decisions in their relationships, including allocation of their earnings, reproductive and sexual health; usually men become the only decision-makers (Saur, Semu & Ndau, 2014). For example, about 57.0% of adolescent girls indicated that they would rather risk pregnancy than ask a partner to use a condom, for fear of conflict, violence, economic loss and rejection (Kaphagawani & Kalipeni, 2017). This shows that men are in control of family affairs.

It was further revealed that 70% of decisions on women's health care are made by men (Saur et al., 2014). Studies conducted in South Africa have found that 84% of male partners made decisions on sexual matters and had the right to decide when to have the first sexual encounter in a relationship (Varga, 2006). For example, the inadequacy of decision-making in women acts as a barrier for contraceptive use for some women, who use contraceptives without the approval of their husbands. These women face some consequences, including divorce once the husbands find out (Saur et al., 2014).

2.3.2 Physical and sexual abuse

Physical and sexual violence are common phenomena performed by men on women (Martin & Curtis, 2004). Violence from a sexual partner includes physical, sexual and emotional abuse. Physical violence, often in the form of beatings, slapping, stabbing and hair pulling, can often end in some form of sexual force which may lead to unplanned pregnancy (Jewkes, Vundule, Maforah& Jordaan, 2013). Studies in Malawi have revealed that 25-56% of rural girls are forced to have sex when they are not ready and when they do not feel like having sex (Munthali, Chimbiri & Zulu, 2011; Saur et al., 2014; Maluwa-Banda, 2014). As women in such circumstances are not prepared for sex, they may not be able to protect themselves, exposing them to the risk of unplanned pregnancies (Martin & Cutis, 2004).

Vundule, Maforah, Jewkes, and Jordaan (2001) found that 33% of young women in South Africa had their first sexual intercourse because their male partners used force, including assault. Physical brutality was a factor in undesired high school pregnancy in South Africa (Jewkes et al., 2013). Similarly, in Malawi, around 25% of adolescent girls have encountered physical brutality (Malawi Demographic and Health Survey (MDHS), 2004). Reports are not accessible for the range investigated, yet the media and healing centre sources have shown that the difficulty is on the increase countrywide. In other cases, perceptions of physical or sexual abuse make adolescent girls vulnerable to unplanned pregnancy (Saewye, Magee & Pettingell, 2004).

2.3.3 Premarital childbearing

The increasing incidence of premarital childbearing in Africa has been variously explained. Firstly, the traditional social controls over the sexual behaviour of adolescents by the extended family is less binding and the traditional mores are changing rapidly owing to contact with Western cultures. Secondly, unmarried women may use sexual relations and pregnancy to achieve marriage (Corcoran, 2014). Thirdly, in some societies, premarital fertility is widespread and culturally acceptable. Lastly, in certain communities in South Africa, the custom that a woman needs to prove her fertility by having a baby before marriage can be considered (De Villiers, 2004). Objections to out-of-wedlock fertility arise from various quarters, including moral precepts, religious beliefs, cultural rules and pragmatic concerns, such as poor support from the father of the child (Makiwane & Udjo, 2006).

Factors that can contribute to the number of adolescents who fall pregnant are gender-power imbalances, lack of negotiating power about the use of contraceptives, lack of access to family planning services and inadequate information on sexual reproductive health (Department of Health, 2010). Other factors that contribute to the number of adolescents who fall pregnant are early sexual debuts, barriers to contraceptive use (seldom used at the sexual initiation) and misinformation on sexual matters (Hagan & Baxton, 2012).

2.4 PSYCHOLOGICAL FACTORS THAT INFLUENCE UNPLANNED PREGNANCY

There are several psychological factors that influence unplanned pregnancy among learners. For the purpose of this study these are categorised into depression and peer pressure.

2.4.1 Depression

Depression has been associated with high school pregnancy (Hamburg, 2015). Child rearing youths will probably suffer more unhappiness when compared with adolescent who have not been pregnant and more seasoned mothers. In most literature mental pain among youthful mothers is seen as caused by psychosocial stressors, identified with the change into the role of being a mother (Kalil & Kunz, 2000).

Loneliness and depression linked to adolescent pregnancy is still a poorly researched phenomenon. In some literature, depression is perceived as a cause of pregnancy rather than a consequence, and sometimes it is implicated in repeated pregnancies (Kalil & Kunz, 2000). Evidence suggests that there is a link between seeking intimacy and early initiation into sexual activity and the resulting pregnancy. It is argued that an adolescent girl who is emotionally deprived may initiate early sex or even decide to have a child in order to get emotional closeness (Furstenberg, Brooks-Gunn & Morgan, 2012). There is thus a need for a survey that would clarify the link between perceived depressive symptoms among adolescent mothers and adolescent pregnancy (Rudra, Bal & Sin, 2013).

In some literature, it is argued that adolescent girls are predisposed to depression (Galambos, Berenbaum & McHale, 2015) and are more disposed to experiencing depressive symptoms than their male counterparts. Possible explanations for this gender difference vary. Firstly, girls are genetically susceptible to stress owing to events like menarche and high emotional intensity resulting from hormonal change (Santelli, Duberstein Lindberg & Finer, 2014). Higher levels of stress are correlated with higher rates of depression. Secondly, girls' interpersonal style puts them at a greater risk of depression. This is because girls tend to be more empathic and are more inclined to seek intimate relationships than their male counterparts (Galambos et al., 2015).

Kalil and Kunz (2000) conducted a comparative study between adolescents who were married and in their twenties at first childbirth, and those who were young adolescents and not married at first childbirth. This study tested the relationship between age and marital status at first birth, to depressive symptoms measured during young adulthood (American Academy of Pediatrics, 2014). The initial findings of the study confirmed the hypothesis that women who first gave birth in adolescence presented with higher levels of depressive symptoms than women who first gave birth as married adults (Boyce et al., 2014). Interestingly, unmarried adolescent mothers and older mothers presented with elevated depressive symptoms when compared to married adolescent mothers (American Academy of Pediatrics, 2014).

However, when individual psychosocial characteristics that existed prior to the pregnancy, for example, self-esteem and academic performance, were controlled, the difference between the groups was not significant. Kalil and Kunz (2000) concluded that the role played by age in causing psychological distress is minimal. Underlying factors associated with adolescent childbirth and psychological functioning in young adulthood may contribute substantially to the prevalence of psychological distress in young adulthood (Langille, Hughes & Murphy, 2015).

2.4.2 Peer group

Peer pressure is a significant factor in the initiation of smoking, drug use and sexual involvement among adolescents. Adolescents spend much time with their peers, who influence them. Lovelife

(2017) investigated why adolescents became sexually active early and found that peer pressure was a significant factor in teenage sexual behaviour. Marsiglio and Mott (2007) maintain that variables such as personality and family relationships determine who has the greater influence: parents or peers. Furthermore, conformity to peer pressure could result from lack of parental attention, interest, warmth and understanding (Marsiglio & Mott, 2007).

Bekaert (2002) emphasises that sexual behaviours are learned, and parents and peers are the two major socialisation agents. Wilson and Williams (2002) found signs of tension among adolescents and increased rebellion against authority at home and at school. If family relationships were supported within their families, adolescent dependence on peers might be reduced (Muyinda, Kengeya, Pool & Whitworth, 2001).

Research suggests that long-term negative social outcomes are not foreseeable (Corcoran, 2014). Several long-term follow-up studies indicate that two decades after giving birth, most former adolescent mothers are not welfare-dependent; many have completed high school, secured regular employment, and do not have large families (Woodard, 2015). Marsiglio and Mott (2007) describe comprehensive adolescent pregnancy programs which seem to contribute to good outcomes, as do home-visitation programs designed to promote good child health outcomes.

2.5 SOCIO-ECONOMIC FACTORS THAT INFLUENCE UNPLANNED PREGNANCY AMONG HIGH SCHOOL LEARNERS

There are several socio-economic factors that influence unplanned pregnancy among learners.

2.5.1. Socio-economic status

Poverty has many negative influences on health outcomes. Some of the results of neediness and monetary disparity for pre-adult women universally incorporate an expanded danger of: jungle fever, blocked off contraception, undesirable pregnancy, dangerous premature births, HIV/AIDS and other sexually-transmitted infections, as well as deaths of new-born children and maternal mortality (Shaw, 2009).

Poverty is both a contributor and a consequence of early pregnancy. Adolescent pregnancy is strongly associated with the continuation of the poverty cycle (Mkhwanazi, 2010). As per centre, gathering exchanges, account pretending, surveys and top-to-bottom meetings with rural and urban youths in KwaZulu-Natal, South Africa, adolescent parenthood is viewed as compromising the financial ambitions both sexes (Varga, 2006). However, research has shown that if girls and women are afforded educational and occupational opportunities to reduce their economic dependence on others, they are less likely to have an early pregnancy. Girls who have and keep

jobs are also better able to negotiate family planning with sexual partners and delay childbearing (Richter, Panday, Emmett, Makiwane, Du Toit, Brookes and Mukhara, 2009).

Adolescent girls may indulge in sexual activity in exchange for goods, money and experiences, such as taking meals in hotels (Palamuleni, 2010). A study in Malawi, found that 66% of adolescents had accepted money or gifts in exchange for sex (Allan Guttmacher Institute, 2006). In some cases, parents may encourage their daughters into relationships with men for consumer goods or girls may go out with men because her parents cannot satisfy their basic needs. Adolescents with unplanned pregnancies are thus more likely to come from low socio-economic situations than those whose pregnancies are planned (Munthali et al., 2011). The level of education of parents, especially the mothers, may also have an influence on the adolescents with regard to pregnancy as they act as role models (Vundule et al., 2001) which may be a preventive factor for unplanned pregnancy.

In Kenya it was reported that women with no education had their first sexual intercourse three years earlier than their counterparts with at least a secondary school education (Kaphagawani & Kalipeni, 2017). Similarly, in Malawi, 63% of adolescents with no education had begun childbearing earlier compared to 19% with a secondary education (MDHS, 2004). Furthermore, adolescents from wealthy families are more than twice as likely to start bearing children earlier than those from the wealthiest families. Marriage is also delayed if adolescents further their education to secondary and post-secondary levels (MDHS, 2004). The level of education has also been reported to influence the use of contraceptives. For example, 27.0% of women with no education, 35.0% with 5-8 years of schooling and 44.0% with some secondary education had used contraceptives (MDHS, 2004).

In Malawi, literacy levels are low (49%) (MDHS, 2004). The low literacy levels may lead to low paying jobs, causing early marriage and influencing non-contraceptive use, thereby increasing the prevalence of unplanned pregnancy. The current socio-economic situation in South Africa means that those who live in poverty are often exposed to more sexual activity because families are required to live in small houses where there is a distinct lack of privacy for the parents (Bezuidenhout & Joubert, 2009). Children that grow up in that situation can easily engage in sexual activity as soon as they enter puberty.

Throughout the developed world, unplanned pregnancy is more common among adolescents who have been disadvantaged in childhood and have low expectations of education or the job market (Langille et al., 2015). The literature shows that adolescents living in poverty have an unplanned pregnancy rate which is five times the average. Socio-economic circumstances seem to play a major role in the rates of unplanned pregnancy (Langille et al., 2015).

There may be a growing 'lost generation' of young people who see no reason not to get pregnant. For some disadvantaged youth, particularly for girls whose self-esteem tends to drop as they mature, sexuality may be all they have to value (Santelli, Duberstein Lindberg & Finer, 2014). Lack of opportunity and hope for the future have also been identified as driving forces behind high rates of unplanned pregnancy (Geda & Lako, 2012). As a result, the rate of pregnancy and childbirth is high among poorer adolescents. Other scholars have found that 83% of adolescents who have babies are from poor families (Hope, 2010).

2.5.2 Sexual information provided by peer groups

Many adolescents entertain the idea that being sexually active is fashionable, and that being sexually inactive is a sign of abnormality (Woodard & Fergusson, 2015). They might, therefore, become sexually active and get pregnant so that they may be accepted by their peers. The extent to which peer groups influence sexual behaviour can be linked to the extent to which peer groups are used as sources of information on sex-related aspects (Corcoran, 2014).

Most adolescents turn to their peers as the principal source of information on sexuality (Bayona & Kanji-Murangi, 2003). Lindsay (2005) found that 78, 0% of young people aged 11 to 19 years received information on sexuality from school peers. Mayekiso and Twaise (2011) found that peer groups were the main source of sexual information among adolescents.

2.5.3 Substance abuse

The use of substances, including alcohol, marijuana and other drugs are risk-taking behaviours associated with unplanned adolescent pregnancy (Guttmacher Institute, 2014). Adolescents drink alcohol to get drunk, forget problems, feel good and have fun (Visser, 2014). Therefore, drug users tend to be at a greater risk of unplanned pregnancy than non-drug users as they may be more sexually active, less likely to use contraceptives and fail to make good decisions about sex (Visser, 2014).

Moreover, adolescents who utilise drugs (cannabis) are four times likely to become pregnant than the individuals who have never smoked (Visser, 2014). In Malawi, information on substance use among adolescents is insufficient and none is accessible for the investigation zone. In any case, measurements from psychiatric doctors' facilities show that weed (Cannabis) is the most ordinarily utilized substance among patients, with 67% of patients going to psychiatric treatment offices. About 3% of these patients were female while those who abused liquor represented 33% of the patients (USAIDS, 2013).

2.5.4 Child support grants

The Child-Support Grant (CSG) is currently the key poverty-alleviating policy (Triegaardt, 2009; SASSA, 2011). Mkhize (2009) specifies that the child support grant is payable to a primary care-

giver in respect of a child or children under the age of 14 years. A primary caregiver is any relative or other person who takes primary responsibility for the daily needs of a child.

There is no evidence that CSG tends to encourage adolescents to have more children, so as to secure the grant. Goldblatt, Rosa and Hall (2006) affirm that many people believe that the grant encourages teenage pregnancy and that girls have babies in order to access the grant. It is also believed that women abuse the grant by spending it on alcohol, lottery tickets and personal luxuries, such as lipstick, cell phones, and clothing for themselves, instead of spending it on the children (Goldblatt at al., 2006).

The rate of adolescent pregnancies in South Africa is among the highest in the world. Yet the reasons for this problem are often misunderstood and riddled with myths and misinformation about adolescent girls. At the same time, much negative debate has developed in South Africa, claiming that the CSG has some perverse incentives. Some observers suggested that the child support grant provided by the Department of Social Service of South Africa was an incentive for adolescents to fall pregnant (Guttmacher Institute, 2014).

Another school of thought claims that the Child Support Grant (CSG) scheme has some perverse incentives, one of which is to encourage women to have more children, especially adolescents (Makiwane & Udjo, 2006). However, according to Makiwane and Udjo (2006), there is no relationship between adolescent fertility and CSG, based on three findings. Firstly, while teenage pregnancy rose rapidly during the 1980s, it had stabilised and even started to decline by the time the CSG was introduced in 1998. Secondly, only 20% of adolescents who bear children are beneficiaries of the CSG. This is extremely low compared with their contribution to fertility. Finally, observed increases in adolescent fertility have occurred across all social sectors, including among young people who would not qualify for the CSG on the means test.

2.2.5 Mass media

Television (TV) and radio broadcasts have a high potential for spreading sexual data. TV is by all accounts not the only wellspring of sexual data accessible to youths, yet it is an open and convincing one. TV can depict human sexuality in socially acceptable ways or as debasing and high-chance practices. TV can make sex practices seem very good with no negative results for the guardians and youngsters (Gesselman, Webster & Garcia, 2017).

Media may also function to pressurise adolescents into having sex earlier than expected (Strasburger, Wilson & Jordan, 2014). According to Singh (2013) television, films, videos, magazines, advertisements, novels, and social networks such as Facebook, WhatsApp and Twitter focus on sex and love. According to the researcher, the media portrays the glamorous side of sex in such a way that adolescents perceive sex as something in fashion. Many

adolescents, especially girls, rely on magazines and social networks as an important source of information about sex, birth control and health-related issues (Strasburger et al., 2014). They ignore the consequences of sex, such as unplanned pregnancy and sexually-transmitted diseases.

Greathead, Devenish, and Funnel (2016) stated that the media portrays sex as something exciting without risk. Heavy doses of television may accentuate adolescents' feeling that everyone is engaging sex except them, and they become engaged in sexual intercourse at an early age (Strasburger et al., 2014). Messages from the media often convey the concept that abstinence is outdated. Coupled with the fact that adolescents seldom think of long-term consequences of their behaviour, they may engage in sexual behaviour to gain immediate feelings of acceptance and self-worth (Bullock, 2016).

2.2.6. Family structures and their influence

According to Panday, Makiwane, Ranchod and Letsoalo (2009) family structures play a vital role in understanding and determining teenage sexual behaviour, including pregnancy. Singh (2013) stated that teenage pregnancy has been linked to low parent education, and that girls who become pregnant often have mothers who gave birth in their teens. Parents of teenage mothers and teenage fathers are often considered to have permissive attitudes regarding premarital sex and pregnancy. However, parents with permissive attitudes about sex or premarital sex, or those that have negative attitudes about contraception have adolescent children who are more likely to practise unsafe sex and become pregnant (Dittus & Jaccard, 2015).

Singh (2013), also states that adolescents who live in an incomplete family are more likely to be sexually active than those who come from two-parent households. An incomplete family refers to the absence of the father or mother (Bezuidenhout & Joubert, 2009). Parental divorce during the early teenage years has also been associated with early onset and increased frequency of sexuality in females. These effects are often due to less monitoring and supervision that typically occur in single-parent households. Adolescents with older siblings who are sexually active or who have had babies are also more likely to begin having sex at a younger age (Singh, 2013).

Family members serve as role models for their children. Thus, adolescents are more likely to initiate sex and experience pregnancy if their parents or other family members have sex outside of marriage, are cohabitating with romantic or sexual partners or have had a child outside of marriage (Panday et al., 2009)

Among the various dimensions of family social support, parent-adolescent communication on issues of sexual behaviour and childbearing is very important (Panday et al., 2009). When the communication between mother and daughter is poor or absent, the girl is placed at a greater

risk of premature sexual activity and potential conception, in part because she looks to others, especially her male peers for nurturing and intimacy. Therefore, families with poor interpersonal relationships may inadvertently encourage the adolescent to look elsewhere for nurturing relationships (Singh, 2013).

Adolescents turn to peers for relationships they cannot foster with their families. Soon pressure from peer clusters can lead to risky behaviour such as promiscuity and neglect of contraception. The cluster of peers may also become the primary source of sexual information. Unfortunately, adolescents who share information about sex may lack the knowledge about their own bodies and about contraception (Singh, 2013). Furthermore, adolescents who are raised in larger families are at increased risk of earlier sex than those who are not. This results from teenagers replicating their siblings' sexual behaviour or because parental monitoring is spread too thinly when more children live in the home (Panday et al., 2009).

2.2.7 The school environment

There is considerable misinformation about sexual health matters among young people. Sexual health education in the form of life skills has been introduced as a compulsory part of the school curriculum. However, the way in which it is implemented is not successful. This is because most educators are not well-equipped with knowledge about how to implement it. Eventually teenagers do not get the necessary information about sex education (Jewkes, Dunkle, Nduna, Shai, and Sterk, 2014), as cited by Panday et al., 2009).

2.6. LEGISLATION ON TEENAGE PREGNANCY

Efforts to combat adolescent pregnancies have met with limited success. Section 2 (1) (a) of the CTOP Act, 92 of 1996 protects the right of persons to make decisions concerning reproduction and security as well as control over their bodies (Choice on Termination of Pregnancy, 1996). The Act also makes provision for access to reproductive health care services, including contraception, TOP, sexuality education, and counselling programs and services. However, it is stressed that TOP is not a form of contraception or population control.

However, despite the SA government's efforts to prevent pregnancies among girls aged 15 or younger in the RSA, the number of adolescents requesting TOPs increases annually. As contraceptives are available free of charge, there is an inconsistency between the current large numbers of adolescent pregnancies and requests for TOPS. Therefore, the ideal situation of unplanned pregnancies is avoided by the effective utilisation of contraceptives (Guttmacher, Kapadia, Naude & De Pinho, 2014).

2.7 Conclusion

In this chapter the factors influencing unplanned pregnancy were presented. The literature indicates that unplanned pregnancy among adolescents is a global health problem. Unplanned pregnancy is increasing, especially in the developing countries. Factors associated with unplanned pregnancy include peer pressure, lack of knowledge regarding contraceptives, attitude of the health workers and substance abuse. Access to contraceptives and negotiation about contraceptive usage by adolescents is still low in many countries.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

Teddlie and Tashakkori (2009) define research methodology as a theory of how an inquiry should proceed. It involves analysis of the assumptions, principles and procedures in a particular approach to inquiry. This chapter presents the research methods used in the study, including the research design, research setting, study population and sampling and data collection processes. A description of reliability and validity of data utilised in the study is also included. The chapter further highlights the ethical considerations and research budget.

3.2 STUDY DESIGN

Silverman (2013) defines research design as a plan for selecting subjects, research sites, and data collection procedures to answer the research question/s. The nature of the study was quantitative design using the survey method to investigate the factors influencing unplanned pregnancy among high school learners. A structured questionnaire was used to collect data. The survey method was useful as it allowed many respondents to complete the questionnaire in a short space of time. In addition, this method is relatively cheap and easy to conduct.

3.3. STUDY SETTING

The study was conducted at a selected high school at Malamulele West Circuit, Collins Chabane Municipality, Vhembe District, Limpopo Province. About 679 learners were registered for the 2018 academic year. The school is situated in Mdabula Village, situated 42 km east of Thohoyandou, 169 km north-east of Polokwane, the capital city of Limpopo Province. Mdabula Village has one clinic and there are no mobile clinics. There are no school health programs provided for learners at Hlalukweni High School. Some members of the community live too far from the clinic. As a result, they have to travel long distances (more than five kilometers) to access the clinic. About five traditional healers are practising within the community.

Collins Chabane Municipality has 57 high schools and 70 primary schools. There are five primary schools and one high school in Mdabula Village. In the high school the subject Life Orientation is taught, in which learners learn about sexual issues. There are about eight taverns and three bottle stores in the community. The majority of the parents are illiterate, to the extent that they

cannot assist the children with sex education. There are also five recreational facilities which are not functioning, owing to the lack of adequate resources.

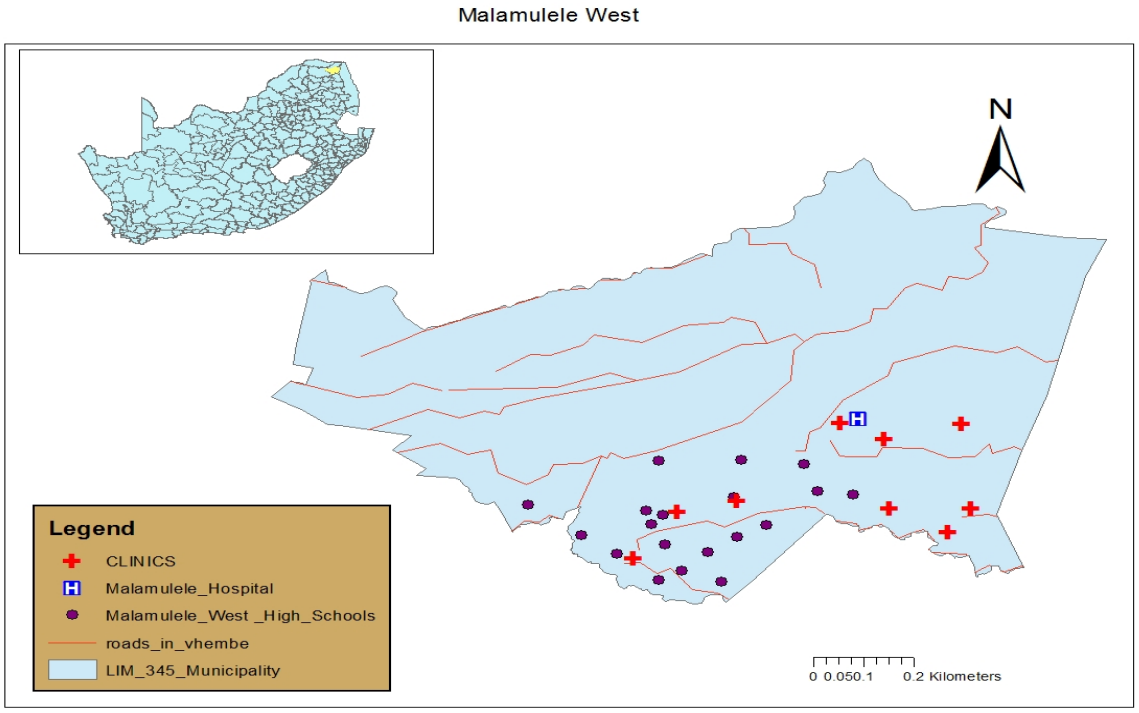

Figure 3. 1 Malamulele Map adopted from: Municipality Demarcation Board (2017).

3.4 STUDY POPULATION AND SAMPLING

3.4.1 Study population

Burns and Grove (2009) define a population as all the elements that meet the criteria for inclusion in a study. For the purpose of this study, the study population was all female learners registered for the 2017 academic year from Grades 8 to 12 in the Malamulele Circuit, in the sub-division Malamulele West. The Malamulele West Circuit sub-division was purposively selected, because it has recorded the highest rate of teenage pregnancy of all the sub-divisions that fall under the Malamulele Circuit.

3.4.2 Sampling

3.4.2.1 Sample of schools

A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study. Purposive sampling is also known as judgmental, selective, or subjective sampling (Grove, Gray & Burns, 2014). Hlalukweni High School was purposively selected, because it has recorded the highest number of teenage pregnancy from all

other schools in the Malamulele West Circuit. The school was selected among 13 schools in in this circuit.

3.4.2.2 Sampling of learners

Total population sampling is a type of purposive sampling technique, where a researcher chooses to examine the entire population, and the population has a particular set of characteristics (Creswell, 2012). Thus, all female learners in the selected school were recruited for this study.

3.4.2.2.1 Sample size

Sample size is an important feature of any empirical study in which the goal is to make inferences about a population from a sample (Marshall & Rossman, 2006). The total sample size in this study was 362; that is, all female learners from the selected high school formed part of the study.

3.4.2.2.2 Distribution of the sample by grades

In a sampling frame each individual or element in the population should have an opportunity to be selected (Mays & Pope, 2014). Therefore, for the purpose of this study, female learners from Grade 8 to 12 were selected to participate in this study.

Table 3. 1: Number of females per grade.

Grades of Hlalukweni High School	**No. of female learners registered.**
Grade 8	71
Grade 9	55
Grade 10	102
Grade 11	72
Grade 12	62
Total	**362**

3.5 INSTRUMENT FOR DATA COLLECTION

A questionnaire is a data accumulation instrument which consists of a progression of questions and other prompts for the aim of collecting information from respondents (Burns & Grove, 2009). A structured self-administrated questionnaire was used to collect data. The questionnaire consisted of close-ended questions. The researcher developed the self-administered questionnaire guided by the study objectives. The questionnaire was translated into Xitsonga by a linguist in the Department of Languages to cater to female learners from Grades 8 and 9.

The questionnaire consisted of five sections as follows:

Section A: Demographic information, such as age, gender, grade, cluster.

Section B: Knowledge of contraceptives (family planning).

Section C: Personal factors that influence unplanned pregnancy.

Section D: Psychological factors that influence unplanned pregnancy.

Section E: Socio- economic factors that influence unplanned pregnancy. (See Appendix 10.)

3.6 MEASUREMENT FOR VALIDITY AND RELIABILITY

3.6.1 Validity

Validity can be defined as how well a test measures what it is purported to measure (Cohen, Manion & Marrison, 2011). The instrument was submitted to an expert (supervisor) in the Department of Public Health. All the items in the instrument were examined by the expert to determine the relevance and arrangement of the items of the questionnaire in relation to the objectives of the study.

3.6.2 Reliability

Reliability is concerned with the consistency of a measurement method (Grove et al., 2014). If similar findings of a study are replicated under similar techniques, then the instrument is considered to be reliable (Maree, 2016). The test re-test method was used to measure the reliability of the instrument.

3.7 PRE-TEST

The instrument was pre-tested at Khatisa High School as they share similar characteristics with Hlalukweni High School by being under the authority of Malamulele West Circuit. About 10% of the population was sampled (19 learners). The purpose of the pre-test was to modify the questionnaire and to make corrections where it was deemed necessary, according to the comments of the respondents. Therefore, supervisors customised the instrument according to the comments of the respondents; they had aligned the instrument according to the objectives.

3.8 DATA COLLECTION METHODS

Data collection involves the selection of respondents and gathering data from them (Kobus, 2016). The instrument was personally administered to the learners by the researcher. The researcher made an appointment with the School Principal in order to arrange a convenient time to administer the questionnaires to the learners.

The researcher administered the questionnaire to the learners after school hours. The learners were gathered in a classroom. The process of data collection took about four months from 02 June to 31 September 2018. The nature and purpose of the study were explained in full, including the autonomy, confidentiality, voluntary participation, informed consent and beneficence. The respondents were required to sign a consent form before taking part in the study, showing that they understood the nature and process of the study. For respondents under the age of 18 years, consent was required to be singned by their parental/ Guradian before they were allowed to participate in the study. The completion of the questionnaire took approximately 30 minutes. The respondents filled in the questionnaires in the presence of the researcher who provided support and clarity where necessary. The researcher collected the completed questionnaires and kept it on a locker, so that no body had access to the completed questionnaires except the reseacher.

3.9 METHODS OF DATA ANALYSIS

Marshall and Rossman (2006) define data analysis as the process of bringing order, structure and meaning to the mass of collected data. The data was analyzed using the Statistical Package for Social Science (SPSS), version 25.0. Descriptive statistics were used to analyze the data which were presented in tables and charts. The chi-square test was used to compare categorical variables and the level of statistical significance was set at p=0.05.

3.10. ETHICAL CONSIDERATIONS

3.10.1. Permission to conduct the study

The research proposal was presented to the Department of Public Health, the School of Health Sciences, and the University of Venda Higher Degree Committee for approval. Then it was sent to the University Ethics Committee for ethical clearance. Ethics clearence were obtained (Project number SHS/18/PH/04/2304), see appendix 1. The researcher had submitted a letter requesting permission to conduct the study at Department of Basic Education in Polokwane, Malamulele West Circuit and the Head of the School (Principal). Permission to conduct the study was granted from the Department of Education, Limpopo Province, Malamulele Circuit and the Head of the School (Principal). See Appendices 2 to 7.

3.10.2 Beneficence

The principle of beneficence was applied in the study by ensuring that the participants' privacy was maximised. The research was beneficial as it created new knowledge. The researcher ensured that no harm was done to the respondents.

3.10.3. Confidentiality

The respondents were informed that the information they gave would be treated with the highest degree of confidentiality. To ensure confidentiality, the respondents were not required to provide their names or identity numbers. The completed questionnaires were stored in a safe locked by the researcher.

3.10.4 Autonomy

The respondents were given full disclosure about the nature of the study and its benefits and an opportunity to ask questions before the data collection was provided. To ensure Autonomy, Respondents were informed that they are free to withdraw from the study at any time, without any resoan even when they have signed the consent form.

3.10.5 Informed consent

After being provided with information regarding the purpose and objectives of the study the respondents were given consent forms to complete. Each respondent was informed that their participation in the study was voluntary. For respondents under the age of 18 years, parental consent was required before they were allowed to participate. Respondents were free to withdraw from participation at any time, if they wished to do so (See Appendix 8 and 9).

3.10.6 Voluntary participation

According to Creswell (2012) participation should be voluntary, and participants should not be threatened or compelled to participate in a study and they should do so of their own will. In this study, participation was voluntary, the researcher informed the respondents about the right to withdraw from the study at any time that they decided not to participate.

3.11. DISSEMINATION OF THE RESEARCH FINDINGS

A copy of the completed mini-dissertation will be submitted to the library of the University of Venda for reference by other researchers. A copy will also be given to the Provincial Department of Education, the Malamulele Circuit and Hlalukweni High School. An article based on the findings will be submitted to accredited journals and presented at national and international conferences.

3.12. CONCLUSION

This chapter presented the methodology used in this study, which includes the study setting, sampling methods, pre-tests, data analysis, data collection and ethical considerations.

CHAPTER 4

ANALYSIS, DISCUSSION AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents and describes the research findings based on the analysis of data obtained from female learners at Hlalukweni high school. The findings present the respondents' demographic information, their knowledge about contraceptives, personal factors influencing unplanned pregnancy and socio-economic factors influencing unplanned pregnancy.

Three hundred and sixty two questionnaires was distributed to all female learners registered at a selected High School for the academic year 2018 and three hundred and forty 340 (94%) were returned. The data were presented in frequency tables and a bar chart. The percentages of the Likert scale are combined and summaries were provided.

Analysis and interpretation was done in line with the following research objectives:

- To assess the knowledge of learners about contraceptives (family planning);
- To determine the personal factors contributing to unplanned pregnancy among high school learners;
- To determine the psychological factors that influence unplanned pregnancy among high school learners;
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

4.2 DEMOGRAPHIC INFORMATION

Demographic information includes the characteristics of the respondents which include age, religion, marital status and the people living with the respondents.

4.1.1 Age distribution of the respondents

The findings of the study revealed that the majority of respondents, 219(64.4%), were in the age bracket of 16-20 years, 66(19.4%) were in the age bracket of 10-15 years, 53(15.6%) were in the age bracket of 21-25 years and 2(0.6%) were in the age bracket of 26 and above. A summary of all the descriptions given above is as shown in Figure 4.1 below.

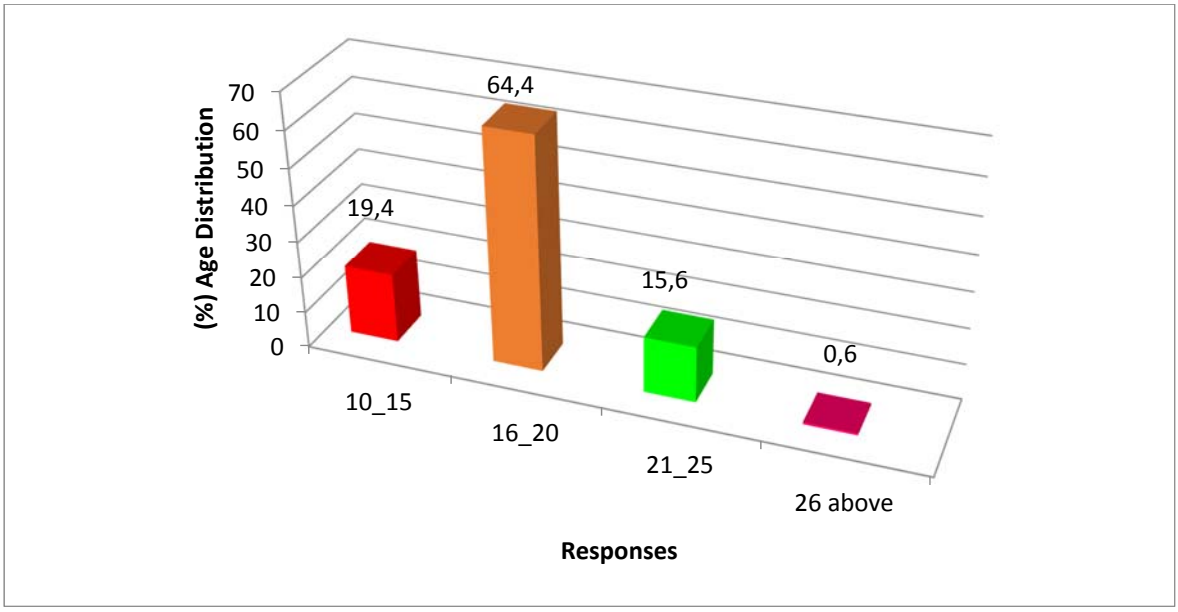

Figure 4. 1 Age distribution of the respondents (n=340).

4.1.2 Learners per grade

The study findings indicate that 100(29.4%) of the study respondents were learners in Grade 11 while 81(23.8%) of the respondents were learners in Grade 12. Furthermore, 62(18.2%) of the respondents were learners in Grade 10, while 50(14.7%) of the respondents were learners in Grade 9 and 47(13.8%) were learners in Grade 8. The summary is shown in Figure 4.3 below.

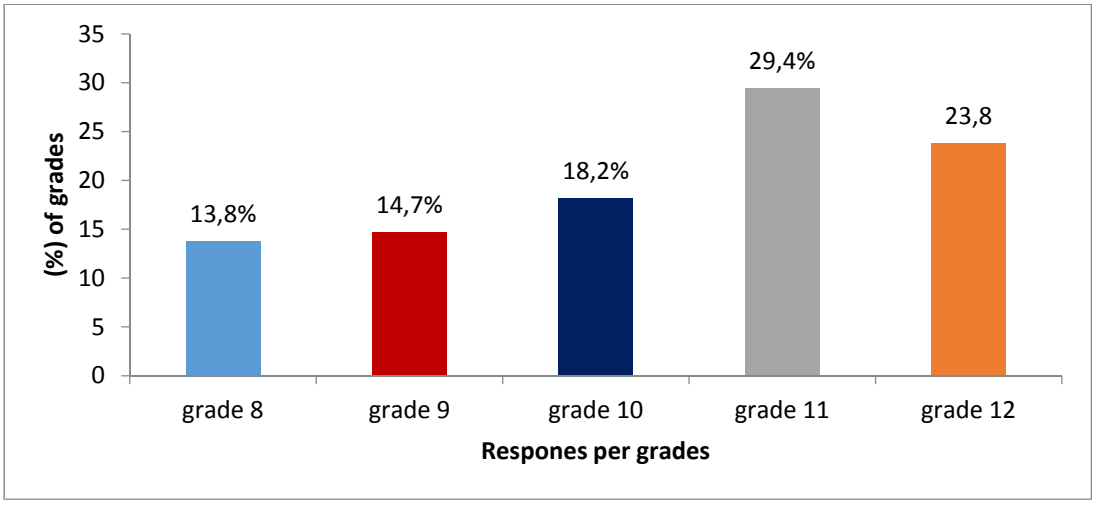

Figure 4. 2 Learners per grade (n=340)

4.1.3 People living with the respondents

The findings indicated that 131 (38.5%) of the respondents lived with their mothers while 120 (35.3%) of the respondents lived with both parents. Furthermore, the findings revealed that 39(11.8%) of the respondents were living with their grandmothers, while 20(5.9%) were living with their brothers. The findings further showed that 16(4.7%) were living with others, 10(2.9%)

were living with their sisters, and 3 (0.9%) were living with their fathers. A summary of all the descriptions given above is shown below.

Table 4. 1 People living with the respondents (n=340)

Items	Frequency	Percentage (%)
Mother	131	38.5%
Both parents	120	35.3%
Grandmother	40	11.8%
Brother	20	5.9%
Others	16	4.7%
Sister	10	2.9%
Father	3	0.9%
Total	**340**	**100%**

4.1.4 Responses regarding children

The findings showed that the majority of respondents 236(69.4%) did not have children while 104(30.6%) of the respondents had children. The findings further showed that 93(27.4%) of the respondents had one child while 10(2.9%) of the respondents had two children and 1(0.3%) had more than two children. Some respondents - 236(69.4%) – did not respond to the question because they did not have children. The summary of all the descriptions given above is as shown below.

Table 4. 2 Responses regarding children (n=104).

Respondents with children	Frequency	Percentage (%)
Yes	104	30.6%
No	236	69.4%
Total	**340**	**100%**
Number of Children	**Frequency**	**Percentage (%)**
One Child	93	27.4%
Two Child	10	2.9%
Two and above	1	0.3%
Total	**104**	**30.6%**

4.1.5 Religion of respondents

The findings revealed that 307(90.2%) of the respondents were Christians while 29(8.5%) of the respondents revealed that they followed a traditional religion. The findings further showed that 4(1.2%) followed other religions. Figure 4.4 below provides a summary of the religions of the respondents.

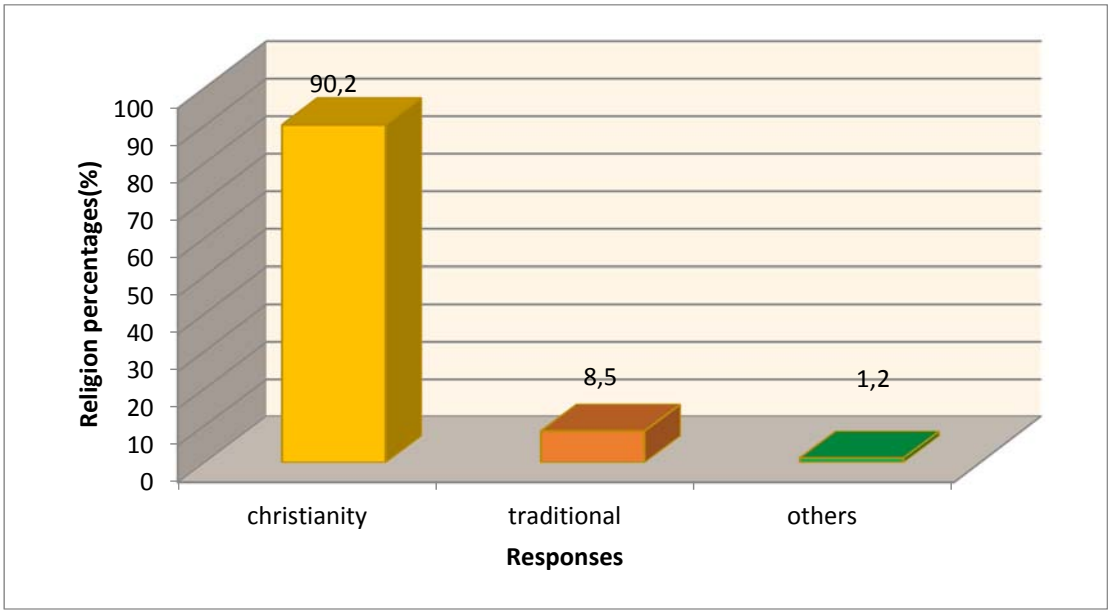

Figure 4. 3 Religions of the respondents (n=340)

4.2 KNOWLEDGE OF LEARNERS ABOUT CONTRACEPTIVES

This presents the study findings regarding the knowledge of the respondents about contraceptives. The questions in this section are followed by the findings.

4.2.1. Do you discuss the choice of contraceptives with your sexual partner?

The findings showed that 177(52.1%) of the respondents revealed that they discussed the choice of contraceptives with their boyfriends while 163(47.9%) of the respondents revealed that they do not discuss the choice of contraceptives. The findings are shown in the summary in Figure 4.4 below.

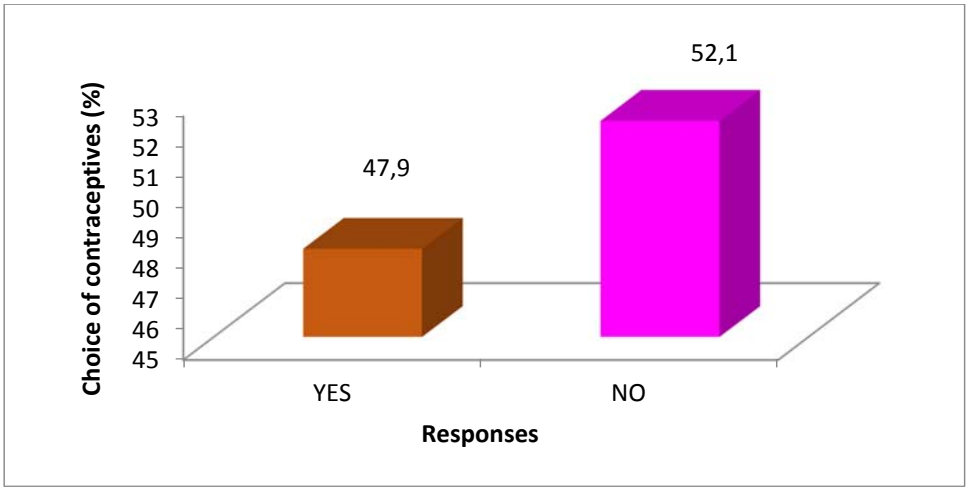

Figure 4. 4 Discussion of choices of contraceptives with sexual partners (n=340)

4.2.2 Are you in favour of a workshop about contraceptives for women and men together?

The findings showed that 196 (57.6%) of the respondents revealed that they were in favour of combined workshops about contraceptives for woman and men, while 144 (42.4%) of the respondents were not in favour of such workshops. A summary of the responses is as shown in Figure 4.5 below.

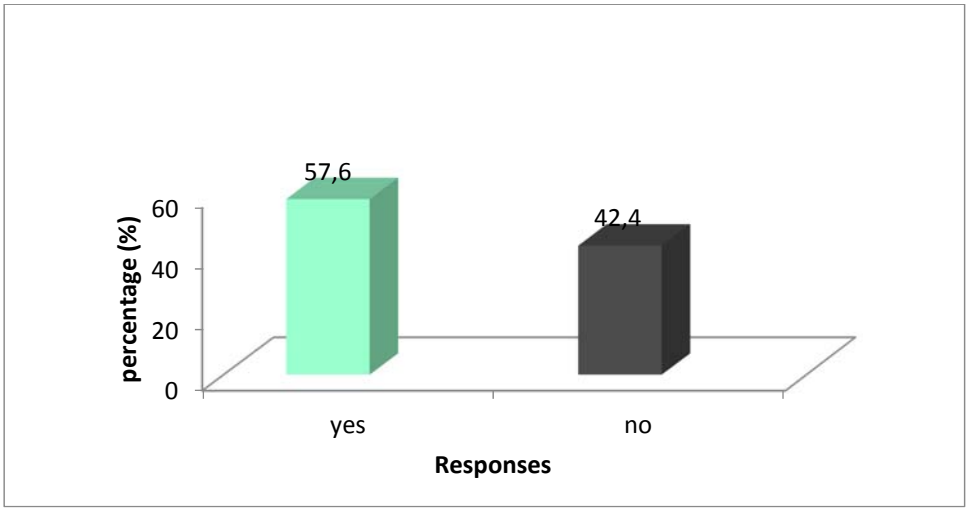

Figure 4. 5 Favouring a workshop about contraceptives for woman and men together (n=340).

4.2.3 Does your sexual partner like using contraceptives?

The findings showed that 174 (51.2%) of the respondents indicated that their boyfriends liked using contraceptives while 168(48.8%) of the respondents indicated that their boyfriends did not like using contraceptives. A summary of the findings is shown in Figure 4.6 below.

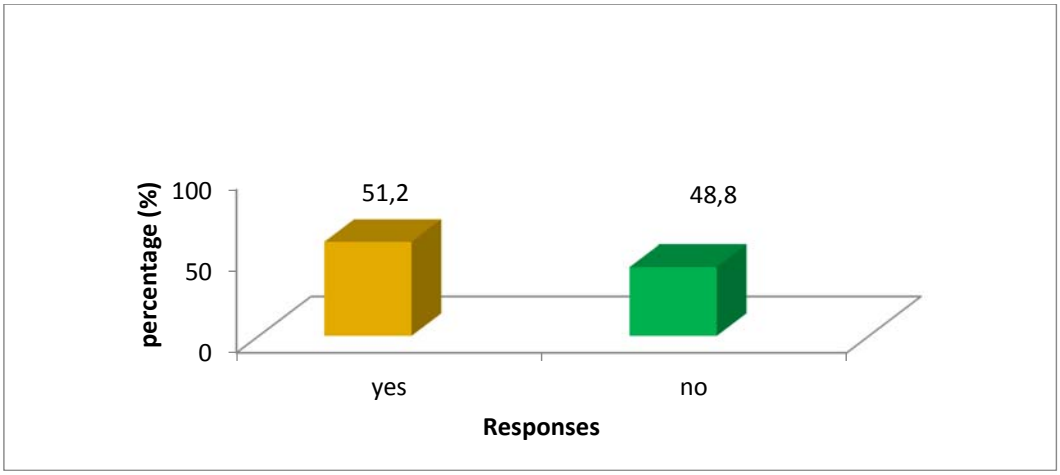

Figure 4. 6 Boyfriends' agreement to use contraceptives (n=340)

4.2.4 Do you think there is a need for more information on contraceptive methods and their uses?

The findings showed that 218 (64.1%) of the respondents indicated that there is a need for more information on contraceptives and their usage while 168 (49.4%) of the respondents indicated that there is no need for more information on contraceptives and their usage. A summary of the findings is shown in the Figure 4.7 below.

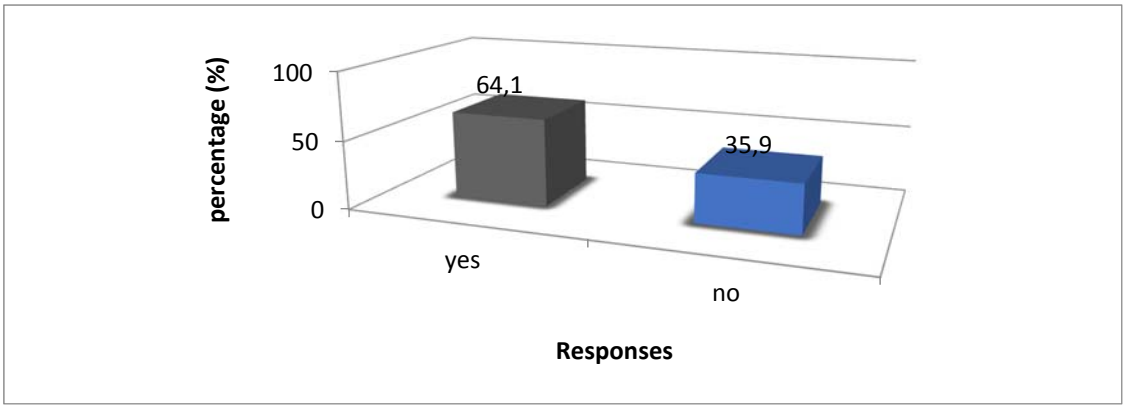

Figure 4. 7 The need for more information on contraceptives methods and their use (n=340)

4.2.5 If you answered yes, where do you think you will get information about contraception?

The findings showed that 104 (30.6%) of the respondents indicated that they would get information about contraceptives from the health facility while 70 (20.6%) of the respondents indicated that they would get information about contraceptives from the family. The findings further showed that 37 (10.9%) of the respondents indicated that they would get information about contraceptives from the school while 24 (7.1%) of the respondents indicated that they

would get information about contraceptives from the radio/newspapers/elevision, and seven (2.1%) of the respondents said they would get information from the church. There were 98 (28.8%) non-responses to this question. A summary of the responses is shown in Figure 4.3 below.

Table 4. 3 Where will you get your information about contraception. (n=242)

Source of information about contraceptives	Frequency	Percentage (%)
Health facility	104	30.6%
Family	70	20.6%
School	37	10.9%
Radio/Newspaper/ Television	24	7.1%
Church	7	2.1%
Non- response	98	28.8%
Total	**242**	**71.3%**

4.2.6 Have you ever used any type of contraceptive?

The findings showed that 198 (58.2%) of the respondents indicated that they had used contraceptives while 142 (41.8%) of the respondents indicated that they have never used contraceptives. A summary of the findings isgiven in Figure 4.8 below.

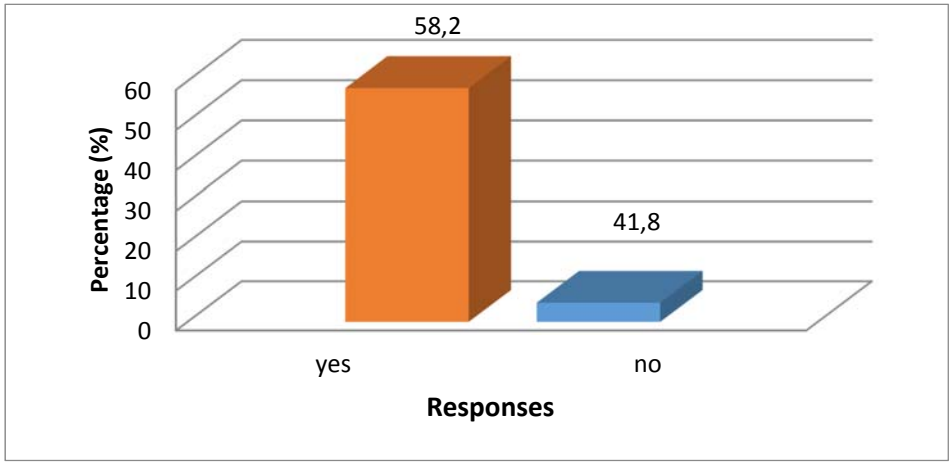

Figure 4. 8 Have you ever used any type of contraceptive? (n=340)

4.2.7 If yes, which method did you use?

The findings showed that 74 (37.4%) of the respondents revealed that they used condoms as a method of contraception while 50 (25.2%) of the respondents revealed that they used a contraceptive pill. The findings further showed that 30 (15.1%) of the respondents revealed that

they used injectable methods of contraception, 20 (10.1%) of the respondents revealed that they used intrauterine contraceptive devices as a method of contraception while 14 (7.1%) of the respondents revealed that they used implants as a method of contraception and 10 (5.1%) of the respondents revealed that they used natural methods of contraception. There were non-responses of 142(48.8%) to the question posed. A summary of the findings is shown in Table 4.4 below.

Table 4. 4 I Which method did you use (n=198)

Responses about methods used on contraceptives	**Frequency**	**Percentage (%)**
Condoms	74	37.4%
Pills	50	25.2%
Injectable	30	15.1%
Intrauterine Contraceptive Device	20	10.1%
Implants	14	7.1%
Natural method	10	5.1%
Non-response	142	48.8%
Total	**198**	**100%**

4.2.8 Did you comply with the instruction on the usage of that contraceptive method?

The findings showed that 145(73.2%) of the respondents revealed that they complied with the instructions on the usage of the contraceptive methods while 53(26.8%) of the respondents revealed that they do not comply with the instructions on the usage of the contraceptivemethods. It appears that the majority of the study respondents complied with the instruction on the usage of the contraceptive methods. These findings are shown in Figure 4.9 below.

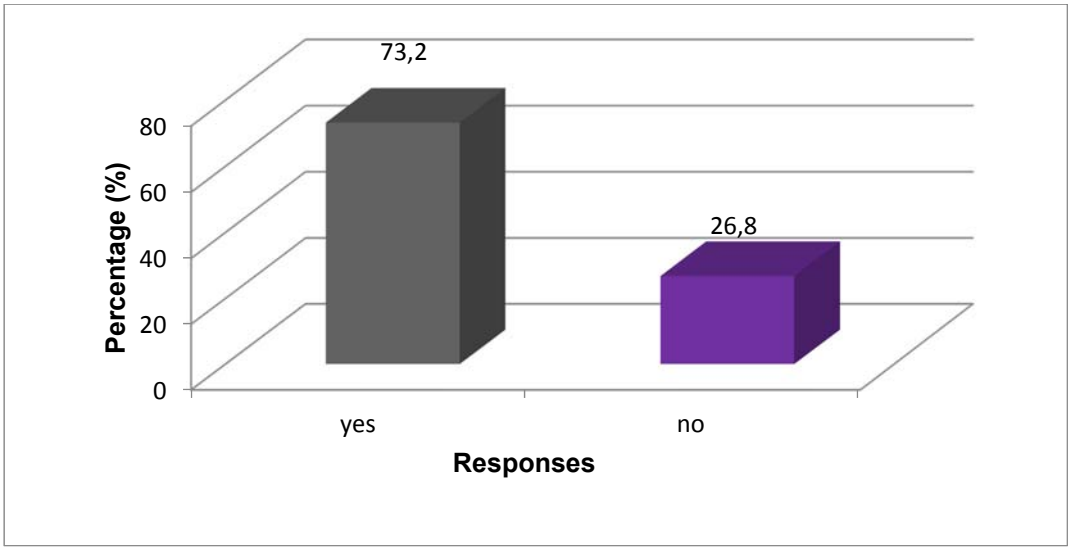

Figure 4. 9 Compliance with instructions on the use of a contraceptive method (n=198).

4.2.9 Do you think that abstaining from sexual activities will help to prevent unplanned pregnancy

The findings showed that 244 (71.8%) of the respondents indicated that abstaining from sexual activities would help to prevent unplanned pregnancyies while 96 (28.2%) of the respondents indicated that abstaining from sexual activities would not help to prevent unplanned pregnancies. The summary of the descriptions given above is as shown in Figure 4.10 below.

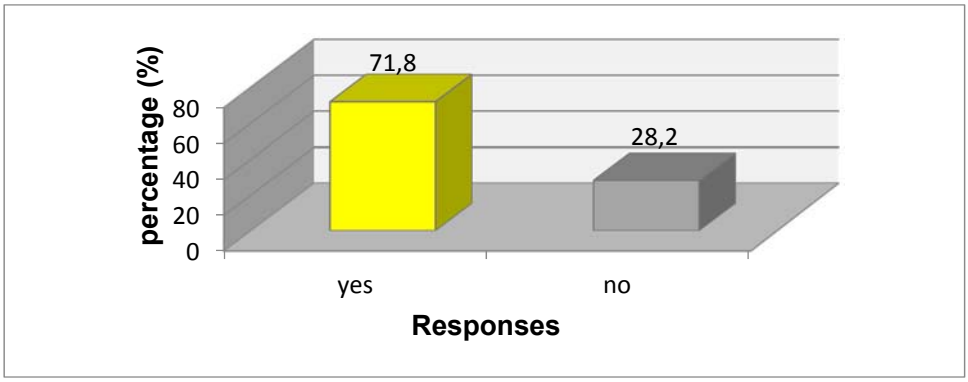

Figure 4. 10 Abstaining from sexual activities to prevent unplanned pregnancyies (n=340)

4.2.10 Would the introduction and teaching sex education help to prevent unplanned pregnancy

The findings showed that 264 (77.6%) of the respondents indicated that sex education at schools would help to reduce unplanned pregnancy while 76(22.4%) of the respondents indicated that this would not help to reduce unplanned pregnancy. The summary of this finding is shown in Figure 4.11 below.

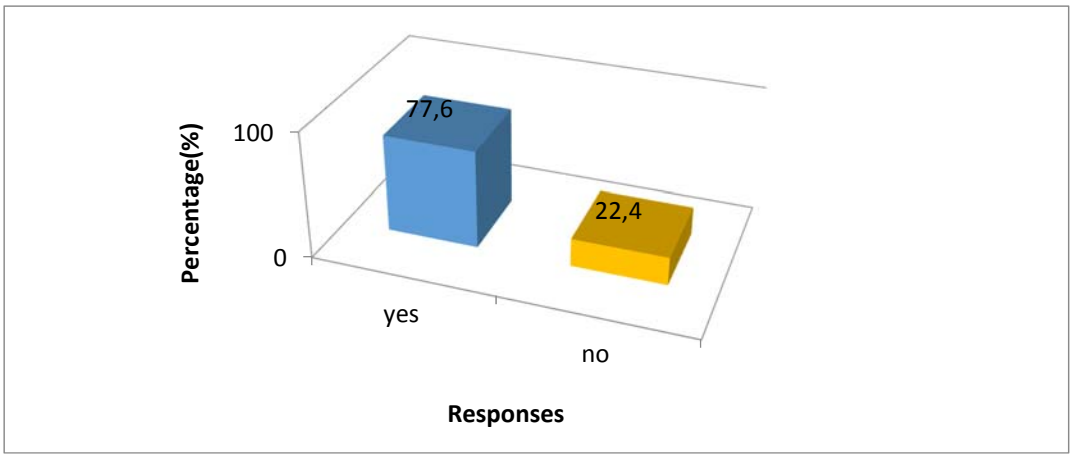

Figure 4. 11 Introduction of sex education at school to reduce unplanned pregnancy (n=340)

4.2.11 Can unplanned pregnancy be prevented by supplying contraceptives at clinics and schools

The findings showed that 172 (50.6%) of the respondents indicated that unplanned pregnancy can be prevented by supplying contraceptives at clinics and schools while 168(49.4%) of the respondents indicated that unplanned pregnancy would not be prevented by supplying contraceptives at clinics and schools. A summary of this finding is shown in Figure 4.12 below.

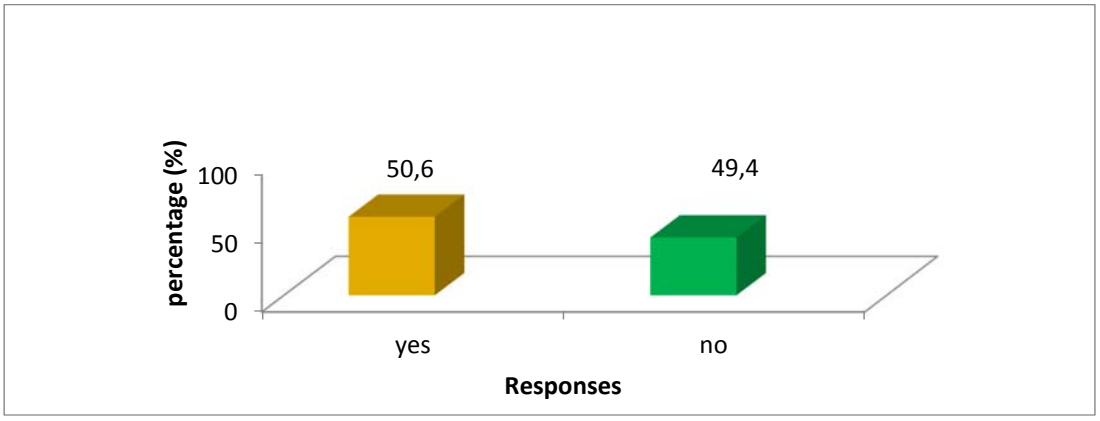

Figure 4. 12 Can unplanned pregnancy be prevented by supplying contraceptives at clinics and school (n=340)

4.2.12 Would teaching religious and moral values to adolescents help to prevent unplanned pregnancy.

The findings showed that 295 (86.8%) of the respondents revealed that teaching religious and moral values into adolescents would help to prevent unplanned pregnancy while 44 (12.9%) of the respondents indicated that teaching religious and moral values into adolescents would not help to prevent unplanned planned pregnancy. A summary of the findings is shown in Figure 4.13 below.

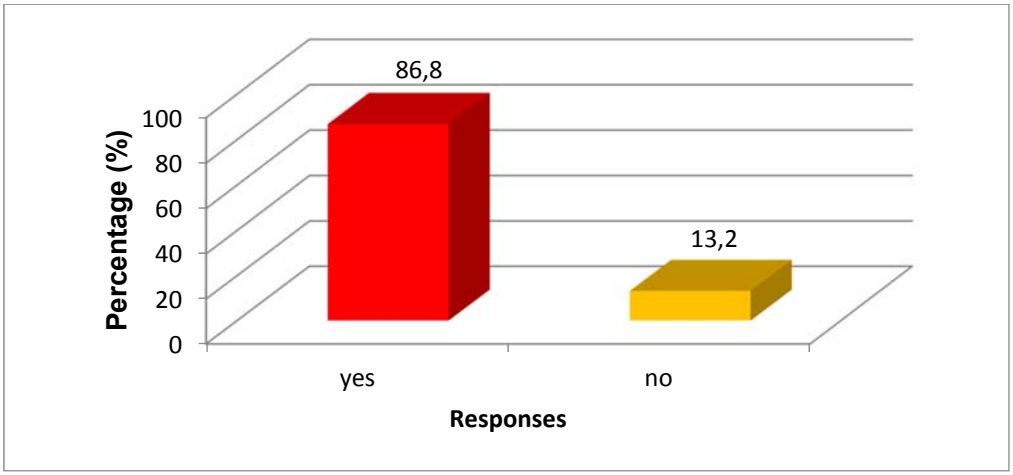

Figure 4. 13 Teaching religious and moral values to prevent unplanned pregnancy (n=340)

4.2.13 Would programs linked to contraceptive services help to prevent unplanned pregnancy?

The findings showed that 296 (87.1%) of the respondents revealed that programs providing contraceptive services would help to prevent unplanned pregnancy while 44(12.9%) of the respondents indicated that such programss would not help to prevent unplanned pregnancy. The summary of this finding is shown in Figure 4.14 below.

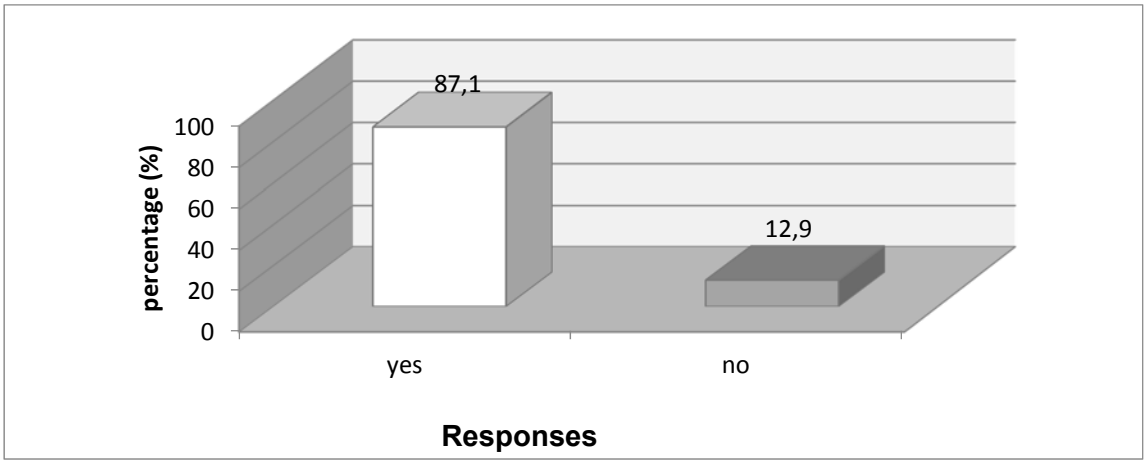

Figure 4. 14 Provision of programs linked to contraceptive services to prevent unplanned pregnancy (n=340).

4.2.14 Would parental education support help prevent unplanned pregnancy?

The research showed that 311 (91.5%) of the respondents agreed that educational support by parents can help to prevent unplanned pregnancy while 29(8.5%) of the respondents did not agree that educational support by parents can help prevent unplanned pregnancy.

A summary of these findings is shown in Figure 4.15 below.

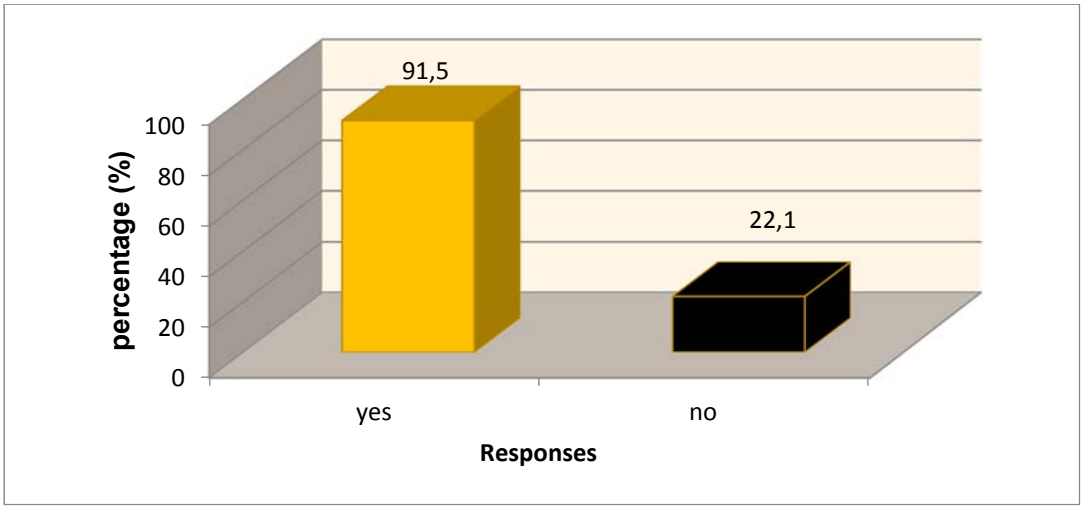

Figure 4. 15 Would educational support by parents help prevent unplanned pregnancy. (n=340).

4.2.15 Can social support and parenting help prevent unplanned pregnancy

The research found that 265 (77.9%) of the respondents agreed that social support and parenting can help to prevent unplanned pregnancyies while 75 (22.1%) of the respondents disagreed. A summary of these findings is shown in Figure 4.16 below.

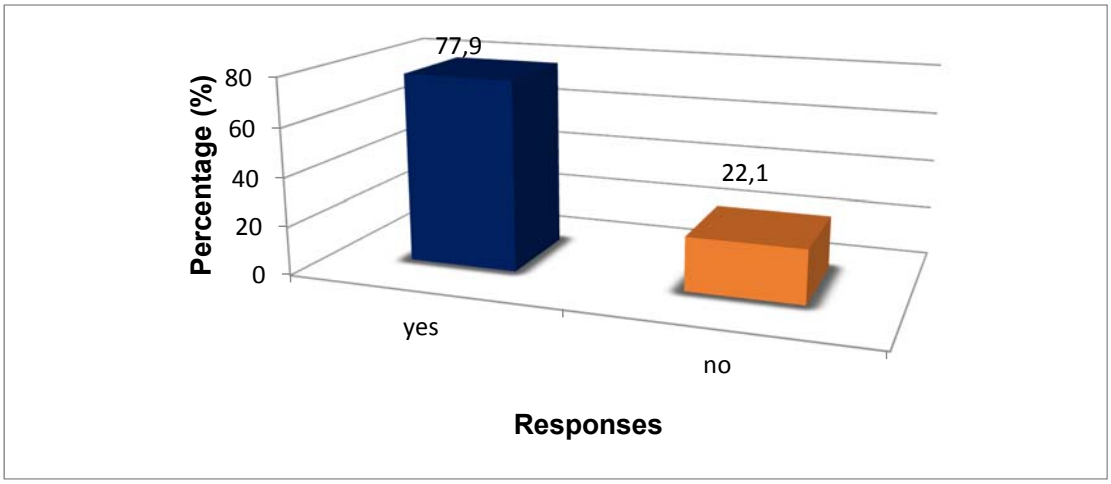

Figure 4. 16 Social support and parenting can help prevent unplanned pregnancy (n=340)

4.3. PERSONAL FACTORS INFLUENCING UNPLANNED PREGNANCY

This presents the study findings of learners regarding personal factors influencing unplanned pregnancy. This section was answered by all the respondents regardless of whether they had children or not. The Likert scale was used to reflect the responses of the respondents. about how strongly they agreed or disagreed aboutthis manner. The findings are summarised as follows:

4.3.1 Lack of self-confidence in decision-making about sexual activity lead to unplanned pregnancy

The findings showed that 196 (57.7%) of the respondents disagree while 108 (31.8%) of the respondents agree that lack of self-confidence in decision-making about sexual activity leads to unplanned pregnancies. However, 36 (10.6%) of the respondents were not sure whether a lack of self-confidence in decision-making about sexual activity leads to unplanned pregnancy. A summary of the responses is shown in Figure 4.17 below.

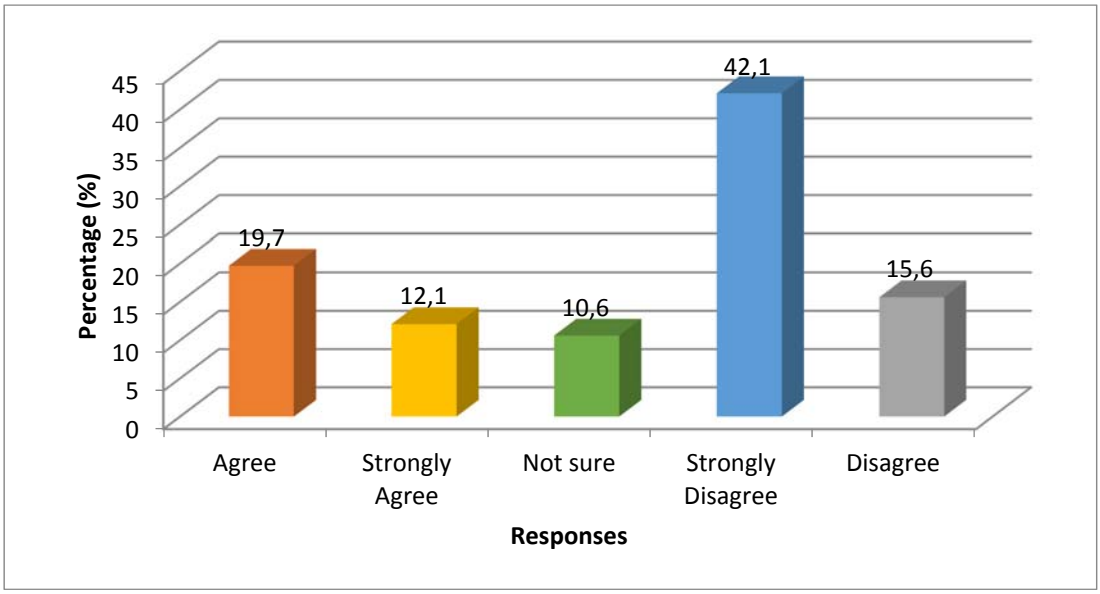

Figure 4. 17 Does lack of self-confidence in decision-making about sexual activity lead to unplanned pregnancy (n=340).

4.3.2 I fear losing my partner if I ask him/her to use contraceptives

The findings showed that 203(59.7%) of the respondents disagreed while 106(31.2%) of the respondents agreed that they feared losing their boyfriends if they asked them to use contraceptives. However, 31 (9.1%) of the respondents were not sure whether they feard losing their boyfriends if they asked them to use contraceptives. Figure 4.18 below summarises the resonses.

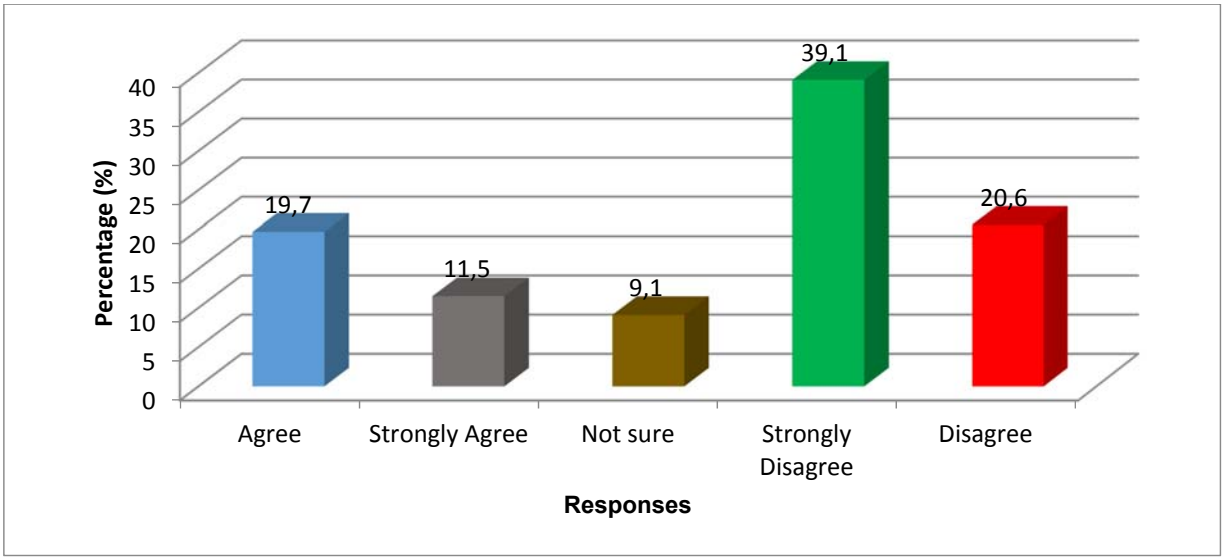

Figure 4. 18 Fear of losing boyfriends if if requesting them to use contraceptives (n=340)

4.3.3 Early menarche increases the risk of pregnancy.

The findings showed that 126 (37%) of the respondents disagreed while 144 (42.3%) of the respondents agreed that early menarche increases the risk of pregnancy. However, 70 (20.6%) of the respondents were not sure whether early menarche increases the risk of pregnancy. A summary of the responses is shown in Figure 4.19 below.

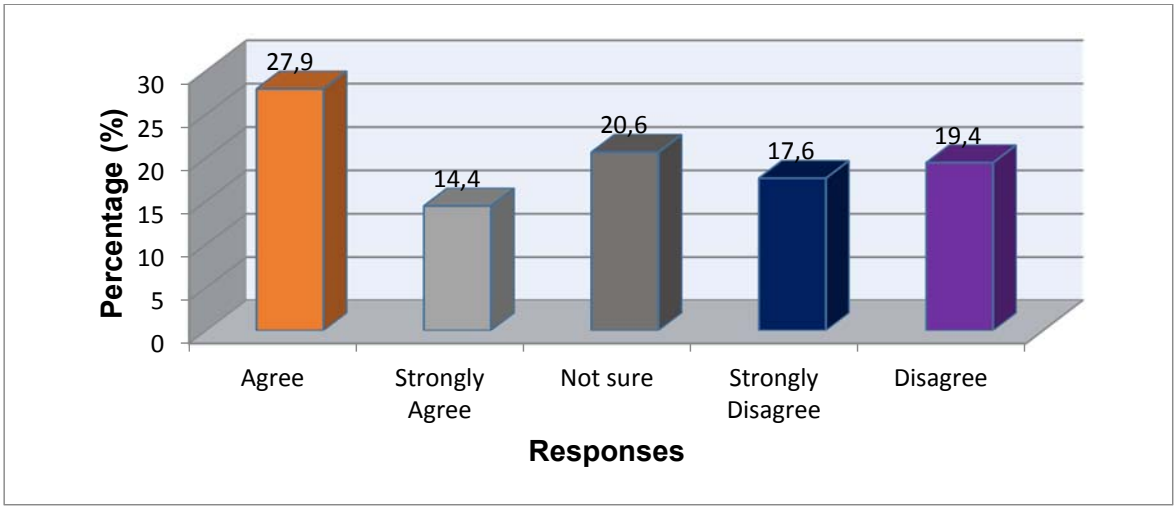

Figure 4. 19 Does early menarche increase the risk of pregnancy (n=340)?

4.3.4 Independence and adult status is gained by having a baby

The findings showed that 175(51.5%) of the respondents disagreed while 104(30.6%) of the respondents agreed that they wanted to become independent by having a baby. However, 61 (17.9%) of the respondents were not sure whether that they wanted to become independent by

having a baby. Figure 4.20 below summarises these responses.

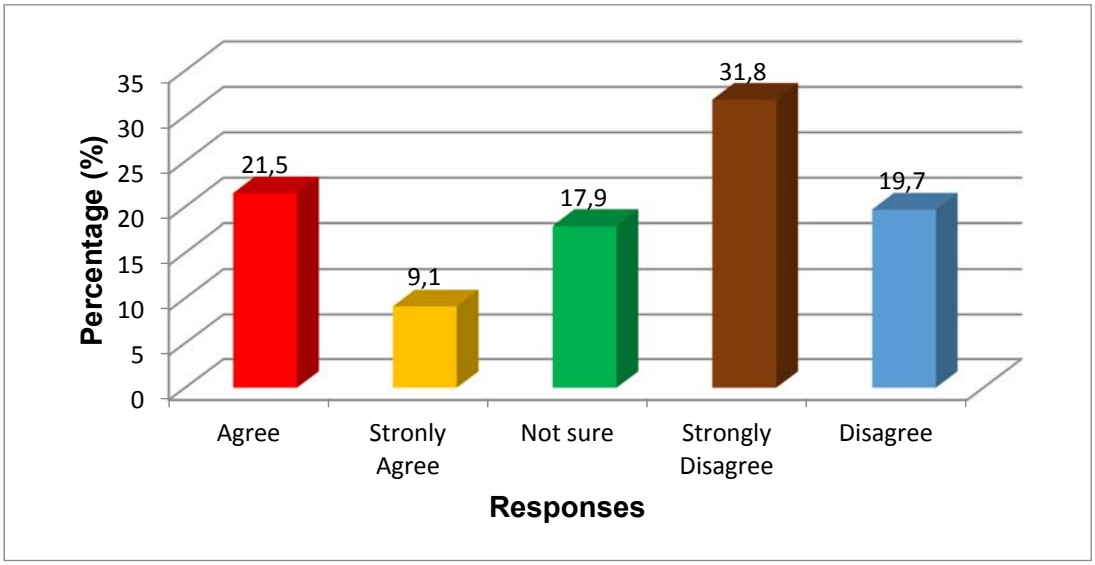

Figure 4. 20 Desire to become independent by having a baby (n=340)

4.3.5 Power imbalances in sexual relationships between male and female adolescents can lead to unplanned pregnancies.

The findings showed that 116(34.1%) of the respondents disagreed while 148(43.6%) of the respondents agreed that power imbalances in sexual relationships between male and female adolescent can lead to unplanned pregnancy. However, 76 (22.4%) of the respondents were not sure whether power imbalances in sexual relationships between male and female adolescents can lead to unplanned pregnancy. A summary of the responses is shown in Figure 4.21 below.

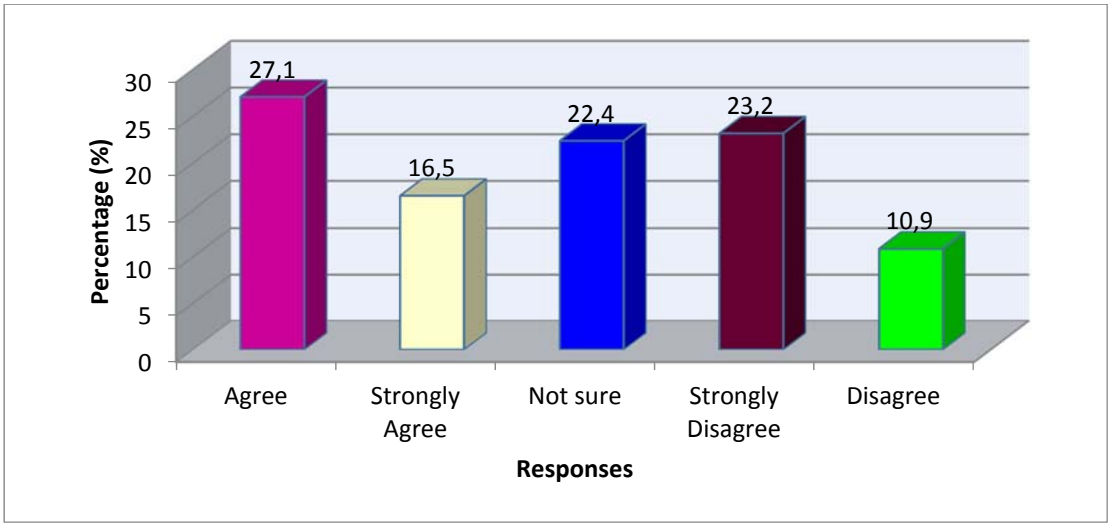

Figure 4. 21 Power imbalances in sexual relationships between male and female adolescents can lead to unplanned pregnancies (n=340)

4.3.6 Fear of visiting clinics can lead to unplanned pregnancies

The research showed that 122(35.9%) of the respondents disagreed while 177(52.0%) of the respondents agreed that fear of visiting clinics can lead to unplanned pregnancy. However, 41

(12.1%) of the respondents were not sure whether the fear of visiting the clinic can lead to unplanned pregnancyies. A summary of the responses is shown in Figure 4.22 below.

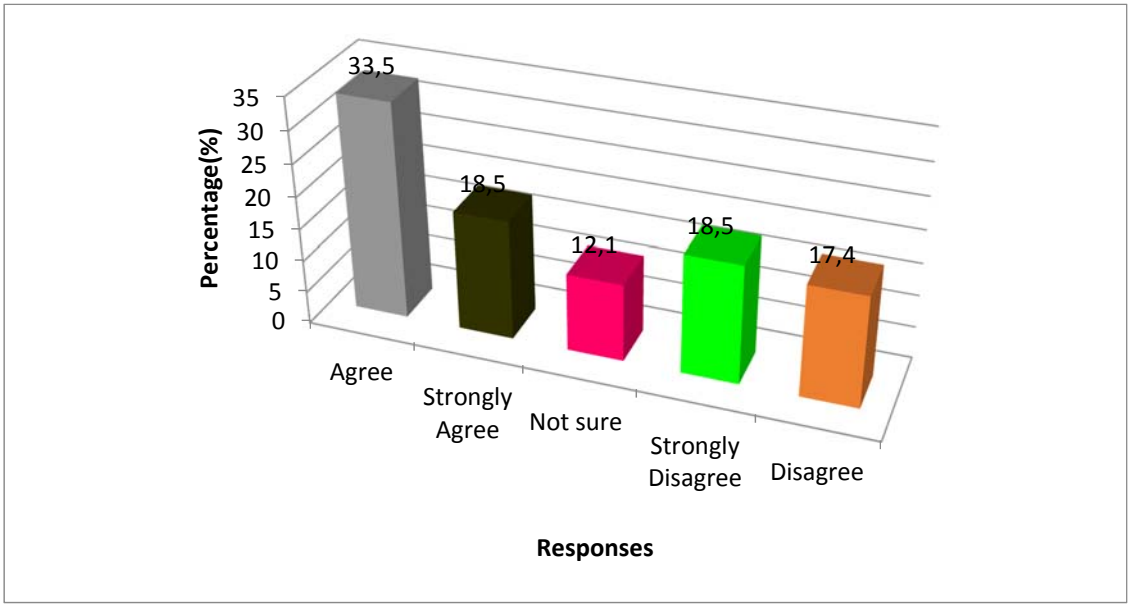

Figure 4. 22 Fear of visiting clinics can lead to unplanned pregnancy (n=340)

4.3.7 Desire to make boyfriends responsible or fear of losing them can lead to unplanned pregnancies.

Fear of losing boyfriends by asking them to take responsibility for contraception can lead to unplanned pregnancy.

The findings showed that 164(48.2%) of the respondents disagreed while 153(45.0%) of the respondents agreed that fear of losing boyfriends by asking them to take responsibility for contraception can lead to unplanned pregnancy.

However, 23 (6.8%) of the respondents were not sure whether fear of losing boyfriends by asking them to take responsibility for contraception can lead to unplanned pregnancy.

Figure 4.23 below shows a summary of the responses.

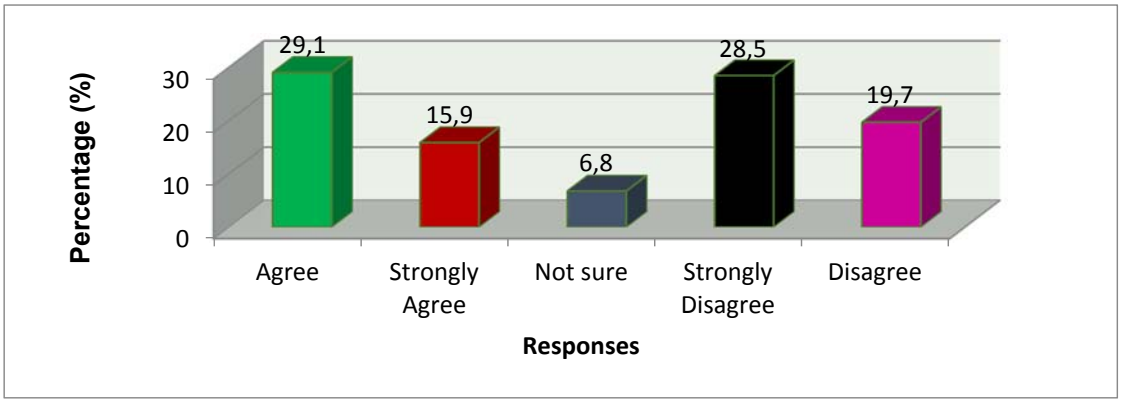

Figure 4. 23 One can fall pregnant because of desire to make boyfriend responsible or because of fear of losing him (n=340).

4.3.8 I fail to use contraceptives consistently

The findings showed that 174(51.2%) of the respondents disagreed while 122(35.9%) of the respondents agreed that they failed to use contraceptives consistently. However, 44 (12.9%) of the respondents were not sure whether they failed use contraceptives consistently. Figure 4.24 below depicts the responses.

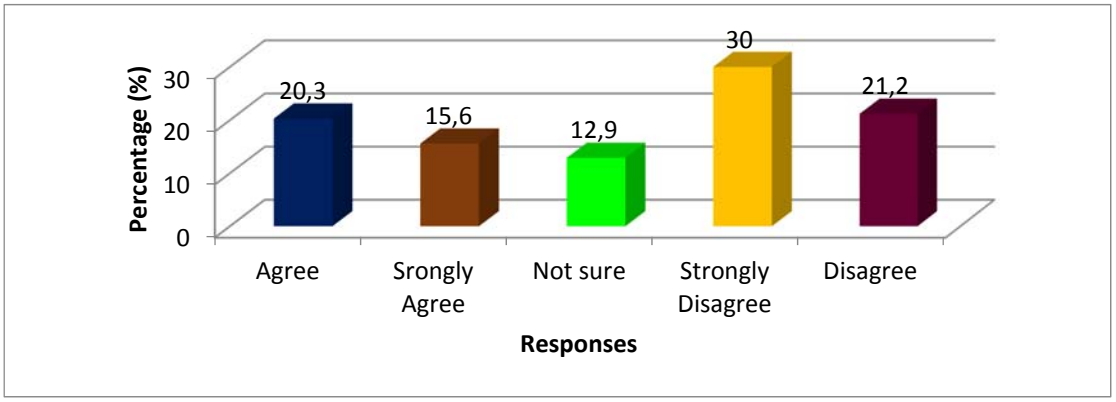

Figure 4. 24 Failure to use contraceptives consistently (n=340)

4.3.9 I am embarrassed to ask boyfriends to use condoms

The findings showed that 221(65.0%) of the respondents disagreed while 92(27.1%) of the respondents agreed that they were embarrassed to ask their boyfriends to use condoms. However, 27 (7.9%) of the respondents were not sure whether they were embarrassed to ask their boyfriends to use condoms. Figure 4.25 below depicts the responses.

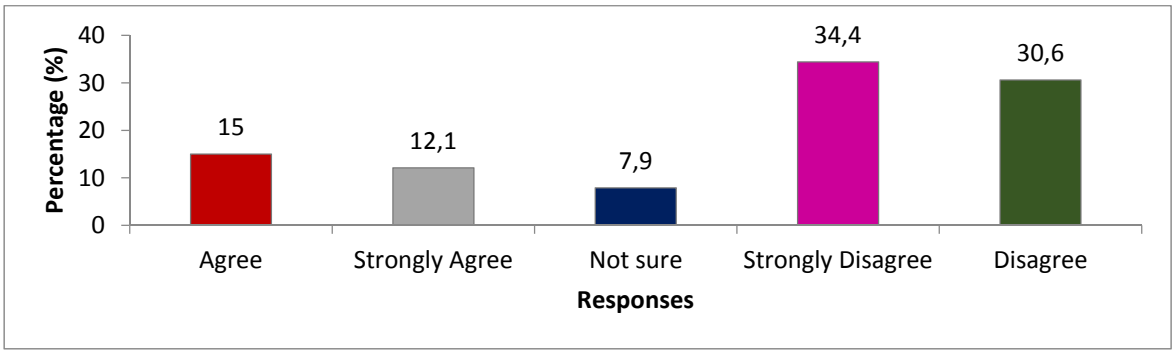

Figure 4. 25 Embarrassment to ask boyfriends to use condoms (n=340)

4.3.10 I am embarrassed that I do not have children while my friends do have children

The findings showed that 198(58.3%) of the respondents disagreed while 107(31.4%) of the respondents agreed that they felt embarrassed about not having children while their friends had children. However, 35 (10.3%) of the respondents were not sure whether they felt embarrassed about not having children while their friends had children. Figure 4.26 below depicts the

responses.

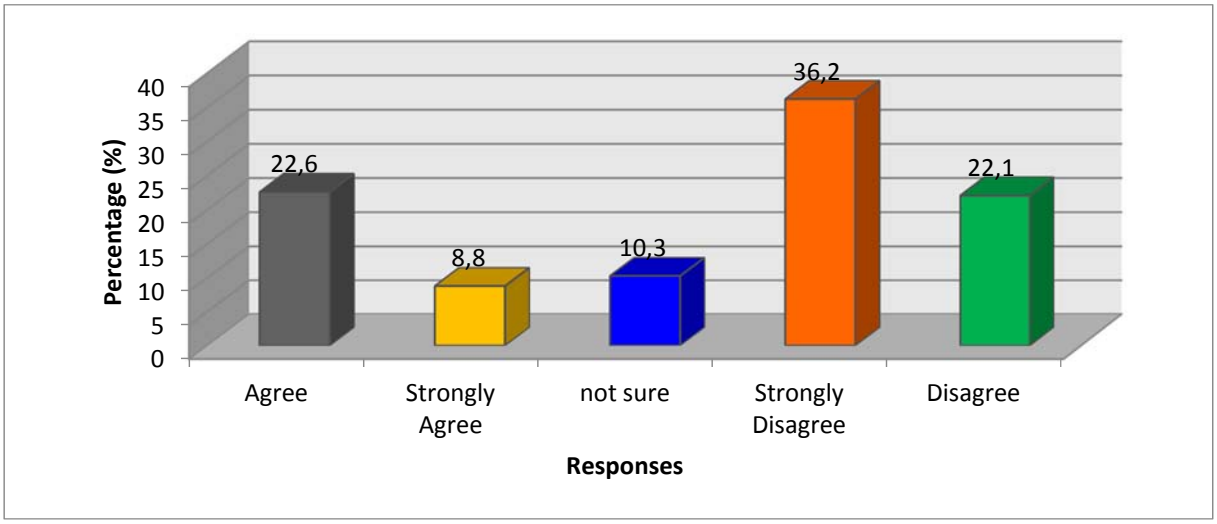

Figure 4. 26 Embarrassment about not having a child while friends had children (n=340).

4.4. PSYCHOLOGICAL FACTORS INFLUENCING THE INCIDENCE OF UNPLANNED PREGNANCY

This section was answered by all the respondents, whether they had children or not. The Likert scale was used to gain the responses categorised as: Agree, Strongly Agree, Disagree, and Strongly disagree.

4.4.1 Disregard for the consequences of sexual activities

The findings showed that 171(50.3%) of the respondents disagreed while 135(39.7%) of the respondents agreed that they disregarded the consequences of sexual activities. However, 34 (10.0%) of the respondents were not sure whether they dsregarded the consequences of sexual activities. Figure 4.27 below depicts the findings.

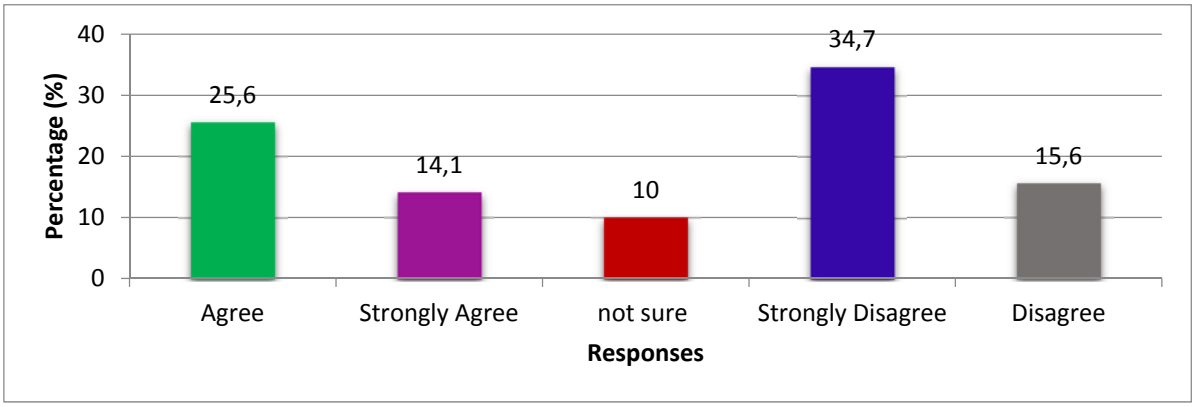

Figure 4. 27 Disregard for the consequences of sexual activities (n=340).

4.4.2 Falling pregnant to prove love for partners

The research showed that 225(66.2%) of the respondents disagreed while 82(24.1%) of the respondents agreed that they became pregnant to prove that they loved their partners. However, 33 (9.7%) of the respondents were not sure whether they became pregnant to prove that they loved their partners. Figure 4.28 below depicts the findings.

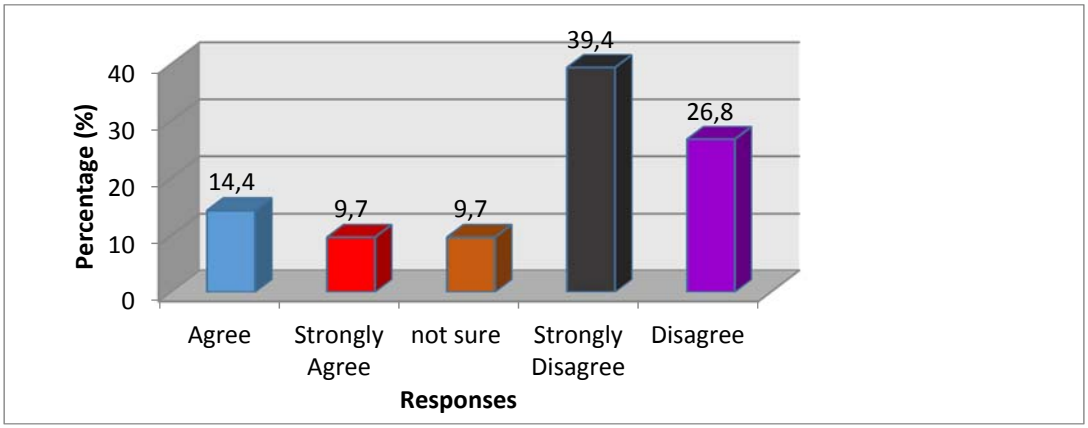

Figure 4. 28 Falling pregnant to prove love for partners (n=340).

4.4.3 Rebellion against parental or religious values

The findings showed that 171(50.3%) of the respondents disagreed while 90(26.5%) of the respondents agreed that they rebelled against parental or religious values. However, 79 (23.2%) of the respondents were not sure whether they rebelled against parental or religious values. Figure 4.29 depicts the findings.

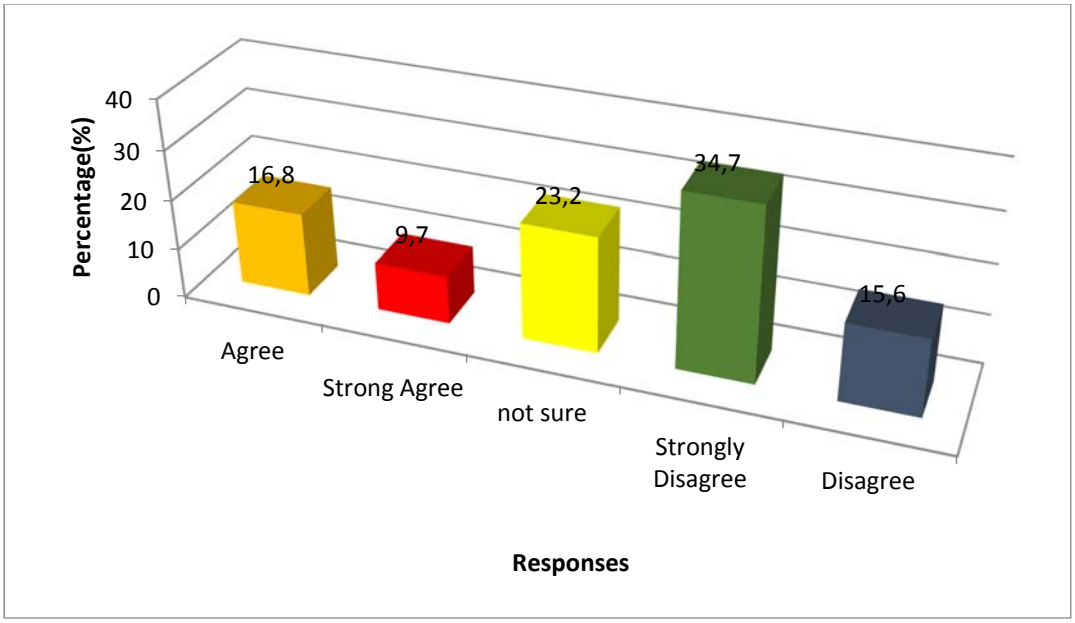

Figure 4. 29 Rebellion against parental or religious limits (n=340).

4.4.4 Seeking physical pleasure as an escape from loneliness

The research found that 172 (50.6%) of the respondents disagreed while 105(30.9%) of the respondents agreed that they sought physical pleasure as an escape from loneliness. However, 63 (18.5%) of the respondents were not sure whether they sought physical pleasure as an escape from loneliness. The findings are depicted in Figure 4.30 below.

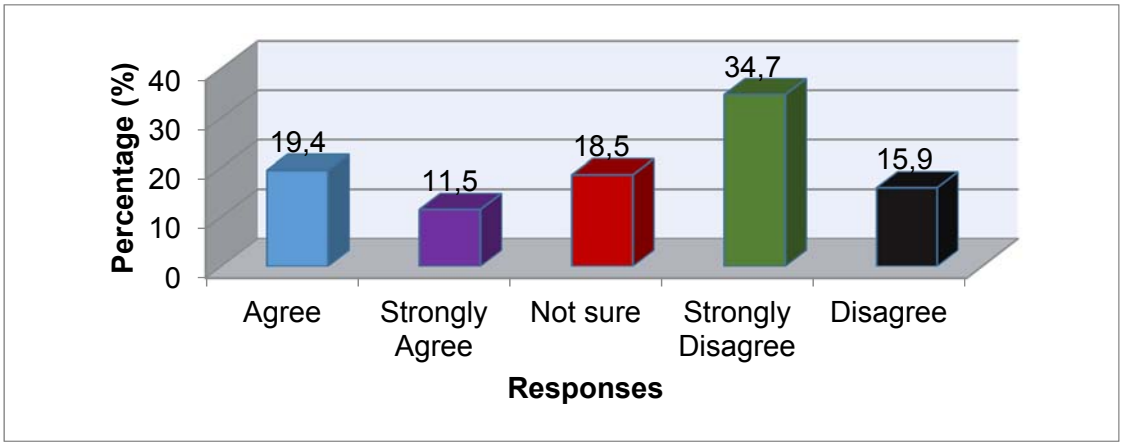

Figure 4. 30 Seeking physical pleasures as an escape from loneliness (n=340)

4.4.5 Losing virginity because of peer pressure

The findings showed that 174(51.1%) of the respondents disagreed while 127(37.3%) of the respondents agreed that they had lost their virginity because of peer pressure. However, 39 (11.5%) of the respondents were not sure whether they had lost their virginity because of peer pressure. The findings are shown in Figure 4.31 below.

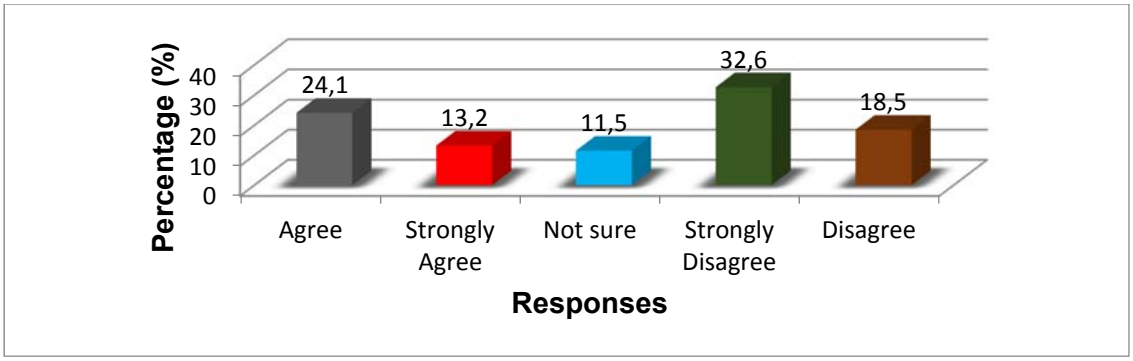

Figure 4. 31 Losing virginity because of peer pressure (n=340)

4.4.6 Pregnancy resulting from emotional deprivation and the need for motherhood

The findings showed that 63(60.5%) of the respondents disagreed while 24(23.0%) of the respondents agreed that they fell pregnant because they were emotionally deprived and needed to be mothers. However, 17(16.5%) of the respondents were not sure whether they fell pregnant because they were emotionally deprived and needed to be mothers. There was a non-response of 236(69.4%) of the overall respondents who did not repond because they did not have children. The findings are shown in Figure 4.32 below.

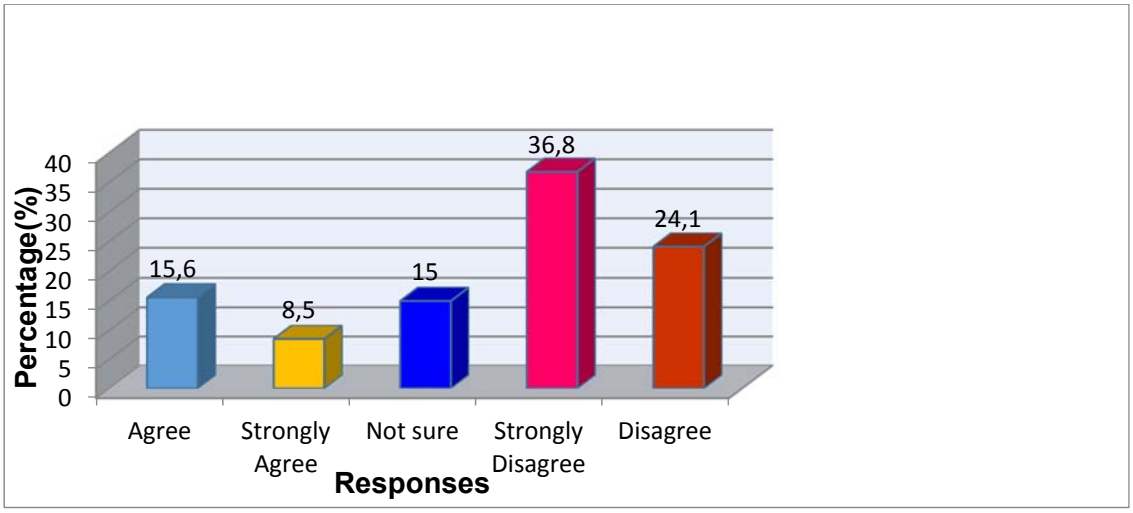

Figure 4. 32 Pregnancy resulting from emotional deprivation and the need for motherhood (n=104)

4.4.7 Information about sex gained from peers

The findings showed that 190(55.9%) of the respondents disagreed while 102(30.0%) of the respondents agreed that they had received information about sex from their peers. However, 48 (14.1%) of the respondents were not sure whether they had received information about sex from their peers. Figure 4.33 below shows the findings.

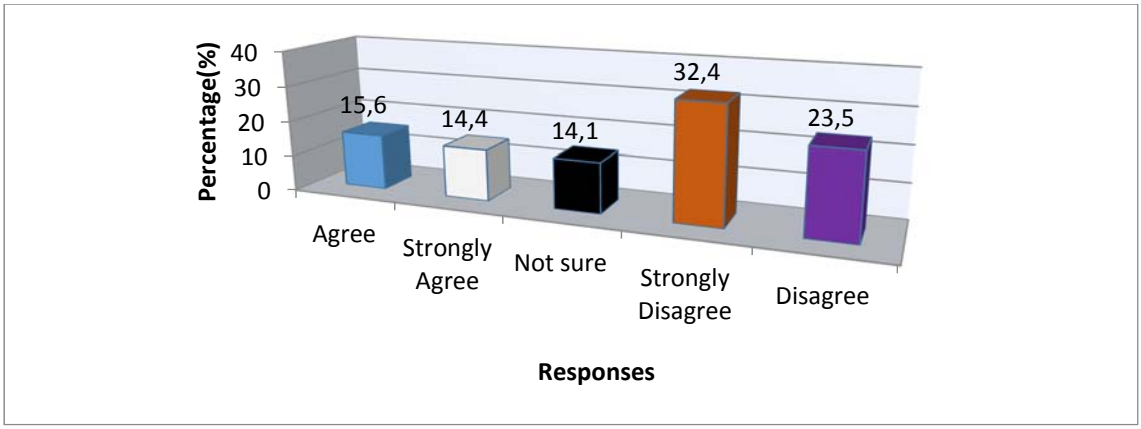

Figure 4. 33 Information about sex gained from peers (n=340)

4.4.8 Decision to fall pregnant because of rejection by peers for being childless

The findings showed that 78(75.1%) of the respondents disagreed while 13(12.5%) of the respondents agreed that they were depressed when their friends rejected them because they had no children and therefore they decided to fall pregnant. However, 13 (12.5%) of the respondents were not sure whether they were depressed when their friends rejected them for being childless and therefore decided to fall pregnant. There was a non-response of 236(69.4%) of the overall respondents who did not answer the question mentioned above because they did not have children. The findings are tabulated below.

Table 4. 5 Decision to fall pregnant because of rejection by peers for being childless (n=104)

Item	No. of responses	Percentage (%)
Agree	7	6.7%
Strongly Agree	6	5.7%
Not sure	13	12.5%
Strongly disagree	48	46.2%
Disagree	30	28.9%
Non-responses	236	69.4%
Total	**104**	**100%**

4.5. SOCIO-ECONOMIC FACTORS INFLUENCING UNPLANNED PREGNANCY

This presents the study findings regarding socio-economic factors influencing unplanned pregnancy. In this section, only 104 of the respondents were able to answer questions in this section because they had children. There was a non-response of 236(69.4%) because they did not have children. The Likert scale was combined to reflect the responses of the participants. The responses were combined and summarised.

4.5.1 falling pregnant will make my boyfriend to love me more.

The findings showed that 256 (75.3%) of the respondents disagreed while 52(15.3%) of the respondents agreed that falling pregnant would make their boyfriends love them more. However, 32 (9.4%) of the respondents were not sure whether falling pregnant would make their boyfriend love them more. The findings are shown in Table 4.6 below.

Table 4. 6 Falling pregnant to gain more love from boyfriends (n=340)

Item	No. of responses	Percentage (%)
Agree	34	10.0%
strongly agree	18	5.3%
Not sure	32	9.4%
Strongly Agree	168	49.4%
Disagree	88	25.9%
Total	**340**	**100%**

4.5.2 Falling pregnant to gain the child support grant

The findings showed that 75(72.1%) of the respondents disagreed while 19(18.7%) of the respondents agreed that they fell pregnant so that they could get the child support grant. However, 10(9.2%) of the respondents were not sure whether that they fell pregnant so that they could get the child support grant. The findings are shown in Table 4.7 below.

Table 4. 7 Falling pregnant to gain the child support grant (n=104)

Item	No. of responses	Percentage (%)
Agree	6	5.7%
Strongly Agree	13	12.7%
Not sure	10	9.6%
Strongly disagree	41	39.4%
Disagree	34	32.6%
Total	**104**	**100%**

4.5.3 Desire to have babies like all their friends

The findings showed that 84(80.7%) of the respondents disagreed while 17(16.5%) of the respondents agreed that all their friends had babies, and thus they wanted to have their own babies. However, 3(2.9%) of the respondents were not sure whether they wantd to have babies like all their friends. Table 4.8 below shows the findings.

Table 4. 8 Desire to have babies like all their friends (n=104)

Item	No. of responses	Percentage (%)
Agree	10	9.2%
Strongly Agree	7	7.2%
Not sure	3	2.9%
Strongly disagree	38	36.5%
Disagree	46	44.2%
Total	**104**	**100%**

4.5.4 Boyfriends promised marriage on condition of first having a baby

The findings showed that 81(77.8%) of the respondents disagreed while 22(21.3%) of the respondents agreed that their boyfriends promised to marry them on condition of first having a baby. However, 1(0.9%) of the respondents were not sure whether their boyfriends promised to marry them on condition of first having a baby. There was a non-response of 236(69.4%) from participants who did not have babies. Table 4.9 below shows the findings.

Table 4. 9 Boyfriends promised marriage on condition of first having a baby (n=340)

Item	No. of responses	Percentage (%)
Agree	18	17.4%
Strongly Agree	4	3.9%
Not sure	1	0.9%
Strongly disagree	50	48.0%
Disagree	31	29.8%
Total	**104**	**100%**

4.5.5 If boyfriends wanted a baby adolescents fell pregnant for fear of losing their partners.

The findings showed that 72(69.3%) of the respondents disagreed while 25(24.0%) of the respondents agreed that they became pregnant for fear of losing their boyfriends. However, 7 (6.7%) of the respondents were not sure about this. Figure 4.34 below depicts these findings.

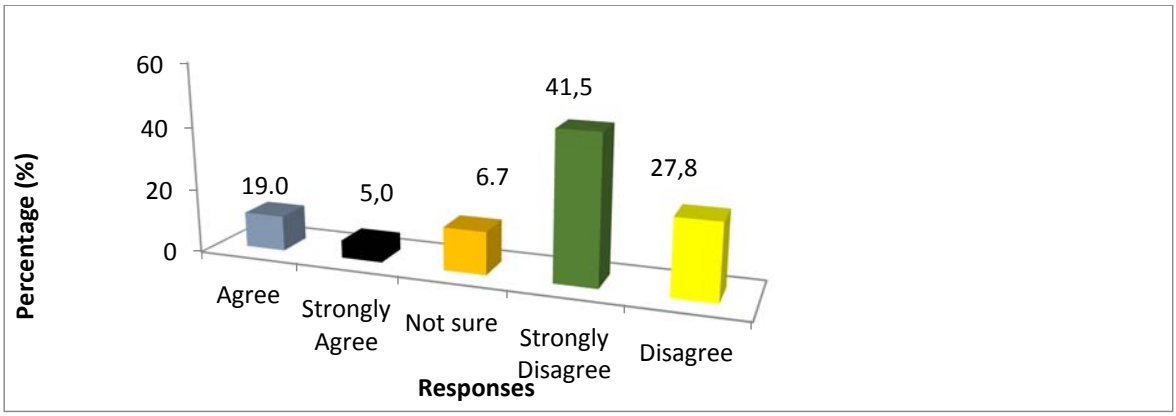

Figure 4. 34 Fear of being abandoned by boyfriends led to their agreeing to become pregnant. (n=104).

4.5.6 Desire to please boyfriends who purchase everything they desire.

The findings showed that 76(73.8%) of the respondents disagreed while 18(17.2%) of the respondents agreed that they fell pregnant to please their boyfriend because they buy everything they desire. However, 10(9.0%) of the respondents were not sure about this. Figure 4.35 below shows these findings.

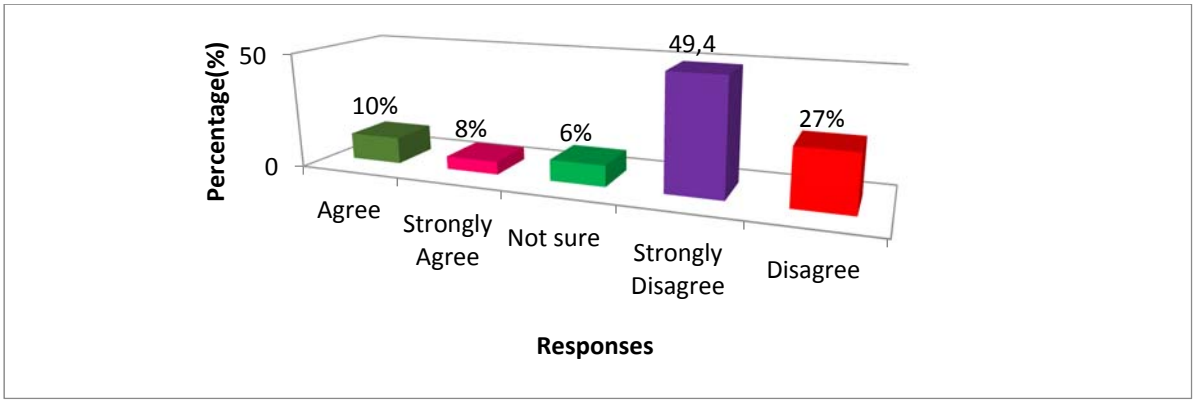

Figure 4. 35 Desire to please boyfriends who purchase everything they desire.(n=104).

4.5.7 Condoms are not always used during intercourse when under the influence of substances (e.g. alcohol)

The findings showed that 210(61.8%) of the respondents disagreed while 95(27.9%) of the respondents agreed that neither of the partners always use condoms during intercourse when under the influence of substances. However, 35(10.3%) of the respondents were not sure about this. Figure 4.36 below shows these findings.

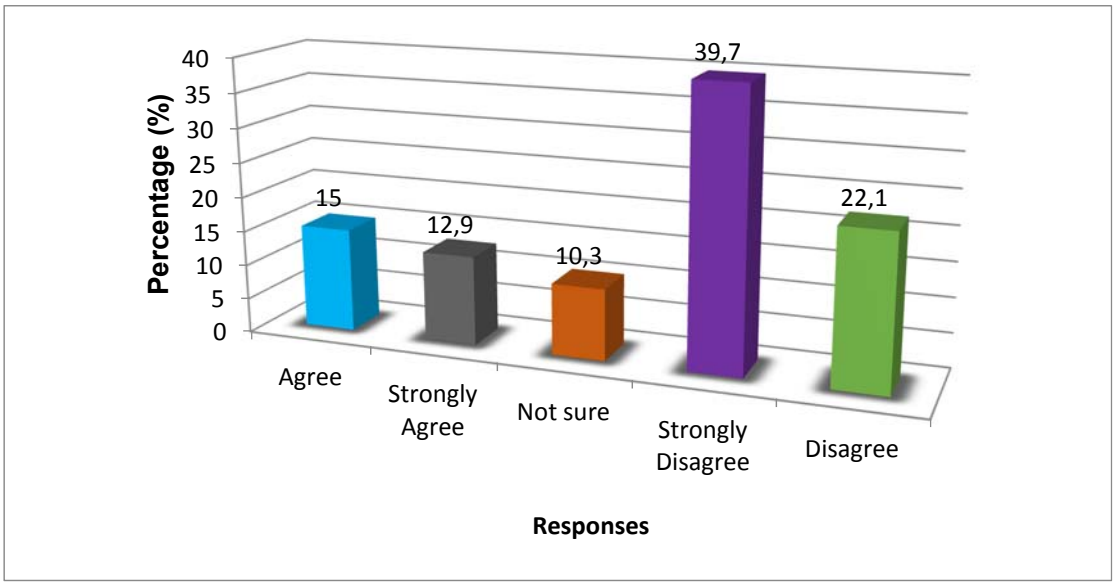

Figure 4. 36 Condoms are not regularly used by partners during intercourse when under the influence of substances (n=340)

4.5.8 Pregnancy to test fertility

The findings showed that 62(60.0%) of the respondents disagreed while 33 (31.7%) of the respondents agreed that they fell pregnant because they wanted to test whether they were fertile. However, 9(8.6%) of the respondents were not sure whether they fell pregnant because they wanted to test whether they were fertile**.** Figure 4.37 below shows these findings.

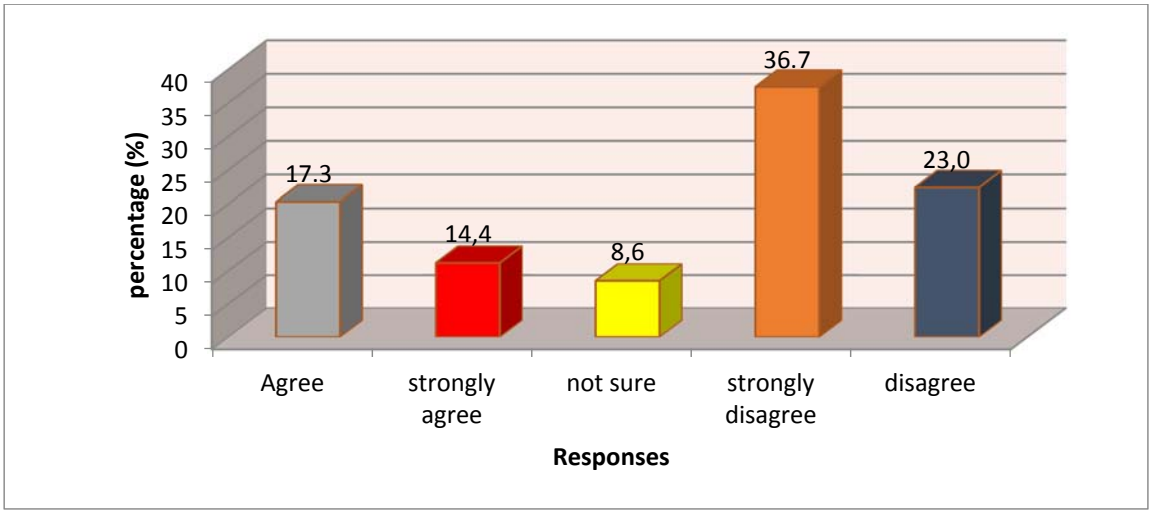

Figure 4. 37 Pregnancies to test fertility n=104)

4.5.9 Negative attitude towards contraceptive use

The findings showed that 193(56.7%) of the respondents disagreed while 86(25.4%) of the respondents agreed that they had bad attitudes towards contraceptive use. However, 61(17.9%) of the respondents were not sure whether they had bad attitudes towards contraceptive use. Figure 4.38 below depicts these findings.

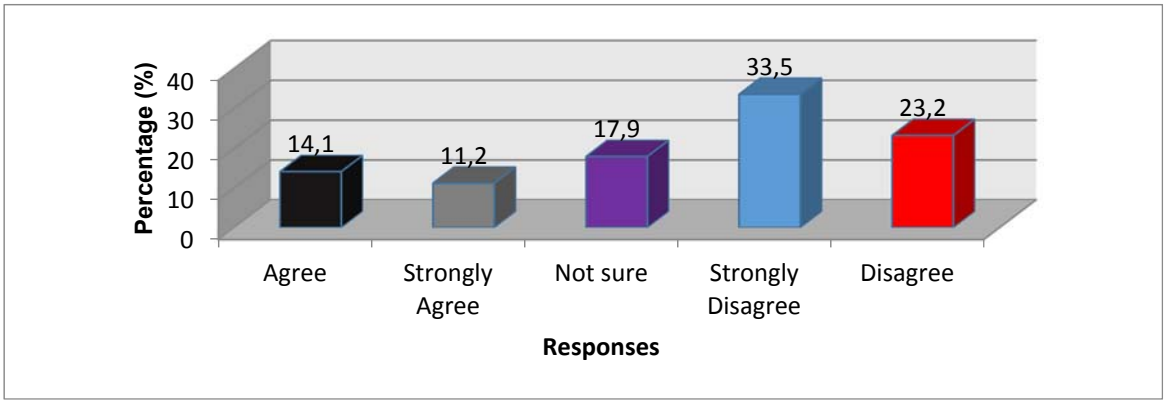

Figure 4. 38 Negative attitudes towards contraceptive use (n=340)

4.6 ASSOCIATION BETWEEN STUDY VARIABLES

Cross tabulation in the study was used in order to establish associations between some of the variables. This involved the application of the Chi-square/Pearson Exact Test of Associations. In this study, a 5% level (p=0.05) of significance was used as the scale for stating whether an association was statistically significant or not.

4.6.1 Association between demographic information and ignoring the use contraceptives

Table 4.10 below shows the association between demographic information and ignoring the use of contraceptives. A cross-tabulation was performed on a pair of variables (i.e. association between age group and ignoring to use contraceptives). From the table, the Pearson Chi-square

test of independence indicated that there was statistically significant difference in the age group and ignoring the use of contraceptives, χ^2 (12), (n=340) =23.958, *p*=0.021. It therefore, indicates that age groups were linked with the respondents ignoring the use of contraceptives. Therefore, Null hypothesis was rejected, which stated that there is no statistically difference between age groups and ignorance on the use of contraceptives.

A cross-tabulation of a pair of variables (i.e. association between school grade and ignoring the t the use of contraceptives). From the table, the Pearson Chi-square Test of Independence indicated that there were statistically significant difference between the school grade and ignoring the use of contraceptives, χ^2 (16), (n=340) =39.385, *p*=0.001. This indicates that school grades were linked with ignoring the use of contraceptives. Therefore, Null hypothesis was rejected which stated that there is no statistically difference between school grades and ignorance on the use of contraceptives.

A cross-tabulation was made of the association between religion and ignoring to the use of contraceptives. From the table, the Pearson Chi-square test of independence indicated that there was no statistically significant difference in religion and ignoring the use of contraceptives, χ^2 (12), (n=340) =18.739, *p*=0.095. This indicates there is association between respondents' religion and ignoring the use of contraceptives. Therefore, Alternative hypothesis is accepted which stated that there is difference between religion and ignoring the use of contraceptives.

Table 4. 10 below shows the association between the demographic information and ignoring the use of contraceptives (n=340).

	Ignoring the use of contraceptives					**Test statistics**	
Demographic information	**Agree**	**Strongly agree**	**Not sure**	**Strongly disagree**	**Disagree**	**Total**	**P-value Pearson chi-square**
Age							
10-15	11(15.9%)	9(16.9%)	9(20.4%)	27(26.4%)	10(14.0%)	66	PCT=23.958
16-20	43(62.3%)	34(64.1%)	34(77.2%)	53(51.9%)	55(76.3%)	219	Df=12
21-25	15(21.7%)	10(18.8%)	10(2.2%)	20(19.6%)	7(9.7%)	53	*P*=0.021
26 and above	0(0%)	0(0%)	0(0%)	2(1.9%)	0(0.0%)	2	
Total	**69**	**53**	**44**	**102**	**72**	**340**	
Grade							
Grade 8	9(13.0%)	7(1.3%)	8(18.1%)	16(15.6%)	7(9.7%)	47	PCT=39.385

Grade 9	11(15.9%)	5(9.4%)	4(9.0%)	18(17.6%)	12(11.7%)	50	Df=16
Grade 10	14(20.2%)	11(20.7%)	10(22.7%)	15(14.7%)	12(11.7%)	62	*P*=0.001
Grade 11	16(23.1%)	14(26.4%)	13(29.5%)	45(44.1%)	12(11.7%)	100	
Grade 12	19(27.5%)	16(30.1%)	9(20.4%)	8(18.1%)	29(28.4%)	81	
Total	**69**	**53**	**44**	**102**	**72**	**340**	
Religion							
Christianity	58(84.0%)	45(84.9%)	40(90.9%)	86(84.3%)	52(72.2%)	281	PCT=18.739
Traditional	9(13.0%)	2(3.7%)	1(2.2%)	7(6.8%)	10(13.8%)	29	Df=12
ZCC	1(1.4%)	5(9.4%)	2(4.5%)	8(7.8%)	10(13.8%)	26	*P*=0.095
Other	1(1.4%)	1(1.8%)	1(2.2%)	1(0.9%)	0(0%)	4	
Total	**69**	**53**	**44**	**102**	**72**	**340**	

4.6.2 Association between the choice of contraceptive by partners and the need for more information on contraceptive methods and their use, as discussed by partners

A cross-tabulation of the association between the the choice of contraceptives and the need for more information about contraceptive methods and their use when discussed by partners. From the table, the Pearson Chi-square test of independence indicated that there was statistically significant difference between these variables, χ^2 (2), (n=340) =7.988, *p*=0.005. There is association between the the choice of contraceptives and the need for more information about contraceptive methods and their use when discussed by partners. Null hypothesis is rejected which stated that there is no association between the the choice of contraceptives and the need for more information about contraceptive methods and their use when discussed by partners.Table 4.11 below depicts this finding.

Table 4. 11 Association between the choice of contraceptive and the need for more information on contraceptive methods and their use as discussed by partners (n=340)

Do you discuss with your boyfriend the choice of contraceptive?	**Do you think there is a need for more information on contraceptive methods and their use?**		**Test statistics**	
	Yes	**No**	**Total**	**P-value Pearson chi-square**
				PCT=7.988
Yes	117(56.6%)	46(37.7%)	163	Df=2
No	101(46.3%)	76(62.25)	177	*P*=0.005
Total	**218**	**122**	**340**	

4.6.3. Association between the use of any type of contraceptives and fear of visiting clinics leading to unplanned pregnancies

A cross-tabulation was made of the association between the use of contraceptives and the fear of visiting the clinic leading to unplanned pregnancy. From the table, the Pearson Chi-square Test of Independence indicated that there was statistically significant difference between the use of contraceptives and the fear of visiting clinics leading to unplanned pregnancy, χ^2 (4), (n=104) =1.365, *p*=0.033.therefore, Null hypothesis is rejected which stated that there is no association between the use of contraceptives and the fear of visiting the clinic leading to unplanned pregnancy Table 4.12 depicts this finding.

Table 4. 12 The association between the use of any type of contraceptives and fear of visiting clinics leading to unplanned pregnancies (n=340)

Have you ever used any type of contraceptives?	**Fear of visiting clinics leading to unplanned pregnancies**					**Test statistics**	
	Agree	**Strongly agree**	**Not sure**	**Strongly Disagree**	**Disagree**	**Total**	**P-value Pearson chi-square**
							PCT=10.459
Yes	14(40.0%)	7(43.75%)	4(26.7%)	7(33.3%)	7(41.2%)	39	Df=4
No	21(60.0%)	9(56.25%)	11(73.3%)	14(66.7%)	10(58.8%)	65	*P*=0.033
Total	**35**	**16**	**15**	**21**	**17**	**104**	

4.7 DISCUSSION OF THE FINDINGS

4.7.1. Demographic information

In this study, age and being single were significantly associated with unplanned pregnancies. A study conducted by Bradley, Croft and Rutstein (2011) reported that female adolescents aged 15-20 years were more likely to have unplanned pregnancies and 80% were single female adolescents with the P value of 0.039. Mbizvo, Kasule, Bonduelle and Chadzuka (2014) found that singles in Zimbabwe were more likely than their married counterparts to report unplanned pregnancies.

This could be because singles may not be in stable relationships, and single parenthood is not acceptable. The same trend was reported in an Ethiopian study which showed that for currently unmarried adolescents the chances of having an unplanned pregnancy was high with OR 1.7 95% CI 1.2, 2 (Solomon & Mesganaw, 2015). This coincides with the findings of Yakubu and Salisu (2018) that revealed that 78 % of singles were more likely to have an unplanned pregnancy compared with their married counterparts with the P value of 0.001.

In this study, school grades were not significantly associated with unplanned pregnancy. In contrast with other studies, this study showed that there was no significant correlation between the level of education and the proportion of unplanned pregnancyes, Khanal, Adhikari, Sauer, Zhao, Egata, Berhane and Heyman (2013) from their study revealed that the level of education plays a big part in determining the rate of unplanned pregnancy. A study conducted in Kenya showed that adolescents with at least a secondary education had had their first sexual intercourse delayed by at least three years (Advocate for youths, 2015). This plays a big part in the reduction of the rate of unplanned pregnancy among adolescents.

In this study, living with their mothers was not significantly associated with unplanned pregnancy. It was further noted that the respondents who had children could be associated with unplanned pregnancy. Similar findings were reported by Khanal, Adhikari, Sauer, Zhao, Egata, Berhane and Heyman (2013) that 39% of adolescents with one child had a higher rate of unplanned pregnancy compared with to their counterparts, and the association is statistically significant. The p-value is 0.001. A study by Devine (2011) revealed that adolescents who fall pregnant with their first child have no clear idea about having children and have multiple sexual partners.

In this study religion was not found to be associated with unplanned pregnancy. A study by Enhlers (2008) revealed that adolescents who follow the teachings of their pastors avoid engaging in immoral sexual activities. They respect their bodies according to the teachings of their faith and follow the teachings of their church with regard to unplanned pregnancy (Maly, Katherine, McClendon, Baumgartner, Nakyanjo, Ddaaki, Serwadda, Nalugoda, Wawer, Bonnevie, & Wagman, 2017).

Furthermore, it was reported by Farber (2014) that adolescents were disturbed when girls who played leading roles in the church become pregnant. Adolescent girls are expected to be more proactive in showing good examples to their peers. Churches should organise seminars where guidance and counselling is provided. Pastors and church members should be concerned if a church has many incidents of unplanned pregnancy among its members because it portrays a bad image (Matheka, 2012).

4.7.2 Knowledge of learners about contraceptives (family planning)

4.7.2.1 Discussion about the choice of contraceptives

According to the findings the majority (52.1%) of the respondents revealed that they had not discussed the choice of contraceptives with their boyfriends and this was associated with unplanned pregnancy. A study conducted in India by Patra and Singh (2013) concur with the findings that the status and dynamic of couples' relationships played role in adolescents' decision about contraceptives. These findings could be significant as young adults are at great risk for contracting STIs and adolescent women have the highest rates of unplanned pregnancy. Patra and Singh (2013) further report that adolescents who had a strong role in the sexual decision-making in relationships were more likely to use condoms, or long-acting methods of birth control. A study conducted in Egypt by Sutay (2010) revealed related factors influencing these contraception choices included the respondents' perceived vulnerability to pregnancy and STIs.

4.7.2.2 Favouring workshops about contraceptives

In this study, favouring workshops about contraceptives for men and women together was significantly associated with the chances of reducing unplanned pregnancies. Similar findings were reported by Oindo (2012), Akella and Jordan (2015), who found that the involvement of males in family planning education improved their attitudes and increased the chances of their girlfriend to use contraceptives.

However, the primary concern is that men are often excluded from these workshops, and yet they are reported not to be in favour of contraception (Masemola-Yende & Mataboge, 2015). It is possible that men do not know the benefits of their partners using contraceptives or they have misconceptions about the perceived disadvantages of using contraceptives (Mataboge, Beukes & Nolte, 2014). A study conducted at Nigeria by Ogori (2013) reported that if men were included in workshops about contraceptives they would be ready to face the challenges of parenting children, and would plan when to start a family with their partners.

4.7.2.3 Boyfriends who favour the use of contraceptives

In this study, where boyfriends favour the the use of contraceptives this could be associated with the reduction of unplanned pregnancy. Similar study findings revealed that adolescents who often use contraceptives prevent diseases including HIV/AIDS, STIs, and avoid unplanned pregnancy (Karandashev, Benton, Edwards & Wolters, 2015). A study by Were (2007) found that though the use of contraceptives among adolescents had a positive effect, only a small proportion of them were using modern methods but that the supply, quality and availability of contraceptives was low.

4.7.2.4 The need for more information on contraceptives methods and their use

In this study, the need for more information on contraceptive methods and their use were significantly associated with the reduction of unplanned pregnancy. The majority of adolescents do not have information about contraceptives (Dulitha, Nalika, Upul & De Silva, 2014). If this knowledge could be passed to them, the problem of unplanned pregnancy would be reduced because they would be aware of the different methods of contraception. Monica, 2008).

4.7.2.5 Sources of information about contraceptives

In this study, information from the health facilities was associated with reduction of unplanned pregnancy. On the contrary, some revealed that they were concerned that the information they received from their family, school and church might be misinformation which could cause the problem of unwanted pregnancies (Aurora, 2012).

A study by Stephen (2014) found that for those who received information from the media, the problem with these media messages is that they are brief and usually do not expand more on pertinent issues surrounding reproductive health. There is also a lack of interaction with populations and communities so that if adolescents fail to understand that what has been said they do not have the opportunity to ask questions. These will lead to them to using contraceptives incorrectly resulting in unplanned pregnancy. It would be of importance if television advertisements were run by health care workers because they would receive queries and questions on air; but seeing that media is expensive this platform cannot be sustained. The media is also cited in Ramathuba, Khoza, and Netshikweta (2012) as the preferred means of information for adolescents.

Akina (2012) commented on this by saying that most of the adolescents derive different information on family planning and contraceptive use from different people especially their peers other than health professionals which is inadequate and could lead to unplanned pregnancies.

4.7.2.6 Respondents' knowledge on the use of various types of contraceptives

In this study, the use of any type of contraceptives was significantly associated with the reduction of unplanned pregnancy. These findings are contrary to the findings of Were (2007) who stated that though the use of contraceptives among adolescents was found to have a positive effect, only a small proportion of them were using modern methods and their supply, quality and availability was low. Hence, community health workers are given condoms to distribute through the community.

Furthermore, it was reported that access to contraceptive services is very important because when they lacked them, then the risks of unplanned pregnancy increases (Winters & Winters, 2012). Moreover, it was found that the responses here varied because the distance could be a

barrier, as other respondents live far from health facilities that are in place, so they could not obtain contraceptive services from the health facilities. The findings further indicated that most adolescents lack information on the use of contraceptives. Many health facilities do not offer education to the adolescents who visit the health facilities. If the knowledge could be passed to them, then the problem of unplanned pregnancy would be reduced (Monica, 2008)

4.7.2.7 Instruction on the usage of contraceptives

In this study, compliance with instructions on the use of contraceptive methods were not significantly associated with unplanned pregnancy. These findings support individual preferences on the method of contraceptive according to their choice. (Kendig, 2014).

Similar study findings indicate that the majority of the respondents thought of condoms, pills and injections to be the best because they required little knowledge on how to use them. Opeyemi (2010) states the contrary finding that the natural method and condom use could be the best alternative because others like pills, injections, IUCD and implants are more complicated and need much supervision, they may have negative results like irregular menstrual flow when using injections, and weight loss or weight gain, especially when using pills, and other methods.

4.7.2.8 Abstaining from sexual activities

In this study, abstaining from sexual activities could help to prevent unplanned pregnancy and it was not significantly associated with unplanned pregnancy. Similar study findings reported by Dryburgh (2016) stated that abstinence from sexual activities is the only form of unplanned pregnancy prevention that is almost a hundred percent of effective. A study conducted in Tanzania by Makundi (2010) argue that every method of contraception has a risk of failure, however small, but an adolescent who practises abstinence will noy become pregnant.

4.7.2.9 Introduction of sex education

In this study, the introduction of sex education was significantly associated with the reduction of unplanned pregnancy. Compulsory sex education can help to empower adolescents, which is the most effective strategy to prepare them for marriage, planned and delayed pregnancy and better motherhood (Malahlela, 2012).

4.7.2.10 The supply of contraceptives at clinics and schools

In this study, the supply of contraceptives at clinics and schools was significantly associated with the reduction of unplanned pregnancy. A school linked with a clinic can either be available on school premises or located close to the school or a number of schools (Primary Health Care (PHC) report, 2013).

Adolescents should have access to reliable information and services concerning their reproductive health and contraceptives. Health clinics must provide information on contraception and pre-and postnatal care. Adolescents must be knowledgeable about methods of contraception. Various contraceptive methods are available and new ones become available as a result of medical research. Choice and information serve as the cornerstones of adolescent health and their reproductive rights (Stephen, 2014).

Providing contraceptives together with information through school-linked health clinics may prevent adolescent unplanned pregnancy. When information about sexuality issues is available from professionals at school-linked health clinics, the onset or frequency of sex decreases (Ross, 2015). Adolescent girls also feel freer to consult clinics about contraceptives and obtain these from the clinic. Evidence from the United States and United Kingdom about the effectiveness of school-linked health clinics in decreasing adolescent unplanned pregnancies is mixed and often weak (Sapin, 2009). However, studies done in developing countries, such as Nigeria and Chile, reported an increase in condom use and a decrease in adolescent pregnancy as well as sexually transmitted diseases (Panday et al., 2009).

4.7.2.11 Teaching religious and moral values

In this study, teaching religious and moral values was significantly associated with the reduction of unplanned pregnancy. Adolescents who are more religious hold more conservative views regarding sexual activities (Whitehead, Wilcox, Rostosky, Randall & Wright, 2012). However, attitudes and expectations typically are only moderately predictive of future behaviour. Terry and Manlove (2015) reported that adolescent pregnancy is the result of a combination of things such as the ignorance of the church, school, parents and the community. God knows our destiny and wants us to live in harmony with each other. The reason why teachers and pastors avoidbreaking the silence is that they do not want to engage with the challenge of unplanned pregnancy (Dudley & Roozen, 2011).

4.7.2.12 Program linked with contraceptives services

In this study, it was found that programs linked with contraceptive services were significantly associated with the reduction of unplanned pregnancy. According to a White Paper on Basic Education in South Africa, the life orientation communication program in schools should include sex education as early as primary school. What is not clear is what information should be given to learners and to what extent, in terms of depth cited by (Ramathuba, Khoza, and Netshikweta, 2012).

The findings of the study by Ikamari, Izugbara and Ochako (2013) revealed that health professionals must be involved in the design of the school curriculum on sex education and also in teaching learners about reproductive health in schools. The findings of the study by Nkhumo

(2015) revealed that involvement of health professionals in the school curriculum should have more depth and clarity so that learners could be persuaded to use contraceptives to curb the high rate of unplanned pregnancy.

4.7.2.13 Parental education and support

In this study, parental education and support were not significantly associated with unplanned pregnancy. The findings revealed that they expressed the opinion that contraceptives should be made available freely and without parental knowledge or consent (Wood &Hendricks, 2017). It seemed that parents hesitated to make sex education and contraceptives available to their adolescents out of fear that adolescents would interpret this as permission to engage in sexual activities (WHO, 2014). Okonofua (2015) emphasises that parents thought it improper to discuss sexual matters with their children. In the study by Okanofua (2015) adolescents revealed that they were not receiving sex education from their parents. The feelings of adolescents were that parents wished their children to complete their school education before engaging in sexual activities. *"My mother told me to finish school first and not rush to do things meant for adults; my time will also come (Setiloane, 2014).*

4.7.2.14 Social support and parenting

In this study, social support and parenting were not significantly associated with unplanned pregnancy. A study conducted by Opeyemi (2010) concurs with the study findings that social and parental education could play a significant role in developing self-confidence, the increasing age of first sexual intercourse and delaying marriage.

4.7.3 Personal factors contributing to unplanned pregnancy

4.7.3.1 Lack of self-confidence about sexual activities

In this study, lack of self-confidence in decisions about sexual activities was not significantly associated with unplanned pregnancy. Sedgh, Singh and Hussain (2014) found that in the United States lack of self-confidence was not significantly associated with unplanned pregnancy or sexual activity. The study conducted by Miller, Barber and Gatny (2015) revealed that adolescents who had engaged in sexual activities and had more liberal attitudes toward premarital sex had greater self-confidence than those who engaged in sex and had more conservative attitudes.

4.7.3.2 Fear of losing boyfriends

In this study, fear of losing their boyfriends when they ask them to use contraceptives was not significantly associated with unplanned pregnancy. Based on the research findings, adolescent mothers and pregnant adolescents fell pregnant because of the pressure from their boyfriends, and it was hard for the adolescents to say no to sexual intercourse (Marino, Skinner, Doherty,

Rosenthal, Cooper Robbins & Cannon, 2013). The findings indicate that many female adolescents lacked power in their relationships. Males are likely to pressure them into unplanned pregnancy or unprotected sexual relations (Yadufashije, Bahati & Samuel, 2017). Lambani (2015) reported that a lack of decision-making autonomy within relationships constrained adolescent girls' ability to practise safe sex. A study conducted in Nigeria by Taiwo (2012) found that adolescents do not know what contraceptives were in most instances. Females are afraid to negotiate using condoms during sexual activity, because they feared that their boyfriends would leave them.

4.7.3.3 Early menarche increases the risk of pregnancy

In this study, early menarche increases the risk of pregnancy and is associated with unplanned pregnancy. One study revealed that the onset of menarche in most countries has largely decreased and seems to have stabilised at an average of 13 years with 0.5 years' variations between countries (Medical Research Council, 2009). A study conducted by Buga, Amoko and Ncayiyana (2006) indicates that the age of menarche is decreasing in both urban and rural black females.

Marteleto, Lam and Ranchhod (2008) reported that early sexual intercourse is defined as having had sexual intercourse before 15 years of age and can be associated with early menarche. Early sexual initiation could have negative effects on adolescent girls' health owing to their inabilitiy to deal with the consequences of such sexual activities (Phillips & Mbizvo, 2016). Research studies have shown that sexual activities at an adolescent age was related to lesser use of contraceptives methods and an increase in sexually transmitted diseases and unplanned pregnancy (Bezuidenhout & Joubert, 2009).

4.7.3.5 Having a baby to become independent

In order to prove their independence adolescent girls engaged in irresponsible sexual activities because they see parenthood as being mature and independent (Miller et al., 2015). Adolescents often want to be independent before they are ready for it or are allowed early independence by non-caring parents (Geda & Lako, 2012). The contrary study reports that adolescents who participate in one form of risky behaviour often partake in other risky behaviour such as alcohol and drug use which increases the chances of unprotected sexual intercourse (Yadufashije et al., 2017).

4.7.3.6 Power imbalance in sexual relationships

In this study, power imbalances in sexual relationships between male and female were significantly associated with unplanned pregnancy. The research revealed that the social construction of gender has been an important focus of related studies (Hoque, Towobola,

Mashamba & Monokoane, 2014: Silk & Romero, 2014: Ray, Mondal, Samanta, Hazra, Sabui, Debnath, Chatterjee, Mukhopadhayay, & Sil, 2016).

The findings of other studies suggest that although female adolescents view themselves as having equal responsibility as males to engage in protected sexual behaviour, gender inequality is perpetuated by subtle power processes (Johnstone, 2013). Similar findings were reported by Ikamari et al. (2013) that adolescents who have greater sexual relationship power will get their way in terms of condom use, and adolescent men seem to have greater sexual relationship power than adolescent girls. Furthermore, decision-making power is not as important as sexual relationship power in determining condom use among adolescents, because the degree of decision-making power is supported by the degree of sexual relationship power (Sekharan, Kim, Oulman & Tamim, 2015; Wood & Hendricks, 2017). Furthermore, it was revealed that adolescents were involved in an asymmetrical sexual relationship power, and females have greater difficulty in taking control over decision-making in condom use negotiations.

4.7.3.7 Fear of visiting the clinic

In this study, fear of visiting the clinic was significantly associated with unplanned pregnancy. Similar findings by Nkhumo (2015) found that 79.2% of adolescents were reluctant to visit clinics for contraceptives. The findings of the study conducted by Najafian, Karami, Cheraghi and Jafari (2010) further revealed that the adolescent concern is that they cannot go to a family planning clinic because they may come across their relatives who might tell their parents that they were at the clinic.

According to Suan, Ismail and Ghazali (2015) adolescents are often too shy to visit an adult family planning clinic. Often contraceptives are provided, while sex education is neglected, because of the heavy workload of the health professionals. According to McCalman, Heyeres, Campbell, Bainbridge, Chamberlain, Strobel and Ruben (2017) adolescents are afraid to make use of family planning services, are dissatisfied with the quality of communication at clinics, and perceive the staff as being unapproachable. They want health care providers to be approachable, friendly and caring.

4.7.3.8 Desire to make boyfriends responsible

In this study, falling pregnant because of the desire to make their boyfriends responsible or because of fear of losing them were not significantly associated with unplanned pregnancy. A similar finding indicates that adolescent girls who went out with older working men saw this relationship as a source of income and support (Sayem & Nury, 2011). If this relationship included a child, they believed that the likelihood of ongoing support was increased. These findings concur with the findings of Jewkes et al. (2014) who reported that sometimes this relationship would provide income for the broader family, but sometimes it only benefited the

adolescent. Contrary findings indicate that adolescents who have unprotected sex can strongly influence their behaviour (Randolf, Pinkerton, Borgat, Cecil & Abramson, 2014).

4.7.3.9 Ignoring the use of contraceptives

In this study, ignoring to the use contraceptives was not significantly associated with unplanned pregnancy. The result shows similar findings by Willan (2013) who reported that the majority of female adolescents do not use any contraceptives and they can easily be infected with HIV and AIDS and other related diseases. Kamini and Avvaru (2014) argued that female learners who are sexually active were more likely to use no contraceptives, which puts them at a high risk of unplanned pregnancy. Some are influenced by their boyfriends regarding birth control or they forget to use contraceptives. Nessa, Zebunnesa, Bari and Saleh (2014) in a study in Kenya found that ignorance also leads to myths such as the belief that the use of contraceptives may cause infertility, and will make them gain too much weight.

4.7.3.10 Feeling ashamed to ask boyfriends to use contraceptives

In this study, feeling ashamed to ask boyfriends to use condoms was not significantly associated with unplanned pregnancy. In the study conducted by Stover and Ross (2010), it was foung that adolescent girls are sometimes in a difficult position because they feel that they have to please their boyfriends to maintain the relationship, which may imply having unprotected sex if requested to do so. On the contrary it was found that peers who have unprotected sex can strongly influence adolescent behaviour (Randolf et al., 2014).

4.7.3.12 Feeling embarrassed about not having a child

In this study, feelings of embarrassment about not having a child while all their friends had children was not significantly associated with unplanned pregnancy. The significant challenges appear to be with peer groups, adolescent mothers are stigmatized and discriminated against by peers who do not have children (Anand & Lissa, 2013). A study by Izugbara (2015) found that adolescent girls may become pregnant because of peer pressure. Peers on the other hand do not support adolescent mothers at school. The negative attitudes of adolescents contribute a lot to adolescents who want to identify with their peers that have children. Overall, young mothers lack support from peers because of the stigma attached to teen motherhood and the discrimination against them.

4.7.4. Psychological factors that influence unplanned pregnancy

4.7.4.1 Ignoring the consequences of sexual activities

In this study, ignoring the consequences of sexual activities was not significantly associated with unplanned pregnancy. Similar findings by Rosenberg, Pettifor, Miller, Thirumurthy, Emch, Afolabi, and Tollman (2015) are that adolescent girls acted submissively and agreed to have unprotected

sexual intercourse even though they knew the consequences. In the study conducted by Crosby, Graham, Yarber and Sanders (2010) it was found that most adolescents perceived falling pregnant as a negative event with consequences such as unemployment, loss of boyfriends, blame from friends and family members, feeling guilty, difficulty at school, complications during pregnancy or delivery, risk of HIV, secondary infertility if abortions are done and not being prepared for motherhood.

4.7.4.2 Falling pregnant to prove love for boyfriends

In this study, falling pregnant because they wanted to prove their love for their boyfriends was not significantly associated with unplanned pregnancy. Similar findings by Thobejane (2015) reported that adolescents are physically forced by their boyfriend to have sex even if they are not yet ready or are not prepared in terms of contraceptive precautions. A study conducted by Stover and Ross (2010) showed that boyfriends may have different expectations in the relationship, especially if they are providing some kind of financial support, and they might feel that it justifies coerced sexual activity.

4.7.4.3 Rebelliousness against parental authority

In this study, rebelling against parental or religious limits was not significantly associated with unplanned pregnancy. Furthermore, ignorance about the physiological aspects of conception led them to believe that first time sex or irregular sex could not cause pregnancy (Kalende, 2008). Adolescents are reluctant to take contraceptive precautions for fear of complications and parental detection. In a study conducted in Uganda it was found that some adolescents believed that not having sex regularly would cause them not to become pregnant (Nalwadda, Mirembe, Tumwesigye, Byamugisha & Faxelid, 2010).

4.7.4.4 Desire for physical pleasure

In this study, seeking physical pleasure as an escape from loneliness was not significantly associated with unplanned pregnancy. A study by Moore and Rosenthal (2006) revealed that adolescent girls admit that an unplanned pregnancy was a strategy which enabled them to escape from loneliness. Furthermore, adolescent girls felt that if their boyfriends treated them as their sexual possession they are free to use them as they please.

A study conducted by Chigona and Chetty (2014) revealed that adolescents may use unplanned pregnancy to escape from loneliness and unhappy home situations.

4.7.4.5 Loss of virginity

In this study, losing their virginity because of peer pressure was not significantly associated with unplanned pregnancy. The WHO (2016) reported that respondents maintained that adolescent girls fell pregnant because they were competing for boyfriends and marriage which led them to

lose their virginity. They sometimes complied for fear of abandonment and experienced peer pressure to have sex (Malawian Government report, 2016). The contrary findings indicate that non-school attending adolescent girls thought it was worthwhile to fall pregnant. They had the impression that childbearing gave a woman a high status and that they were bound to have children (Jewkes et al, 2014).

4.7.4.5 Emotional deprivation

In this study, falling pregnant because they were emotionally deprived and needed to be mothers was not significantly associated with unplanned pregnancy. A health survey conducted in 2010 found that having a pregnant classmate, or friend may have a direct influence on other adolescents who then also became pregnant without knowing exactly what they are doing or what they wanted (Department of Health, 2010).

4.7.4.6 Information about sex

Failure to get information about sex from their peers was significantly associated with unplanned pregnancy. A study conducted in South Africa by Mushwana et al. (2015) found that another possible reason for adolescent unplanned pregnancy is that sex regularly takes place because adolescents perceive that people of their age (peers) are sexually active. Similar findings in a study conducted in Ghana by Kumi-Kyereme, Awusabo-Asare and Darteh (2014) revealed that the peer group plays an important role during adolescence and adolescent girls often feel pressure from their peers to engage in sexual activities as a means to gain peer group respect. Books, magazines, films, videos, and the Internet with explicit descriptions or scenes concerning sex are freely available (Aransiola, Asa, Obinjuwa, Olarewaju, Ojo & Fatusi, 2016).

4.7.4.7 Depression when rejected by friends

In this study, depression resulting from rejection by friends because they had no child and then deciding to fall pregnant was not significantly associated with unplanned pregnancy. A study conducted in Nigeria by Aransiola et al. (2016) reported that unplanned pregnancy makes adolescents lose their friends. Some perform poorly academically during their pregnancy as they are discriminated against by their peers and some suffer from low self-esteem.

4.7.5 Socio-economic factors that influence unplanned

4.7.5.1 Falling pregnant to make boyfriends love them more

Falling pregnant to make their boyfriends love them more was not significantly associated with unplanned pregnancy. Studies by Mlambo (2016) and Mwaba (2015) found that the pressure by boyfriends and their refusal to use condoms during sexual intercourse are the main reasons for unplanned pregnancy.

4.7.5.2 Child support grant

In this study, child support grants were not significantly associated with unplanned pregnancy. The contrary study findings by Kanku and Mash (2010) reported that the child support grant is also seen as a way of ensuring some sort of income for the family or for the adolescent mother herself. However, the Alliance for Children's Title to Social Security argues that research has failed to show any link between adolescent pregnancy and the uptake of the grant (Yadufashije et al., 2017).

A study by Allan Guttmacher Institute (2010) found that there is no support for the belief that the child support grant encourages unplanned pregnancy as there was a decrease in the adolescent fertility rate in South Africa over the same period. There are numbers of factors that influence the fertility rate, which, however, are clearly more complex than just the child support grant, rates have also fallen worldwide and in countries without such a grant (Biyase, 2012). The role of the child support grant on unplanned pregnancy therefore remains unclear and requires further study (Mays & Pope, 2014).

4.7.5.3 Pregnancy to please boyfriends

In this study, falling pregnant to please boyfriends as providers of everything wanted was not significantly associated with unplanned pregnancy. In support of the study findings, financial support from older men, because of poor socio-economic conditions, can be a key factor in the development of transgenerational sexual relationships (Yidana, Ziblim, Azongo and Abass, 2015). The power and gender imbalance in these relationships and resultant unsafe sex leads to increased risk of STIs, HIV and unplanned pregnancy among adolescent girls (Wang, Wang & Hsu, 2003). According to Hope (2010), adolescent girls may have power to choose their boyfriends and to end the relationships, but once there is sexual interaction, it is the boyfriend who has control over what precautions to take in terms of contraception. The study findings by Luke and Kurz (2014) reported that a reduction in transgenerational sex may therefore, have an impact on the prevalence of unplanned pregnancy, STIs and HIV.

4.7.5.4 Friends are all having babies

The wish to have babies like their friends was not significantly associated with unplanned pregnancy. Moore and Rosenthal (2006) revealed that adolescent pregnancy are not unplanned but having a baby is a planned and deliberate choice. The decision to become a mother is often influenced by social factors such as having a mother who had her own first child earlier than the average, having friends who are themselves young mothers and having a stable relationship which may or may not be marriage with a partner (Karacam, Onel & Gercek, 2011).

4.7.5.5 Promises of marriage by boyfriends on condition of pregnancy

In this study, the promises of marriage by boyfriends on condition of pregnancy were not significantly associated with unplanned pregnancy. The findings reveal that adolescents fell pregnant because they were competing for boyfriends and marriage (McCall, Bhattadharya, Okpo & Macfarlane, 2014). “My boyfriend fell in love with my best friend, so I fell pregnant to force him to marry me.” They sometimes complied for fear of abandonment and experienced peer pressure to have sex (Faisal-Cury, Menezes, Quayle & Matijasevich, 2016).

4.7.5.6 Boyfriends desiring a baby being a reason for pregnancy

In this study, boyfriends desiring a baby being the reason for pregnancy was not significantly associated with unplanned pregnancy. The contrary findings conducted in Ethiopia by Ayalew, Mengistie and Semahegn (2014) reported that adolescent girls are sometimes put in a difficult position in the relationship because they feel that they have to please their boyfriends to maintain the relationship, which may imply having unprotected sex if requested to do so. The findings of the study conducted in Kenya by Achoka and Njery (2017) revealed that adolescents become pregnant because of being pressurised by their boyfriends. Furthermore, the findings of the study by Tripp and Viner (2014) revealed that adolescents who have been in long relationships know their boyfriends want to have sex with them and they have sex with them. Sometimes they do not have contraceptives and become pregnant. Adolescent girls often do not negotiate and think that saying no to sexual intercourse will end the relationship. They fallpregnant because they want to please their boyfriends and are afraid to inform them that they do not want to sleep with them (Lema, 2015).

4.7.5.8 Substance abuse

In this study, the failure to use condoms when having sex when under the influence of substances was not significantly associated with unplanned pregnancies. In a study by Markowitz, Kaesthner and Grossman (2016) it was reported that adolescents like to spend time in shebeens, and that alcohol, well-known for its ability to weaken choices, can be a gateway to unsafe sex, sexually transmitted diseases and unplanned pregnancy.

Caputo and Bordin (2008) further supported these findings by reporting that alcohol may also be purchased in exchange for sex and the environment of the shebeens increases the chance of rape or assault. Therefore, it is important for law enforcement to apply the law the strictly in terms of under-age drinking. Studies by Speizer, Pettifor, Cummings, Macphail, Kleinschmidt and Rees (2009) concur with the findings in this study that substance abuse can influence the occurrence of unplanned pregnancy. The link between higher rates of sexual violence and higher rates of unplanned pregnancy has also been confirmed in a recent study by Caputo and Bordin (2008). Substance abuse among adolescents remains a public health challenge and any effective

intervention to prevent substance abuse among adolescents would also have an impact on unplanned pregnancy.

4.7.5.9 Pregnancy to test fertility

In this study, pregnancy to test fertility was not found to be significantly linked with unplanned pregnancy. A similar study conducted by Handulay (2008) in subSaharan Africa reported that there is also a perception that one needs to prove one's fertility through pregnancy. Furthermore, it was reported that adolescents who were previously ostracised because of unplanned pregnancy may today be proud of their motherhood and receive social support and acceptance. (Malahlela, 2012). The findings indicate that traditionally it was not acceptable to fall pregnant before marriage, but cultural norms have shifted and having an unplanned pregnancy now is not seen as so immoral (Papri, Sarwat & Morsheda, 2016).

4.7.5.10 Bad attitudes towards contraceptives

In this study, bad attitudes towards contraceptive use were not significantly associated with unplanned pregnancy. The similar findings were reported by Mukoma, Kagee, Mathews and Flisher (2010) this encouraged adolescents to develop positive attitudes towards contraceptive use and the desire to avoid unplanned pregnancy and child bearing during adolescence. Findings by Dulitha et al. (2014) reported that adolescents were encouraged to develop negative attitudes toward contraceptive use but this was due to misinformation regarding the side effects of the use of contraceptives.

Furthermore, the wrong information held by adolescents was that girls who use contraceptives experience childbirth problems. Thus for the respondents, contraceptives were meant for married or single adults that have children already. Adolescent men thought that contraceptives had permanent side effects such as infertility and they tended to avoid them (Liabsuetrakul, 2013). These findings are consistent with other previous studies in Malawi and Uganda (Munthali et al., 2011; Kaphagawani & Kalipeni, 2017). Pregnant adolescents that experience school interruption bring shame and disgrace to their families (Perez-Lopez, Chedraui, Kravitz, Salazar-Pousada& Hidalgo, 2011). These adolescents are forced into early marriage when they become pregnant hence negatively affecting their lives as they struggle to raise the children since they are mostly financially dependent (Ahikire & Madanda, 2015).

4.7.6 Discussion of the association between variables using the chi-square test

This section presents a cross tabulation using the Pearson chi-square to compare variables. These variables were to examine whether age causes adolescent not to visit clinics or to ignore the use of contraceptives.

4.7.6.1 Age group versus ignoring to use contraceptives

The study found statistically significant between age group and ignoring the use of contraceptives (P=0.021). The study conducted by Kelly (2014) found no significant association between the age of 15-20 years and ignoring to use contraceptives with the P value scores of p = .046. With regard to ignoring to use contraceptives, it was found that eighty percent of adolescents are sexually active and had ignored the use of contraceptives during their first sexual encounter. This finding concurs with the study by Yadufashije et al. (2017) who stated that the adolescent stage can be a confusing period in life. This ignorance makes adolescents susceptible to many blunders.

4.7.6.2 Religion versus ignoring the use of contraceptives

The study also considered the association between religion and ignoring the use of contraceptives. There is no statistically significant found between these variables (P=0.095). Religion was seen as not having a large influence on ignoring the use of contraceptives towards sexual activities, but it had an impact on the use of contraceptives. The study by Meekers and Nassoro (2014) argue that Christian respondents had sexual intercourse but Muslims were less open to talk about sexual intercourse publicly and wanted a larger family than Christians. Adolescent girls did not support the idea of using contraceptives, giving religious beliefs as the main reason (Akintade, Pengpid & Peltzer, 2011).

4.7.6.3 The use of any type of contraceptives versus Fear of visiting the clinic leading to unplanned pregnancy

The study found an association between using any type of contraceptives and Fear of visiting the clinic leading to unplanned pregnancy; they were statistically significant with the P_value of 0.033. The study conducted by Weiss (2011) reveal that there was significant link between these two variables with a P-score of P<0.001. A study in Botswana by Ash and Ogakwu (2014) revealed that a positive relationship between adolescents and healthcare providers is often associated with increased utilization of contraceptives or family planning services. Furthermore, adolescents prefer to receive advice regarding contraceptives from service providers whom they deem to be relatable and up-to-date with current norms (Hoque, et al., 2014). In addition, the conditions at the clinic, the long queues, waiting times and negative staff attitudes prevented adolescents from visiting the clinic. Furthermore, adolescents describe clinic staff members as being rude and unsympathetic about the long lines and poor clinic conditions that adolescents experienced. Furthermore, a study by Hoque and Ghuman (2012) revealed that there were also adolescents who presented to the clinic early but were turned away by the booking staff and told to return at a later date without assessment or explanation.

4.8 Conclusion.

This chapter presented the results and discussion of the data analysis and interpretation, with the use of frequencies tables and bar charts. It appears that the majority of the respondents have knowledge regarding contraceptives. Majority of the respondents do not have children while a minority of the respondents have children. The statistical tests across different variables were performed to test the association among variables or to test whether there was a link between the variables. The chi-square tests were used to compare categorical variables and the level of statistical significance which were set to be $p<0.05$**.** The discussion presented above showed the significance of variables which were associated with unplanned pregnancy, while other variables were not significantly associated with unplanned pregnancy. Furthermore, the variables were compared to determine whether there was an association between respondents' ages and other variables. These variables were compared using chi-square tests to determine the association among variables regarding unplanned pregnancy.

CHAPTER 5

SUMMARY, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the summary, limitations, conclusions and recommendations of the study. The summaries are based on the results of the study and the limitations of the study were based on the challenges unaccounted in the study. The conclusions of the study are based on the results of the study.

5.2 SUMMARY OF THE STUDY

The purpose of the study was to investigate the factors influencing unplanned pregnancy among learners in a selected high school in the Collins Chabane Municipality, Limpopo Province, South Africa. In order to achieve this, four research objectives were posed which include:

- To assess the knowledge of learners about contraceptives (family planning);
- To determine the personal factors contributing to unplanned pregnancy among high school learners;
- To determine the psychological factors that influence unplanned pregnancy among high school learners;
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

The study was quantitative using survey methods. The instrument for data collection was the structured self-administrated questionnaire. Validity and reliability issues were considered in the study in order to ensure consistency of the work.

The sample size was 362 female learners registered for the 2018 academic year in a selected high school, Hlalukweni High School who were purposively selected from the 13 high schools in the Malamulele West Circuit.

The data were analysed using SPSS version 25.0 and results were presented using bar charts, frequency tables, and the chi-square statistical test was used to compare variables. The significance levels of the variables were tested at 0.005.

5.2.1 Demographic information

The results of the study showed that the majority of the respondents (64.4%) were aged 16-20 years, all the respondents were single and 29.4% were in Grade 11. It was further discovered from the study that 38.5% of the respondents were living with their mothers, 69.4% of respondents had no child/children and 90.2% were Christians.

5.2.2 Knowledge of learners about contraceptives

The findings revealed that 52.1% of the respondents discussed the choice of contraception with their boyfriends, 57.6% of the respondents were in favour of a workshop about contraceptives for men and women together. Furthermore, 51.2% of the respondents' boyfriends favoured the use of contraceptives and 64.1% of the respondents needed more information on contraceptive methods and their use. It was also revealed that 30.2% of the respondents derived their information about sexual matters from the health facilities which was an advantage to them because there was a presence of skilled professionals at these facilities.

It was found that 58.2% of the respondents had used variouus types of contraceptives while 73.2% of the respondents were found to comply with instructions on the usage of the contraceptive methods. Furthermore, it was found that 71.8% of the respondents reported that they abstained from sexual activities to prevent unplanned pregnancy. It was noted that 77.6% of the respondents revealed that teaching sex education would help to prevent unplanned pregnancy. However, 50.6% of the respondents maintained that unplanned pregnancy can be prevented by supplying contraceptives at clinics and school.

The study discovered that 86.8% of the respondents indicated that teaching religious and moral values would help to prevent unplanned pregnancy while 87.1% of the respondents indicated that parental educational support can help prevent unplanned pregnancy. However, 77.1% of the respondents reported that social support and parenting would help to prevent unplanned pregnancy.

5.2.3 Personal factors influencing unplanned pregnancy

In this study, it was found that 57.7% of the respondents disagreed that lack of self-confidence in decisions about sexual activities would lead to unplanned pregnancy while 59.7% of the respondents disagreed that they had fears of losing their partners, when they ask them to use contraceptives. Furthermore, it was found that 42.3% of the respondents agreed that early menarche increased the risk of pregnancy. It was found that 51.5% of respondents disagree that they wanted to become independent.

The study found that 43.6% of the respondents agreed that power imbalances in sexual relationships between male and female. However, It was found that 52.0% of the respondents

feared that visiting the clinic would lead to unplanned pregnancy. The results of the study found that 48.2% of the respondents disagree that they fell pregnant because of the desire to make their boyfriends responsible or because they feared losing them. It was found that 51.2% of the respondents disagree that they had ignored to the use contraceptives. However, 65.0% of the respondents disagree that they were ashamed to ask their boyfriend to use a condom. It was further found that 58.3% of the respondents disagree that they felt embarrassed about not having a child while all their friends had children.

5.2.4 Psychological factors influencing unplanned pregnancy

In this study, it was found that 50.3% of the respondents disagreed that they had ignored the consequences of sexual activities while 66.2% of the respondents disagree that they were forced to fall pregnant because they wanted to prove that they loved their boyfriends. The study found that 50.3% of the respondents disagreed that they were rebellious against parental or religious limits. It was found that 50.6% of the respondents disagree that they sought physical pleasures as an escape from loneliness. However, 51.1% of respondents disagree that they had lost their virginity because of peer pressure.

The study found that 60.9% of the respondents disagree that they fell pregnant because they were emotionally deprived and needed to be a mother. Moreover, 55.9% of the respondents disagreed that they got information about sex from their peers. It was found that 65.9% of the respondents disagreed that they were depressed when their friends rejected them because they had no children and therefore they decided to fall pregnant.

5.2.5 Socio-economic factors influencing unplanned pregnancy

In this study, it was found that 65.9% of the respondents disagreed that falling pregnant will make their boyfriend to love them more. However, 72.1% disagreed that they fell pregnant so that they could get the child support grant. The study found that 73.8% of the respondents disagreed that they fell pregnant to please their boyfriends because they are the ones who buy everything that they want. It was found that 65.9% of the respondents disagree that falling pregnant will make their boyfriend to love them more.

It was noted that 80.7% of the respondents disagree that all their friends have babies, so they wanted to have their own babies. Furthermore, 77.8% of the respondents disagreed that their boyfriend promised to marry them on condition having a baby first. It was found that 69.3% of the respondents disagree that their boyfriends' wish for babies was a reason why they fell pregnant, because they were afraid of losing them. Furthermore, the study found that 61.8% of the respondents disagree that both partners did not always use condom when they are under influence of substances. The study found that 60.0% of the respondents disagreed that they had

fallen pregnant because they wanted to test if they were fertile while 56.7% of the respondents disagreed that they had a bad attitude towards contraceptive use.

5.3. LIMITATIONS OF THE STUDY

The results of the study cannot be generalised to the whole of the Limpopo province because the study focused only on one municipality; other municipalities in Limpopo Province were excluded from the study.

5.4 CONCLUSION

A summary of the study presented the findings of the study, limitation, conclusion and recommendations. The study found a variety of factors associated with unplanned pregnancy among sexually active adolescents. Lack of knowledge leading to unplanned pregnancies includes factors such as the need for more information on contraceptives methods and their use, the type of contraceptives used by adolescents, and abstaining from sexual activities would help to prevent unplanned pregnancy. Even if adolescents have access to contraceptives, they are often unable to negotiate their use with their partners. It is essential for adolescents to consider contraceptives before intimacy. Parent should educate adolescents about practising safe sexual intercourse and changes in cultural norms that talking about sexual intercourse is taboo. Personal factors associated with unplanned pregnancy were power imbalances in sexual relationships between male and female adolescents, early menarche increasing the risk of pregnancy and fear of visiting clinic lead to unplanned pregnancy.

Psychological factors that influence unplanned pregnancy include ignoring the consequences of sexual activities, gaining information about sex from peers and losing virginity because of peer pressure. Socio-economic factors that influence unplanned pregnancy among sexually active adolescents include boyfriends promising marriage on condition of having a baby, falling pregnant to test fertility and falling pregnant to obtain the child support grant.

5.5 RECOMMENDATIONS

Based on the research findings and the conclusions of this study, the researcher would like to suggest the following recommendations:

5.5.1 Recommendations for learners

- Adolescents should be taught about the advantages of contraception which would assist them to realise their goals in life and to focus on their future.
- Adolescents should be given adequate information about contraceptives in terms of the advantages, disadvantages and side effects and how to manage the side effects.

This would help mitigate negative attitudes that the adolescents have toward contraceptives owing to misinformation and misconceptions.

5.5.2 Recommendations for teachers

- Teachers should play a parental role by ensuring that health education programs are presented in the schools. These programs must emphasise the positive aspects of contraceptive use which include protection against STIs and unplanned pregnancies.
- Teachers should recruit Lovelife (NGO) to render awareness campaigns on contraceptive usage and to provide knowledge on how to curb unplanned pregnancy.
- Teachers should encourage learners to visit the school health nurse, for acquiring more information related to contraceptive usage. This information should include advantages and disadvantages of contraceptives use.
- Teachers should counsel learners to facilitate behaviour change on visiting clinics to seek reproductive health.
- Teachers should educate learners about the consequences of substance abuse related to unplanned pregnancy and sexually transmitted diseases.

5.5.3 Recommendations for school health nurses

- School health nurses should use Information Education Communication (IEC) materials on family planning continuously to increase awareness about family planning and to prevent unplanned pregnancies. The IEC materials should be in the most common languages of Limpopo Province, i.e. Sepedi, Xitsonga and Tshivenda for a clear understanding of the content.
- Guidance counsellors and social workers at schools should be easily approachable so that adolescents will seek their advice regarding sex and report sexual abuse whatever the case may be. The introduction of family planning education in schools is a good start to educate young people on the availability of contraceptives and the consequences of being sexually active at a young age. Lessons on sexual activities should start before children become sexually active. This can be done in the form of role-play.

5.5.4 Recommendations for the policy makers (Department of Education)

- Policy makers should draft policies that direct curriculum developers to include contraceptive education as part of the education curriculum at schools. Curriculum developers must ensure that they develop contraceptive instructional material or manuals, coordinate their implementation by teachers and principals, and assess their effectiveness.

- Curriculum developers should include contraception, substance use and sexual intercourse in the Life Orientation program offered in schools in order to improve learners' knowledge.

5.5.5 Recommendations for the clinics

- Local clinics need to be promoted more positively and should be seen as a place where adolescents feel comfortable to obtain advice and contraceptives, if desired.
- Health care workers should be sensitive to the needs of adolescents by creating supportive environments and programs to address the causes of adolescent pregnancies.
- Health care providers should uphold confidentiality and maintain privacy at all times when dealing with adolescents. Positive attitudes should be encouraged.

5.5.6 Recommendations for future research

It is recommended that further studies should be done in other municipalities and schools using other research designs, including other variables that have significant influence on unplanned pregnancy, and other respondents such as adolescent boys.

Topics could include:

Factors contributing to the high prevalence of teenage pregnancy in the Vhembe District Municipality, Limpopo Province, South Africa;

Perceptions of rural teenagers about teenage pregnancy in the Thulamela Municipality, Vhembe District, Limpopo Province, South Africa;

Managing teenage pregnancies at secondary schools in the Vhembe district, Limpopo Province;

The causes of unplanned pregnancy among adolescents in Limpopo Province, South Africa.

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Appendix 1: Approval from University of Venda ethical committee.

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr NV Khosa

Student No:
11625895

PROJECT TITLE: **Factors influencing unplanned pregnancy among selected high school learners in Collins Chabane Municipality, Limpopo Province, South Africa.**

PROJECT NO: SHS/18/PH/04/2304

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof AK Tugli	University of Venda	Supervisor
Dr SA Mulondo	University of Venda	Co - Supervisor
Mr NV Khosa	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2018 -04- 24
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

Appendix 2: Letter to the Department of Basic Education

University of Venda

P.O. box 1249
Malamulele
0982

The Department of Education
Private Bag X9489
Polokwane
0700

Dear sir/ madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I the undersigned Khosa Ntiyiso Vinny a registered Masters student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study at a school under Malamulele Circuit. The proposed topic of my research is: Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa. The study objectives are:

- To assess the knowledge of learners about contraceptives (family planning).
- To determine the personal factors contributing to unplanned pregnancy among high school learners.
- To determine the psychological factors that influence unplanned pregnancy among high school learners.
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Kind regards
Mr. N.V Khosa
Student no: 11625895

Signature: _____

Date: _____

Appendix 3: Approval from Department of Education

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
EDUCATION

Ref: 2/2/2 Enq: MC Makola PhD Tel No: 015 290 9448 E-mail:MakolaMC@edu.limpopo.gov.za

Khosa NV
P O Box 1249
Malamulele
0982

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

1. The above bears reference.
2. The Department wishes to inform you that your request to conduct research has been approved. Topic of the research proposal: **"FACTORS INFLUENCING UNPLANNED PREGNANCY AMONG LEARNERS IN A SELECTED HIGH SCHOOL IN COLLINS CHABANE MUNICIPALITY".**
3. The following conditions should be considered:

3.1 The research should not have any financial implications for Limpopo Department of Education.

3.2 Arrangements should be made with the Circuit Office and the schools concerned.

3.3 The conduct of research should not in anyhow disrupt the academic programs at the schools.

3.4 The research should not be conducted during the time of Examinations especially the fourth term.

3.5 During the study, applicable research ethics should be adhered to; in particular the principle of voluntary participation (the people involved should be respected).

REQUEST FOR PERMISSION TO CONDUCT RESEARCH KHOSA NV

CONFIDENTIAL

Cnr. 113 Biccard & 24 Excelsior Street, POLOKWANE, 0700, Private Bag X9489, POLOKWANE, 0700
Tel: 015 290 7600, Fax: 015 297 6920/4220/4494

The heartland of southern Africa - development is about people!

3.6 Upon completion of research study, the researcher shall share the final product of the research with the Department.

4 Furthermore, you are expected to produce this letter at Schools/ Offices where you intend conducting your research as an evidence that you are permitted to conduct the research.

5 The department appreciates the contribution that you wish to make and wishes you success in your investigation.

Best wishes

Ms NB Mutheiwana
Head of Department

30/05/18
Date

REQUEST FOR PERMISSION TO CONDUCT RESEARCH KHOSA NV

CONFIDENTIAL

Appendix 4: Letter to Malamulele circuit

University of Venda

P.O. box 1249

Malamulele

0982

Dear sir/ madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SCHOOL

I the undersigned Khosa Ntiyiso Vinny am a registered Masters student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Malamulele Circuit. The proposed topic of my research is: Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa. The study objectives are:

- To assess the knowledge of learners about contraceptives (family planning).
- To determine the personal factors contributing to unplanned pregnancy among high school learners.
- To determine the psychological factors that influence unplanned pregnancy among high school learners.
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Kind regards
Mr. N.V Khosa
Student no: 11625895

Signature: _____

Date: _____

Appendix 5: Approval from Malamulele west circuit

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
EDUCATION

MALAMULELE WEST CIRCUIT

Ref : 11625895
Enq : CHAUKE K.C

Malamulele West Circuit
Department of Education
04-06- 2018
Telefax : (015) 851 0035
P/Bag X 9208 Malamulele 0982

Dear Mr N.V Khosa

PERMISSION TO CONDUCT RESEARCH.

1. The above matter bears reference.

2. It is with great pleasure to inform you that your request to conduct research on "Factors influencing unplanned pregnancy among learners in Hlalukweni High School has been approved.

3. You are therefore requested to adhere to the conditions as set out in the Departmental approval (i.e. item 3.1 – 3.6).

4. We wish you success in your investigation.

CIRCUIT MANAGER
MALAMULELE WEST CIRCUIT

04.06.2018
DATE

Malamulele West Circuit Building next to Shitlhelani Clinic, Private Bag X 9133, Malamulele , 0982,
Tel: (015 851 7919, 20, 21)

Appendix 6: Letter to the school

University of Venda

P.O. box 1249
Malamulele
0982

To the head of the school (principal).

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SCHOOL

I the undersigned Khosa Ntiyiso Vinny am a registered Masters student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Malamulele West Circuit. The proposed topic of my research is: Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa. The study objectives are:

- To assess the knowledge of learners about contraceptives (family planning).
- To determine the personal factors contributing to unplanned pregnancy among high school learners.
- To determine the psychological factors that influence unplanned pregnancy among high school learners.
- To describe the socio-economic factors that influence unplanned pregnancy among high school learners.

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Kind regards
Mr. N.V Khosa
Student no: 11625895

Signature: _____

Date: _____

Appendix 7: Approval from Hlalukweni high school

HLALUKWENI HIGH SCHOOL

Enq : Makhubele M.J
Cell : 079 546 8237

☎ 072 290 8651
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KHUPUKANI

"It is the mission of this school to provide excellent and relevant education to our learners by educators working to the highest professional standards, using knowledge skills and attitudes that exemplify dedication and excellence in the belief that all people are valuable, capable and responsible".

Dear Mr N.V Khosa

The school writes this letter to confirm that Mr Ntiyiso Vinny Khosa of student no 11625895, was given permission to do dissertation at the above mentioned school.

The student was granted permission without reservation and he was liberty to do his research at his convenience. We have schedule data collection 1st June to 31 October 2018.Under the topic entitled: **Factors influencing unplanned pregnancy among selected high school leaners at Collins Chabane Municipality, Limpopo province, South Africa.**

During his data collection, he conducted himself well, and timeously submits to the rules, regulations and the code of ethics of the school.

Kindly regards

The head of the school (Principal)

Mr M.J Makhubele

DEPARTMENT OF EDUCATION
HLALUKWENI HIGH SCHOOL
THE PRINCIPAL
05 JUN 2018
P.O. BOX 1122 MALAMULELE 0982
LIMPOPO PROVINCE

Appendix 4: participant's information letter

University of Venda

Information sheet

Introduction

I Khosa Ntiyiso Vinny, am a registered Masters student in the Department of Public Health at the University of Venda conducting a research on a study under the topic: 'Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa. I am hereby requesting permission from you to participate in the study by giving information concerning factors influencing unplanned pregnancy.

How will you participate in the study?

In case you voluntarily participate in this study, you will be required to complete questionnaire on the study. Questionnaires will consist of five sections. It will take almost 30 minutes. Your answers will not be assessed as wrong or right since people have different opinion, your opinion will be helpful on the factors influencing unplanned pregnancy.

What are your rights as research respondents?

When you have opted your choice to participate in the study, participation is voluntarily there is no reward. You are free to reject or to accept to be part of the study. you aew alsoallowed to withdraw at any time when you wish not to continue with the study. You are allowed to withdraw at any time when you wish not to continue with the study, without being asked or to explain the reason.

How will your personal privacy and confidentially be protected?

All your answers will be strictly kept confidential manner. Furthermore, you will not be requested to write your name or id number on the questionnaire. Information collected will not be associated with any name in the report of the study and information collected will only be accessed by the researcher. Nobody will access the information accept the researcher.

_____ _____

Researcher Signature **Date**

For further information, please do not hesitate to contact me at 072 858 8418 or 078 113 9522. Khosavn@gmail.com in order for clarity.

Appendix 8: Consent form

University of Venda

CONSENT FORM

- I hereby confirm that I have been informed by the researcher, **Khosa Ntiyiso Vinny**, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

I,…….. …… …… ……..

(***Khosa Ntiyiso Vinny***) herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

……. Date**…….** Signature**……**

Full Name of Witness (If applicable)

……. Date **…….** Signature**……..**

Full Name of Legal Guardian (If applicable)

……. Date**…….** Signature**…….**

Appendix 9: Assent letter

Assent form for minors

Introduction

I Khosa Ntiyiso Vinny, am a registered Masters student in the Department of Public Health at the University of Venda conducting a research on a study under the topic: Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane municipality, Limpopo province, South Africa.

Can anything bad happen to you?

In case you have emotional problems, if you were being misled to have sexual intercourse some statements may remind you of such an event.

Can anything good happen to you?

There is no benefit from participating in the study, expect the experience of evaluating yourself on knowledge and practices regarding condom use.

Will anyone know that you were participating in the study?

No third party will know that you were part of the study because all your answers will be strictly kept in a confidential manner. You will also not be requested to write your name or id number on the questionnaire. The Information collected will not be associated to any name in the report of the study and will only be accessed by the researcher.

Who can you talk to about the study?

For further information please do not hesitate to contact me at 072 858 8418 or 078 113 9522 in order for clarity.

What if you do not want to participate?

Participation in this study is voluntary and there's no reward after wards and when you are participating, even though your parents/legal guardian have agreed on your behalf to take part in the study, you are not forced to do so. You are also allowed not to be part of the study at any time without prejudice.

I_____ agree to participate in the study / I disagree to participate in the study.

_____ _____

Minor's Signature Date

Appendix 10: Research instrument

University of Venda

Instructions

- Please read through each statement carefully before giving your opinion.
- Please make sure that you do not omit a question, or skip any page.
- Please be totally free when giving your opinion.
- Please do not discuss statements with anyone.
- Please return the questionnaire after completion.

Section 1 Demographical Information.

1. How old are you? **1**=10-15 **2**=16-20 **3**=21-25 **4**=26 and above	☐
2. Which grade are you in? **1**=Grade 08 **2**=Grade 09 **3**=grade 10 **4**=Grade 11 **5**=Grade 12	☐
3. Who do you live with at home? **1**= Both parents **2**= mother **3**= father **4**=brother **5**= sister **6**= Grandmother 8=others	☐
4. Do you have a child? **1**=yes **2**=no	☐
5 If your answer is yes in question 5, how many? **1**= one child **2**= two children **3**=other	☐
6. Which religion do you practice? **1**= Christianity **2**= Traditional **3**= Islam **4**= other	☐

Section 2 knowledge of learners about contraceptives (family planning).

Statements	1=yes	2=no
7. Do you discuss r the choice of contraceptivewith your sexual partner?		
8. Are you in favour of a workshop about contraceptives for women and men together?		
9. Does your sexual partner like using contraceptives?		
10. Do you think there is a need for more information on contraceptive methods and their uses?		
11. If yes, where will you get your contraceptive information? **(tick all that apply)**		
12. Have you ever used any type of contraceptive?		
13.If yes, which method did you use?**(tick all that apply)**		
14. On the method selected on question 14 above, did you comply with the instruction on the usage of that contraceptive method?		
15. Do you think that abstaining from sexual activities will help to prevent unplanned pregnancy?		
16. Would the introduction and teaching sex education help to prevent unplanned pregnancy.		
17. Can unplanned pregnancy be prevented by supplying contraceptives		

Family	
School	
Church	
Radio/Newspaper/Television/posters	
Health facility	

Condoms	
Pills	
Injectable	
Implants	
Intrauterine Contraceptive Device	
Natural method	

program at clinics and school.		
18. Would teaching religious and moral values to adolescents help to prevent unplanned pregnancy.	☐	☐
19. Would programs linked to contraceptive services e.g. in life orientation, help prevent unplanned pregnancy	☐	☐
20.Would parental education support help prevent unplanned pregnancy	☐	☐
21. Can social support and parenting help prevent unplanned pregnancy	☐	☐

Section 3 Personal factors influencing unplanned pregnancy

Statements	1=Agree	2=Strongly agree	3=Not sure	4=Strongly Disagree	5=Disagree
22. Lack of self-confidence in decisions about sexual activity leasd to unplanned pregnancy					
23. I fear losing your partner, if I ask him/her to use contraceptives					
24. Early menarche increases the risk or pregnancy					
25 Independence and adult status is gained by having a baby					
26. Power imbalances in sexual relationships between male and female adolescents can lead to unplanned pregnancy					
27 Fear of visiting clinics can lead to unplanned pregnancy					
28. Desire to make boyfriends responsible or fear of losing them can lead to unplanned pregnancies.					
29. I fail to use contraceptives consisyrntly					
30. I am embarrassed to ask boyfriends to use condoms.					

31. I am embarrassed that I do not have children while my friends do have children					

Section 4 Psychological factors influencing unplanned pregnancy

Statements	1=Agree	2=Strongly agree	3=Not sure	4=Strongly Disagree	5=Disagree
32. I ignored the consequences of sexual activities.					
33. I was forced to fall pregnant because I wanted to prove that I love him					
34. I was rebellious against parental or religious limits.					
35. I sought physical pleasures as an escape from loneliness.					
36. I lost my virginity because of peer pressure.					
37. I fell pregnant because I was emotionally deprived and needed to be a mother					
38. I got information about sex from my peers.					
39. I was depressed when my friends rejected me because I had no child and therefore I decided to fall pregnant					

Section 5 Socio-economic factors influencing unplanned pregnancy

Statements of socio- economic factors	1=Agree	2=Strongly agree	3=Not sure	4=Strongly Disagree	5=Disagree
40. Falling pregnant will make my boyfriend love me more.					
41. I fell pregnant so that I could get the child support grant.					

42. All my friends have babies, so I want/wanted to have my own baby, just like them.					
43. My boyfriend promised to marry me on condition I first had a baby					
44. My boyfriend's wish for a baby is a reason why I fell pregnant, because I was in afraid of losing him.					
45. I fell pregnant to please my partner because he is the one who buys everything that I want.					
46. I and my partner do not always use condom when we are under influence of substances(e.g alcohol)					
47. I fell pregnant because I wanted to test if I am fertile					
48. I had a bad attitude towards contraceptive use					

Appendix 11: Switirhisiwa swa ndzavisiso

University of Venda

Swileriso

- U komberiwa ku hlaya u twisisa xitatimende xin'wana na xin'wana hi vukheta ungase nyika mavonelo ya wena.
- Tiyisisa leswaku unga tluli xivutiso kumbe pheji.
- Nyika mavonelo ya wena u tshuxekile.
- U nga buli na munhu hi switatimende leswi.
- Vuyisa nongonoko wa swivutiso loko u heta ku hlamula.

Xiyenge xa 1. Vuxokoxoko bya demogirafiki

1. Una malembe ma ngani? **1**=10-15 **2**=16-20 **3**=21-25 **4**=26 nikuya enhla	☐
2. Ule ka ntangha mani? **1**=Ntangha 08 **2**= Ntangha 09 **3**= Ntangha 10 **4**= Ntangha 11 **5**= Ntangha 12	☐
3. U tshama na mani ekaya? **1**= Vatswari hinkwavo **2**= Manana **3**= Tatana **4**=Boti **5**= Sesi **6**= Kokwana 7=Vanwana	☐
4. Xana una n'wana? **1**=Ina **2**=E-e	☐
5 Loko nhlamulo ya wena kuri Ina, xana I vangani? **1**= one child **2**= two children **3**=other	☐
6. Xana hi byihi vukhongeri lebyi u byi hlawuleke? **1**= Vu kreste **2**=Xintu **3**= Islam **4**= Byinwana	☐

Xiyenge xa 2: Vutivi bya vadyondzi mayelana na swisawutiso (Ku kunguhata ndyangu).

Switatimende	**1=Ina**	**2=E-e**

7. Xana wa bula na muringani wa wena hi swisawutiso leswi u swi hlawuleke?		
8. Xana u yima na yona ndzetelovutivi hi swa sawutiso ya vavanuna ni vavansati va hlanganile?		
9. Xana muringani wa wena wa swa masangu wa swi tsakela ku tirhisa swi sawutiso?		
10.U ehleketa kuna. Xiboho xa ku engetela hungu mayelana na swa sawutiso ni matirhiselo ya swona?		

11. Loko kuve lna, xana unga ri kuma kwihi hungu leri?**(Hlawula laha hansi)**

Ndyangu	
Exikolweni	
Ekerekeni	
Xiyanimoya/ phepha-hungu/ Mavona-kule/ tiphositara	
Tindhawu tari hanyo	

12. Xana u tshama u tirhisa muxaka wun'wana na wun'wana wa swasawutiso?		

13.Loko kuri ina, hi yihhi ndlela leyi uyi tirhiseke?**(Hlawula laha hansi)**

Khondomu	
Tiphilisi	
Nayiti	
Implant	
Intrauterine Contraceptive Device	
Ndlela ya ntumbuluko	

14. Eka ndlela leyi uyi hlawuleke eka xivutiso xa 14 laha henhla, xana u landzelerile switsundzuxo hi matirhiselo ya sawutiso walowo?		
15. Ku papalata timhaka ta masangu swi sivela nyimba yoka yinga kunguhatiwanga.		
16. Ku tumbuluxa na ku dyondzisa hi dyondzo ya swa masanguswita pfuna ku sivela nyimba yoka yinga kunguhatiwanga.		
17.Khwiri roka ringa kunguhatiwanga hiku phakela nongonoko wa swa sawutiso eti tliliniki nale swikolweni.		
18. Ku dyondzisa mahanyelo lamanene hi nkarhi wa xijaha na xinhwana		

swi sivela khwiri roka ringa kunguhatiwanga.		
19. Minongonoko leyi fambiselanaka na swa sawuto. Xik. Dyondzo ya swa vutomi yinga pfuna ku sivela khwiri roka ringa kunguhatiwanga.	☐	☐
20. Nseketelo ya dyondzo ya swa vutswari.	☐	☐
21.Vanhu vo sekela na vutswari eka hungu ro kunguhata khwiri.	☐	☐

Xiyenge xa 3: Swivangelo swa n'winyi leswi hlohletelaka khwiri roka ringa kunguhatiwanga.

Xitatimende	1=Pfumela	2=Pfumela hi matimba	3=Kanakana	4=Ala hi matimba	5=Ala
22. Ku kala ku ti tshemba eka ku teka swiboho eka masangu.					
23. Ku chava ku lahlekeriwa hi muringani wa mina loko ndzo n'wu vutisa hi swa sawuto.					
24. Xana ku hatlisa kuya emasikwini swiengetela nghozi kumbe ku kuma khwiri?					
25. Kuva u kota kuti hlayisa.xik. Hi kuva na n'wana xiyimo xa vukulukumbha xifikeriwile.					
26. Matimba yoka yanga ringani eka vuxaka bya masangu exikarhi ka majaha ni va nhwana					
27. Ku chava ku endzela ti tliliniki leswi vangaka khwiri roka ringa kunguhatiwanga					
28. Munhu a nga vani khwiri hiku navela kuva ni vutihlamuleri kumbe hikwalaho ko lahlekriwa hi muringani wa wena.					
29. Ku honisa ku tirhisa swi sawutiso					
30. Swi ndzi khomisa tingana ku kombela muringani wa mina					

leswaku atirhisa khondomu					
31. A ndzi twa ndziri ni tingana hikuva ndziri hava n'wana. Tani hileswi vanghana va mina vanga na vana.					

Xiyenge xa 4: Swivangelo swa miehleketo leswi hlohlotelaka khwiri ro ka ringa kunguhatiwanga

Xitatimende	1=Pfumela	2=Pfumela hi matimba	3=Kanakana	4=Ala hi matimba	5=Ala
32. Ku honisa switandzhaku swa masangu					
33. Ndzilo sindzisiwa kuva na khwiri hikuva a andzi lava ku nwi khorwisa leswaku ndza nwi rhandza					
34. A ndzi ala ku yingisa vatswari na milawu ya vukhongeri.					
35. Ndzi lavile Ntsako wo khomeka leswaku ndzita susa xivundza.					
36. Ndzi lahlekeriwile hi vunhwana bya mina hikwalaho ka ntshikelelo wa tintangha.					
37. Ndzi vile na khwiri hikuva andzi ri ni ntikelo wa moyeni kutani andzi lava kuva manana.					
38. Ndzi kumile vuxokoxoko bya swa masangu eka tintangha ta mina.					
39. A ndzi na ntshikelelo emiehletweni loko vanghana va ndzi jikela hiku kala n'wana. Kutani ndzi teka xibiho xo va na khwiri.					

Xiyenge xa 5: Swivangelo swa timali leswa hlohletelaka khwiri roka ringa kunguhatiwanga.

Xitatimende	1=Pfumela	2=Pfumela hi matimba	3=Kanakana	4=Ala hi matimba	5=Ala
40. Ku vava ni khwiri swita endla leswaku muringani wa mina a ndzi rhandza swinene.					
41. Ndzivile ni khwiri ku endlela leswaku ndzi ta kuma mudende wa vana.					
42. Vanghana va mina hinkwavo van a vana. Kutani na mina ndzi/andzi lavan'wana, ku fana na vona.					
43. Muhlekisani wa mina uni tshembise kuni teka ntsena loko ndzi ri na n'wana.					
44. Ku navel aka muhlekisani wa mina leswaku ava na nwana swi endle leswaku ndzi va na khwiri hikuva a ndzi chava leswaku a nga ndzi tshika.					
45. Ndzi ve na khwiri ku tsakisa muringani wa mina hikuva hi yena a ndzi xavelaka hikwaswo leswi ndzi swilavaka.					
46. Mina ni muringani wa mina ahi tirhisi khondomu loko hiri hansi ka hlohlotelo wa swi dzidziharisi.					
47. Ndzi vile ni khwiri hikuva a ndzi lava ku vona loko ndzi tswala.					
48. A ndzi tsakeli kutirhisa swisawutiso.					

Appendix 12: Proof of English and academic editing

Jean Mitchell Consulting

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24 October, 2018

DECLARATION

To whom it may concern

This is to declare that I have edited the Masters' dissertation of N. V. Khosa entitled *Factors influencing unplanned pregnancy among learners in a selected high school in Collins Chabane Municipality, Limpopo Province, South Africa*.

To my knowledge the manuscript is free of language errors.

Yours faithfully

Dr J. E. Mitchell