A study of the high rate of teenage Pregnancy in high schools in the ILembe District

By

THANDIWE ROSE NKWANYANA

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF EDUCATION

IN THE SUBJECT

PSYCHOLOGY OF EDUCATION

AT THE UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR A.M. DICKER

FEBRUARY 2011

ACKNOWLEDGEMENTS

The researcher alone could not have successfully completed this study all by herself. It was through the efforts of various personnel who rendered their academic assistance that this study became a reality. Among these are:

- God, who gave me the effort and opportunity to do this study.

- Dr A.M. Dicker, the supervisor of this research, for her love, patience, dedication and scholastic assistance.

- Dr H. Muller, for her tireless efforts and patience in processing and analyzing all the questionnaires.

- Dr H. N. Hlongwa, for assistance, support when most needed in preparation of the study.

- Finally, I would like to thank my husband, Sibusiso, my daughters Thandolwethu and Siphokazi, and my son Aphelele for allowing me to work on this dissertation during the time I should have spent with them

TABLE OF CONTENTS

CHAPTER 1
AN INTRODUCTORY ORIENTATION

CHAPTER TWO
LITERATURE REVIEW ON TEENAGE PREGNANCY

CHAPTER 3
PRESENTATION OF RESEARCH FINDINGS

CHAPTER 4
CONCLUTION AND RECOMMENDATION

CHAPTER ONE
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Young people are far more 'sexual' and sexually active than ever before, and a perception has been cultivated that if something isn't done the age of young people having sex will continue to get lower (Lee, 2002:38). Teenage pregnancy is seen as the result of early sexual activeness.

Teenage pregnancy has become a very serious social problem in South Africa, and pregnancy under the age of seventeen has been viewed as a catastrophe for individuals, family and society (Greathead, 1998:21). According to Heaven (2001:176) teenage mothers are having more babies compared with a generation ago. Moreover, the younger adolescents are when having their first child, the more likely they are to have another child while still a teenager.

Falling in love, developing crushes and forming romantic relationships are all parts of a sequence which may culminate in sexual intercourse (Moore & Rosenthal, 2006:8). It is frightening that the youth of today do not seem to be afraid of falling pregnant or contracting the HIV Aids virus. It is disturbing to note that though adolescents are having sex earlier and more often, sometimes with multiple partners, they lack the basic knowledge about contraceptives. According to Lots of essays .com (2008:1), as to be found on the internet, says that the number of teenage pregnancies has been alarming for many years, and it seems to be a particular problem in urban and poor areas, though it occurs across all social and demographic lines.

Teenage pregnancy is one of the major contributory factors to population growth. The increase in population in the developing countries represents a major obstacle to the economic development of the country. With nearly half the total population in these countries being below the age of fifteen, the low ratio of workers to non-workers creates what is called a 'burden of dependency'(Macleod, 1999:9).

1.2 **BACKGROUND TO THE PROBLEM**

The society in which adolescents grow up has an important influence on their development, relationships, adjustments and problems. Teenagers in South Africa live in a society undergoing rapid technological changes. Children as young as seven years old have their own cell phones. Adolescent in South Africa also engage in MXit, the way of chatting to each other via cell phones. It is estimated that more than one billion people worldwide use the internet. More adolescents are raised by single parents or foster care as a result of the high extramarital birth rate, divorce rate and AIDS. The high rate of drug abuse to teenagers and poverty are the challenges that the youth of South Africa are facing today (Gouws, Kruger and Burger, 2008:5).

Most teenagers spend a lot of time looking in the mirror or examining body parts in detail, and it does not end there, but also become more interested in that of others. They become more fascinated with basic facts about human reproduction. Gradually they become more interested in sexual experimentation with others. Part of this is motivated by curiosity, part by a desire for sexual stimulation and release, part by a need for love, affection, intimacy, and acceptance from another person (Rice, 1992:367).

There are many reasons that drive teenagers towards sex. Some teenagers do sex just because they want a quick fix to relieve biological drives. But often adolescent sexuality is driven by emotional needs that have nothing to do with sex. These emotional needs include the desire to receive affection, ease loneliness, gain acceptance, confirm masculinity or feminity, booster self-esteem, express anger, or escape from boredom. Sex becomes a means of expressing and satisfying nonsexual needs (Rice, 1992:377)

According to Tips on pregnancy: pregnancy guide (2005:1) teenage is a delicate stage of life when both girls and boys may indulge themselves in certain irresponsible activities and end up being unexpected mothers and the fathers. When parents come to know about their daughter’s pregnancy they general have mixed reactions. They first get extremely angry accusing their daughters for the sense of irresponsibility they have shown. The expectations they had for their dearest suddenly appear to be vague and an almost sheer impossibility. They go on wondering how their child will be able to fulfill the

responsibility of parenthood and at the same time seek for respectable and successful careers.

On the other hand, some parents consider themselves responsible for their daughters' wrongdoings. They consider that there is something missing in their method of upbringing, which has given their daughters an opportunity of degrading their self-esteem. All in all, there are many factors that can lead to teenage pregnancy (Tips on pregnancy: pregnancy guide, 2005:1).

Current studies indicate that teenagers become sexually active in early puberty. During this time, the teenager is faced with various challenges such as the onset of menstruation in girls and wet dreams in boys. Compared to urban areas, the incidence of teenage pregnancy, abortion and childbirth is significantly higher in rural areas. These teenagers become sexually active at an early stage and without using any form of contraceptives (Mlambo, 2005:2; Makiwane 2010:195-196)).

Adolescent pregnancy affects the emotional, social, physical, and economic well-being of the teenage parent and child (Rice, 1992:395). When a pregnant teenager is emotionally disturbed she ends up taking wrong decisions. Sowetan (2010: 2) stated that a desperate teenage mother abandoned her one-year-old toddler because the child no longer fits into her lifestyle. Another child aged between one and three was discovered in Mayibuye section of Thembisa. The number of abandoned children in South Africa is steadily increasing. Child Welfare South Africa recorded 2392 new cases of abandonment over the past year with the majority being black. Current statistics put the figures of abandonment at: Black-1500, coloured-700, Indians-70 to 80 and white-3 (Sowetan, 2010: 2)

Teenage pregnancy among blacks is proportionately higher than any other racial group. In the United States. Black teenagers make up only 15 percent of the adolescent population, yet account for 31 percent of all births to adolescents and 44 percent of all births to unmarried adolescent. (U S Bureau of the Census (1991). This means the issue of teenage pregnancy was a problem long time ago, but it looks like it is deteriorating. As these teenagers do not want to use the reliable means of birth control,

the number of premarital pregnancies among 15- to 19- year olds has skyrocketed to over 1 million a year (Rice, 1992:395).

Teenage pregnancy can lead to depression, poor school performance and emotional instability. The teenager develops fear of the unknown with regards to abandonment by a boyfriend or deprivation. A strong relationship between teenager pregnancy and depression can also be assumed. Depression is associated with impaired decision-making, lack of motivation and a low self-esteem. Amongst girls, pregnancy reflects an attitude of passivity and of not caring about what happens in their lives. Some teenagers fall pregnant because they are assertive (Mlambo, 2005: 1).

1.3 STATEMENT OF THE PROBLEM

The study focus was mainly to establish whether the high rate of teenage pregnancy in the high schools of Ilembe District is caused by the child support grant or maybe there are other factors that contribute towards it. The study also focuses on the best methods that will stop or minimize the high rate of pregnancy in teenagers

The primary question is:
What are the causes for teenage pregnancies in the Ilembe Distrct?

Sub-questions arising from the primary question are:

- What are the causes for teenage pregnancies?
- What factors contribute to early teenage pregnancy?
- Does the child support grant contribute significantly to teenage pregnancy?
- How can teenage pregnancies be stopped or minimised?

1.4. AIMS OF THE STUDY

Teenage pregnancy is considered to be a disaster by most people. Yet teenage pregnancies are increasing in number each year. Further more teenagers pregnancies are occurring at younger and younger ages. (Devenish, 1992:180). South Africa has a huge teenage pregnancy problem- one in three girls has had a baby by the age 20.

(Irin, 2007:1)

The pregnancy in teenagers at Ilembe district is also very high. When the researcher visited several high schools, she found out that there are more than ten girls pregnant. When the researcher walks along the road she also notice that there are many pregnant learners that are wearing their school uniform. What has become the most problem is that those that already have babies, often become pregnant again. Some teenagers fall pregnant two or three times before they complete their grade twelve.

The investigation was conducted to find out the number of teenagers younger than 20 years that give birth in a year at Mandini Clinic at Ilembe District. The researcher found out that there were 178 teenagers in 2008, 30 were admitted with incomplete abortions, 21 had legal termination of their pregnancies, and from January to March 2010, there are already 41 girls that have received their babies in the clinic. The nurses told the researcher that the number of teenagers is increasing every year, and that there are some teenagers that come to the clinic to ask for the fertility tablets. In that light of the above teenage pregnancy is indeed a problem at Mandini area at Ilembe District.

The study on teenage pregnancy in high schools of Mandini ward at Ilembe district, aims at:

- Finding out the cause behind the teenage pregnancy
- Finding empirical data on causes for the teenage pregnancy.
- Recommendations and guidelines that will help the teenagers of at Ilembe district.

1.5. STATEMENT OF HYPOTHESIS

The statements of hypothesis are calculated guesses that are quite useful in shaping the direction of the study. The questionnaires were formulated in such a way that they address the concern that encompassed in the statement of hypothesis. In this study the following hypotheses are postulated:

- That poverty at Ilembe District leads to high teenage pregnancy
- That the teenagers think that the child support grant is a lot of money that they can use to raise their children and also spend it on their own needs.

- That the teenagers have poor understanding of the negative effects of pregnancy.
- That parents and schools do not teach sex education properly to the teenagers.
- The high rate of alcohol and drug abuse in teenagers lead to high teenage pregnancy.
- Ignorance and the incorrect use of contraceptives lead to high teenage pregnancy.

The above stated hypotheses were calculated guesses of the researcher; they were subject to acceptance or rejection pending on the outcome of data analysis.

1.6 DEFINITION OF TERMS

The following concepts need to be defined so as to prevent any ambiguity that may result from their misinterpretation. These terms, and the accompanying definitions follows.

1.6.1 **Cause**:

According to the Oxford dictionary (1994:141) *cause* is a thing that produces an effect.

1.6.2 ***Pregnancy***

Pregnancy can be referred to as a process whereby a female carries a live offspring from the time of conception to childbirth.

1.6.3 Adolescent

Adolescence is a period of transition between childhood and adulthood. It commences with physical changes at puberty. It terminates with assumption of adult roles and responsibilities, e.g. economic, social, political, legal and sexual independence (Greathead, 1998:3).

Jaffe (1998:36) further defines adolescence as the life period that begins with the onset of puberty and the shift to the middle school and ends when an individual is

economically self-sufficient and has taken on several adult roles. The adolescent is any person, usually between the ages of 11 and 19, who has clearly started the search for a personal identity

According to Gouws, at al, (2008:2), the term 'adolescent' derived from the Latin verb *adolescere,* meaning to grow up or to grow to adulthood., thus referring to a development phase in the human life cycle that is situated between childhood and adulthood.

Adolescence is an important period for one's educational attainment, especially with regard to the completion of high school and preparation for ones' vocation. Further more, adolescence is an important period of a person's psychosocial development (Naidoo, 2005:56). The word teenager is used interchangeable with adolescent.

1.6. 4 . Teenage pregnancy

Teenage pregnancy can be defined as a teenage or underage girl, usually within the age of 13-19, becoming pregnant. The term in everyday speech usually refers to women who have not reached legal adulthood, which varies across the world, who become pregnant (Wikipedia, the free encyclopedia, 2008:1). Teenage pregnancy also referred to a bodily process which includes conception, pregnancy and giving birth by an unmarried adolescent (Davids, 1989:89). Quantitatively teenage pregnancy refers to the fertility rate or number of births per 1 000 women between the ages 15-19 (Makiwane 201:195).

Teenage pregnancy or teenage mother are therefore those adolescents between 15-19 years of age that are pregnant or had a baby.

1.7 DELIMITATION OF STUDY

The study is confined to Mandini area. Mandini is a small town situated in Ilembe District in the Northern side of KwaZulu Natal. It is a small area that is found next to SAPPI and Isithebe industrial area. SAPPI is a big company that pays employees a reasonable salary, but Isithebe industries are paying people that are working there from R50 to R500 a week. Therefore the rate of poverty is high in that area. Most people cannot

afford to build or buy houses so they reside in the informal settlement. Most learners that attend high schools there are from the informal settlements. There is a small location called Sundumbili. At Sundumbili there are four high schools. Three other high schools are at the semi-urban area, outside Sundumbili, called Isithebe. Other high schools are in the rural areas far from Mandini. People living in these areas usually have transport problem. It is very difficult for them to visit the town and the clinics. Mandini area is very small but the number of people infected or affected with HIV/AIDS is high. There are ten high schools at Mandini ward and the study will be conducted to those high schools in order to find out the cause behind the teenage pregnancy.

To ensure that the study is focused on the specific subject the scope of the study was delimited. Although the overall study is aimed at reducing the high pregnancy rate in Ilembe District it may also help all the teenagers of KwaZulu Natal as a whole, and contributing to better life for all.

1.8 RESEARCH METHODOLOGY

The study investigates the cause behind the high rate of pregnancy in teenagers at Ilembe District. It is also going to find out if the child support grant has something to do with the increase in pregnancy rate or maybe there are other factors that need be considered. Existing literacy sources will be used as complementary sources to strengthen the authenticity of the study. The methodology of this study deals with the selection of sample, instruments of data collection and method of date analysis.

1.8.1 Literature study

The literature study consists of a review of relevant sources (books, journals, internet) to describe the phenomenon of teenage pregnancy. The literature study forms the basis and provides grounding for the empirical research.

1.8.2 The sample

There are ten high schools under Mandini ward at Ilembe District. All these high schools will be used to collect data. Ten girls from each high school will be selected. The sample technique that will be used will be a random sample.

1.8.2 Instrument of data collection

Van den Aardweg and Van den Aardweg (1993:198) define a questionnaire as a prepared question form submitted to certain person (respondents) with the view of obtaining information. A questionnaire is a set of questions dealing with the same topic or related group of topics, given to a selected group of individuals for the purpose of gathering data on a problem under consideration (Van Rensburg, Landsman and Bodenstein, 1994: 504)

A questionnaire is a self report data collection instrument that each research participant fills out as part of a research study (Johnson and Christensen, 2000:127). Researchers use questionnaires so that they can obtain information about thoughts, feelings, attitudes, beliefs, values, perceptions, personality, and behavioural intentions of research participants. However, the study will be conducted using the questionnaires. The questionnaires will have closed questions. If there is any information that is needed, focus group interview will be conducted

1.8.3 Method of data analysis

The collected data would be coded and frequency table will be drawn to display relationships between the variables.

1.9 ORGANIZATION OF THE STUDY

Like most scientific studies, this study consists of four chapters, i.e. introduction chapter, literature review chapter, data analysis and interpretation chapter, and summary and conclusion chapter.

Chapter 1 serves as a prelude to other chapters. In this chapter a tentative orientation of the study is revealed. Terminology which is prevalent in this study is explained and contextualized. The conceptual and spatial narrowing of the scope otherwise known as delimitation of study is done in this chapter. This chapter also contains the aim of this study which has been narrowed down to objectives of the study. One of the most important components of this chapter is the statement of hypothesis

Chapter 2 is a review of relevant literature. It provides a conceptual framework for the investigation. It looks at existing literature and investigations of how previous scholars related to teenage pregnancy.

Chapter 3 will explain the empirical research conducted and on the interpretation of data

Finally, chapter 4 focuses on the conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW ON TEENAGE PREGNANCY

2.1 INTRODUCTION

The children are always considered to be a gift from God, but for some, it is either considered a mistake or a misfortune, especially when it in not planned for. The arrival of the child is usually prepared for, even before it becomes a foetus. In the case of the child giving birth to a child, the preparation is done out of inconvenience, since its coming was not prepared for. When it comes to a child giving birth to a child, teenage pregnancy is always a central idea. Teenage pregnancy, of late, has become a topic of discussion in most of our society and the media (Ghanaian Chronicle, 2009:1).

More adolescents become sexually active at an early age, risking unwanted pregnancies, as well as sexually transmitted diseases (Rice, 1992:395). Society's treatment of pregnant teenagers has improved considerably since mid-century. Formerly, girls who were pregnant out of wedlock were outcasts, banished from their schools, shunned by their peers, often shipped out of town to give birth or to get an illegal abortion. Today, we encourage pregnant teenagers to give birth, keep their babies, and stay in school. Some schools provide day care for their students' offspring. Pregnant young women appear on afternoon TV talk shows justifying their choices and life styles, imploring views to not judge them. Critics complain that by being "tolerant" of these young mothers, we are condoning irresponsible sexual behaviour. (Jaffe, 1998:378)

According to Singh (2005:14) teenage pregnancy is a universal problem that affects all the communities. It is not a new phenomenon, but it is strange that in the era of sexual literacy and contraception, teenage pregnancy is still a major problem throughout the world. So we often read in the media of the increasing number of teenage pregnancies. Recently, the mass media reported that teenage pregnancy is escalating at a dramatic pace because the teenagers of today are practicing their democratic right.

2.2 HISTORICAL OVERVIEW OF TEENAGE PREGNANCY

Teenage pregnancy has come very much into the public debate in recent year, at least partly as a result of three social forces. Firstly, child poverty rates are high and rising. Secondly, the number of welfare recipients and concomitant costs of public assistance rising dramatically. And thirdly, among those on welfare, we see a much higher proportion of never-married women, younger women, and women average long period of dependency (Maynard, 1997:1).

The rising of incidence of adolescent mothers throughout South Africa causes concern and is becoming a critical issue. This happens in spite of free contraceptives services, including emergency contraception. As from 1996 in South Africa pregnant women are able to terminate their pregnancy (irrespective of age), at their request during the first 12 weeks of pregnancy. Despite of that legislation the adolescent mothers have failed to use the available family planning, emergency contraceptive or termination of pregnancy services (available free of charge at clinics). This has been reflected by an increased number of abandoned babies Kansumba (2002:29)

According to Nolan (2003:12), some cultures are very accepting of young parents. For them, a teenager who has a couple of children by the time she is eighteen is simply doing what her mother and grandmother did before her. The teenager might be a part of a supportive, caring community and have friends embarking on motherhood at the same time as herself. Young mothers and fathers are well looked after and shown how to care for their babies. There are people around who will watch the baby for them and give them a break.

In Western societies, young parents are given a hard time. They can be accused of being irresponsible, selfish, careless and immature. They are thrown out of their homes when they tell their parents they are pregnant. The parents feel ashamed and worried about what their relatives and neighbours will say. They may feel that all the opportunities for the future of their daughter have been dashed (Nolan, 2003:13).

Teenage pregnancy has increased all over the world (Bull, 1998:348) and seen as a great concern in South Africa. According to Lee (2002:13), most pregnant teenagers and teenage mothers are found in areas that are economically poor.

It is true that teenagers cannot raise their children alone while they are still at school. Due to inability to provide adequately for their children, pregnant or parenting adolescents are most likely to drop out of school, receive less educational attainment, exhibit lower educational achievement than peers. They are also less likely to live in poverty, receive welfare, and have low income (Loila-Nuahn, 2004:13).

2.3. FACTORS CONTRIBUTING TOWARDS TEENAGE PREGNANCY

According to Gouws, at al, (2008:208), in South Africa more than 30% of all babies born each year are conceived by teenagers. Teenage pregnancies are reaching alarming proportions. A national figure is not available, but some communities have reported that 30 % of all births are attributed to teenage mothers (Greathead, 1998: 223). Some factors that contribute to teenage pregnancy are to be discussed below.

2.3.1 Myths and superstitions

In South Africa the large number of myths and superstitions associated with pregnancy and contraception has contributed to the increased rate in pregnancy in teenagers. Many teenagers believe that the use of contraceptives makes them sterile, and that plastic wrap make an effective condom. Some teenagers believe that they can't get pregnant in the first time of sexual intercourse, if they are having their period, if the male withdraws in time, and they are having sex in a standing position (Gouws, at al, 2008:208).

2.3.2 Social Pressures

Teenage pregnancy is a very big problem here in South Africa in general and particularly at Ilembe district, and there are many factors that lead to pregnancy. According to Albert (2007**:**1**),** there are social pressures that push the teens toward falling pregnant. Some girls feel that they will only be accepted as girls once they have proved their fertility, and

there are some mothers that want their daughters to become pregnant so that they could have a baby at home again.

According to Moore and Rosenthal (2006: 200) to some teenagers, pregnancy is not accidental and unwanted but having a baby is a planned and deliberate choice. For these teenagers 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 average, having friends who are themselves young mothers and having a stable relationship - which may or may not be marriage with a partner.

In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy. For an example, in some sub-Saharan African countries, early pregnancy is often seen as a blessing because it is proof of the young women fertility. In the Indian subcontinent early marriage and pregnancy is more common in traditional rural communities compared to the rate in cities (Wikipedia, the free encyclopedia 2005:1).

Article on teenage pregnancy “issues in our world” (2008:1**),** also states that pregnancy in teenagers is sometimes the result of traditional roles and early marriage. Teenage pregnancy is seen as a blessing and a proof that the young woman is fertile. Once more because of the change in time, the teenagers feel that having sex before the age of 20 is the normal thing, and thus they engage themselves to it without the provision of comprehensive information about sex. Due to the shortage of knowledge, eventually they fall pregnant.

2.3.3 Poverty

The current socio-economic situation in South Africa means that those who live in poverty are often exposed to more “live” sexual activity because families are required to live in small houses where there is distinct lack of privacy for the parents (Bezuidenhout & Joubert, 2008:32). Children that grow up under that situation can easily engage themselves on sexual activity as soon as they entered the puberty stage.

Throughout the developed world, teenage pregnancy is more common among young people who have been disadvantaged in childhood and have low expectation of education or the job market. The literature shows that youth living in poverty have a teenage pregnancy rate which is five times the average. Socio-economic circumstances seem to play a major role in rates of teenage pregnancy. There may be a growing 'lost generation' of young people who see no reason not to get pregnant. For some disadvantage youth, particularly for girls whose self esteem tends to drop as they mature, sexuality may be all they have to value. Lack of opportunity and hope for future, have been identified as a driving force behind high rates of teenage pregnancy (Gender and poverty, 2008:1)

The rate of pregnancy and childbirth is high among poorer adolescents. Other scholars found out that 83 percents of adolescents who have babies are from poor families. (Helen, at al, 2006: 43)

The major causes of teenage pregnancy are the educational level and the higher rate of poverty. Poverty is associated with the increased rate of teenage pregnancy. Economically poor countries such as Niger and Bangladesh have far more teenage mothers compared with economically rich countries such as Switzerland and Japan. Some girls fall pregnant just because they want social grant (Wikipedia, the free encyclopedia, 2008: 5)

2.3.4 Adolescent Sexual Behavior

According to Wikipedia, the free encyclopedia, (2008:3), teenage pregnancy can be caused by adolescent sexual behavior. Some teenagers fall pregnant because they lack information or access to conventional method of preventing pregnancy. For example, inexperienced teenagers may use condoms incorrectly or forget to take oral contraceptives. Contraceptive failure rates are higher in teenagers, particularly girls from the poor social backgrounds.

Greathead, et al, (1998:103) states that the teenager's sexual decisions may be influenced when:

- One is suffering from boredom and wants to be fashionable.

- One is ignorant of the consequences of sex
- One is carried away by passion.
- One is coerced by ones partner and wants to prove ones love.
- One is under pressure and cannot say no.
- One believes that one is obligated because of the cost of the date.
- One is under the influence of drugs and alcohol.
- One is part of the group that values sexuality.

According to Greathead, et al, (1998:103) teenagers may decide to become sexually active for the following reasons:

- Rebellion against parental or religious restraints.
- Seeking physical pleasures as an escape from loneliness.
- To boost poor body image, feelings of inadequacy or poor self-esteem.
- Desire to make the partner responsible for her or fear of loosing him.
- Virginity perceived to be a 'burden' because of peer pressure.
- Desire for pregnancy by an emotionally deprived girl who needs to be a mother and wants to be a mother

2.3.5 Age Discrepancy

According to Lesser, at al. 2001 in Helen, Holgate, Evens and Yuen (2006:47), in the age-differential relationships in which the female is the younger partner, male power and control may undermine the woman's ability to negotiate sexual intercourse and the use of contraception. An older partner may pressure the adolescents into participating in unprotected sexual activities, basing the encounter on ideas of trust and fidelity.

Recently, there has been a tendency for older men to develop sexual relationships with younger females. This places the females at even greater risk of contracting infections or becoming pregnant or both because men have longer sexual histories. Additionally, in these partnership young women has less power to negotiate safer sexual practices, particularly since some of them have been promised financial assistance from older men. (Radhakrishna, et al, in Manzini, 2004:45)

Age discrepancy can also be a factor that leads to teenage pregnancy. Teenage girls in relationship with older boys and in particular adult man, are more likely to become pregnant than when they are involved with someone of their own age. According to a review of California's 1990 vital statistics found that men older than high school age sired 77% of all births to high school-aged girls (age 16-18) and 51% of births to junior high school-age girls (15 years and younger). Men over age 25 fathered twice as many teenage births as did boys under age 18, and men over age 20 fathered five times more births to junior high school-aged girls than did junior high school-aged boys. The Guttmacher Institute found that 60% of girls who had sex before age 15 were coerced by males of an average of six years their senior (Wikipedia, the free encyclopedia, 2008).

According to teenage Pregnancy Issues in our world Today (2007), rape as a sexual abuse, has more effect in the lives of our teenage girls because they cause unwanted sex and teenage pregnancy.

2.3.6 Violence and Coercion

Gender power inequalities play a significant role in women's vulnerability to early and unprotected sex as well as pregnancy in South Africa. Sexual and physical violence have come to characterize relationships between men and women in some communities in SA (Moore & Rosenthal, 2006:200). On many occasions, young women have less power over their own bodies than men, and often required to be more accountable for their actions than young men (Naidoo, 2005:31). The 2003 RHRU survey reported that 2% of 15-24 year old males and 10% females had been physically forced to have sex. In a case of controlled study among pregnant teenagers in Cape Town, 25% of pregnant teenagers reported. Recent research has shown that both a history of physical abuse by a partner and current involvement in a physically abusive relationship were associated with becoming pregnant (Moore & Rosenthal, 2006:200).

South Africa is a very patriarchal society and as a result of its violent political history, the use of physical violence as a first line strategy to gain or to keep a position of ascendants or resolve conflict is common (Simpson, 1991). In schools there is a widespread problem of violence and lack of discipline, which involves both students and teachers. The 1998 South African Democratic and Health Survey found that school

teachers were the most common perpetrators of rape of young girls (Jewkes, Vundule, Maforah & Jordaan, (2000) as cited by Panday, et al, (2009:54).

Girls who date gang members are twice as likely to become pregnant as compared to those not seeing boys involved with gangs. Further more, girls, whose boyfriends were in jail are also likely to become pregnant. Gang involved youth may be under increased social pressures to have a baby, and the belief that pregnancy strengthens the commitment between couples or influences the status of females within a relationship are strong with gang-involved couples. Women with gang-involved partners may feel less power to negotiate condom use (The Times of India, 2008:1).

According to Wikipedia, the free encyclopedia (2008:4), dating a violent person also leads to teenage pregnancy. Some studies have indicated that adolescent girls are often in abusive relationships at the time of their conceiving. They have also reported that knowledge of their pregnancies has often intensified violent and controlling behaviors on part of the boyfriends. Women under age 18 are twice as likely to be beaten by their child's father as women over age 18. A UK study found that 70% of women who gave birth in their teens had experience adolescent domestic violence. Similar result have found in studies in the U.S.A Washington study that of teenage mothers has been beaten by their boyfriends. According to 2006 survey, 30 percent of girls in South Africa said that their first sexual experience was forced or under threat of force (Irin, 2007:1).

2.3.7 Childhood environment

Women exposed to abuse, domestic violence and family strife in childhood are more likely than those without such experience to have a teenage pregnancy, and the risk increases with the number of adverse childhood experiences. According to a 2004 study, one-third of teenage pregnancies could be prevented by eliminating exposure to abuse, violence and family strife. Studies have also found out that boys rose in homes with a battered mother, or who experienced physical violence directly, were more likely to impregnate a girl than boys who had not (Wikipedia, the free encyclopedia, 2008:5).

According to the article by YCC (2007:1), pregnancy rate is high because teenagers lack responsibility. The article stated that teenagers lack responsibility because teens get

pregnancy because they usually don't practice safe sex and definitely do not practice abstinence. Teenagers also fell pregnant because they lack respect for themselves, do not care about themselves, and some are just lazy. In other words, it is hard for them to say no. Once the teenager engages herself self in unprotected sex, it might happen that she is lazy, she does not want to go to the family planning where she will get contraceptives.

2.3.8. The school environment

There is a considerable misinformation about sexual health matters amongst young people. Sexual health education in the form of life skills have been introduced as a compulsory part of the school curriculum, but the way in which it is implemented is not successful. Most educators are not well equipped on how to implement it. Eventually teenagers do not get the necessary information about sex education (Jewkes, at al, 2001)as cited by Panday, at al (2009:53)

School experiences, school achievements, and educational aspirations influence patterns of adolescent pregnancy and childbearing. Young women engaged in school activities are less likely to get pregnant. If the education system is discouraging, some adolescents drop out school early. Adolescents that attend large and overcrowded schools staffed by relatively inexperienced educators, and, in addition, have to face safety concerns problems with gangs, and language difficulties, are more likely to complete their high school education. Poor-quality schools and social exclusion prepare young people for low-age and unstable employment offering and little incentive to stay in school (Helen, at al, 2006:44).

2.3.9. Drugs and Alcohol

Adolescents who participate in one or other form of risk behavior often partake in other risk behaviors (Essau, 2004, in Panday, at al, 2009: 61). The high rate of drug and alcohol abuse contributes a lot to teenage pregnancy. When a teenager is being intoxicated with drugs and/or alcohol she may find herself doing unprotected sex which may result in pregnancy or HIV (Teenage pregnancy issue in Our World Today, 2008:2).

According to Morejele, Brook, and Kachieng'a (2006) as cited by Panday et al, (2009:61), the psychoactive effects of alcohol and drugs used are taught to increase sexual arousal and desire, decrease inhibition and tenseness, diminish decision-making capacity, judgment and sense of responsibility, and generally disempowered women to resist sex. The studies have reported on the increased risk of forced sex and the decreased likelihood of using condoms when under the influence of alcohol. These effects are facilitated in a context of high unemployment, and in an environment where peer norms promote heavy drinking, alcohol and drugs are easily assessable and casual sex readily available.

2.3.10. The Lack of Education on Safe Sex

The reality of bringing up a child alone and usually on a low income is not being brought home to teenagers. They do not know how easy it is to get pregnant, and how hard it is to be a parent (Social Exclusion Unit 1999:7).

Miller (2006:58) stated that the lack of education on safe sex**,** either on the side of the parents or the educators, may lead to teenage pregnancy. Many teenagers are not taught about methods of birth control. The cost of living is too high these days, and parents are expected to work to boost the income. Therefore teenagers are left on their own for the whole day. In that case a lot might happen while parents are at work. According to Martin (2007:102) girls are allowed to dress like common prostitutes and boys are trained to treat them as such. They are also free to stay out all hours of the night. This shows the high possibilities for the girls to fall pregnant.

Conger (1991:243) states that the most adults feel that sex education, even in secondary school is dangerous and premature for impressionable adolescents and is likely to lead to indiscriminate promiscuity. Furthermore he found that most adults believe that parents should teach sex education in the privacy of their homes. Surprisingly he found out that the adolescents are in disagreement with adult. The adolescents felt that sex education should be taught in school as a course on its own. They did not want sex education to be slipped into other courses such as health and biology.

There is strong evidence that school-based sex education can both delay and promote safe sex.

2.3.11. Contraceptives

Some people believe that teaching about contraception encourages sexual activity, concluding that if contraception was not available sexual activity would be prevented. However, research shows that the majority of teenagers are already sexually active for between six months and one year before attending a family planning (Greathead, 1998:223).

According to (Panday, at al, 2009:87), family planning services are provided to young people with the purpose of making available reproductive health services, provide contraception including condoms and improving their knowledge and skills to use them. But Macleod (1999:11) point out that until recently the family planning program in South Africa has concentrated its effort on older women, or women who are already mothers. In other words there is a lack of support from surrounding communities, a lack of co-operation between schools, clinics, and Youth Health Centres, and adolescent services often forming part of over-crowded adult family planning services.

Clinic-based services are, in general, accessible only to the motivated and informed teenagers. In rural areas the situation is exacerbated by the fact that the majorities have to travel long distances to clinics. Teenagers have indicated in various studies that they do not have easy access to the contraceptives clinics. Misunderstandings contribute to this in that teenagers believe that the clinics are only for married adults (Macleod, 1999:11). Newman and Newman, (2006:329) agree that some teenagers do not use contraceptives consistently, and in some cases, not correctly. Incorrect usage can lead to tears in condoms and missed doses of birth control pills can lead to ovulation (Panday, at al, 2009: 56).

There are some girls that fall pregnant simply because they do not want to use contraceptives. Those teenagers usually tends to hold fatalistic attitude: They are more likely to feel unable to control their own lives, have a low sense of personal competence, and take a passive, dependent approach to male-female relationships. They avoid

contraceptive use because they are afraid that it will spoil the spontaneity of the relationship or because they think it would indicate that they expected to have intercourse (Conger 1991:260).

Negative perceptions about contraceptives play a significant role in whether adolescents will use them. Such conceptions often arise from false belief about contraception such as a condom could slip off during intercourse and be left inside a women's vagina, condoms reduce sexual enjoyment, condoms are of a poor quality, and fear of the physical effects (weight gain or nausea) and fertility-related side effects of contraceptive use (Panday ,at al, 2009:57)

Premarital sex is on the increase and thousands of teenagers are giving birth out of wedlock. Hence, there is a need for parents and educators to provide the teenagers with information about contraceptives. Many adults hesitate to provide information about contraceptives because they believe it may foster promiscuity. The reality is that many teenagers are already sexually active and without this vital information they may end up being pregnant. Many parents hesitate to give their children contraceptives because they are afraid that their children may believe that they are giving them the permission to engage in sex.

Resent research has confirmed that, generally, young men regard the acquisition of contraceptive supplies and the use of contraceptive method to prevent unplanned pregnancies as the responsibility of women (Naidoo, 2005:28).

There are some teenagers that do not use contraceptives because they are afraid of loosing their partners. They preferred to use injectable contraceptives as they require no user involvement except attending for bi- or tri- monthly injections and can be a secrete. Unfortunately they often cause amenorrhoea, which is a particular problem in a cultural context where menstruation is perceived to be essential for body cleanliness. As a result sexually active teenagers commonly take 'contraceptives breaks' in order to see menstruation and may at this time fall pregnant (Panday, at al, 2000: 56).

2.3.12 Family Structure and its influences

According to Panday, et al, (2009:62) family structural characteristics play a vital role in understanding and determining teenage sexual behavior including pregnancy. Singh (2005:17) stated that teenage pregnancy has been linked to low parent education, and that girls that get pregnant often have mothers who gave birth in their teens. Parents of teenage mothers and teenage fathers are often considered by their teenagers 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 teenagers who are more likely to have unsafe sex and become pregnant (Dittus & Jaccard, 2000: 26).

Singh (2005:17), also states that teenagers who live in an incomplete families are more likely to be sexual active than those who come from two parent households. A incomplete family refers to the absence of the father or mother (Bezuidenhout & Joubert, 2009:63). 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 occurs in single parent households. Teenagers who have older siblings (more especially sisters) who is sexually active or who has had a baby are more likely to begin having sex at a younger age (Singh, 2005:17).

Family members serve as role models to their children. 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, at al, 2009:63)

Among the various dimension of family social support, parent-adolescent communication on issues of sexual behavior and childbearing is very important (Panday, at al, 2009:64). When the communication between mother and daughter is poor or absent, the girl is placed at a greater risk for premature sexual activity and potential conception, in part because she looks to others, especially her male peers for nurturing and intimacy. Families with poor interpersonal relationships may inadvertently encourage teenagers to look elsewhere for nurturing relationships. Teenagers turn to peers for relationships they cannot foster with their families. Soon pressure from peer clusters can lead to risky behavior such as promiscuity and neglect of contraception. The cluster of peers may

also become the primary source of sexual information. Unfortunately, the teenagers who share information about sex may lack the knowledge about their own bodies and about contraception (Singh 2005:17).

Teenagers who are raised in larger families are at increase risk of earlier sex than those who are not. This result from teenager's replicating their siblings' sexual behavior or because parental monitoring is spread too thin when more children live in home (Panday, at al, 2009:63).

2.3.13. Child Support Grant

There is a substantial body of evidence indicating that one of the most consistent risk factors for early pregnancy is lower socio-economic status and poverty. Several studies conducted in developing countries indicated that adolescent mothers are more likely to have been brought up in a less-advantageous social environments, come from poor families and experience pre-existing disadvantage that results from poorer economic circumstances (Panday, et al 2009: 78)

Some observers have suggested that the child support grant provided by the state was an incentive to young girls to fall pregnant (Irin, 2007: 1). The Human Science Research Council (HSRC) says that it has found no evidence to support public perception that young girls are falling pregnant so they can claim the child care grant. The researchers found the number of pregnancies among girls between 15 and 19 years peaked in 1996, two years before the grant was introduced, and had been declining slightly since, although they remained high (Cape Times, 2007: 2).

2.3.14. Health services and nurses Attitudes

Adolescents represent a large population. Adolescents mature and some of them become sexually active. They face more serious health risks. Most face risks with too little factual information, too little guidance about sexual responsibility and multiple barriers to accessing health service. There are health service that do not function effectively due to inadequate budget, insufficient staff with sufficient time, staff not being specifically designated and trained for the job, too little participation from teenage

population, lack of support from surrounding communities and a lack of co-operation between the schools, clinics and youth health centers, and adolescent services often forming part of the overcrowded adult family planning services (Kansumba, 2002: 28).

There are some girls that fall pregnant because they are afraid of visiting clinics, where they will get some contraceptives. The reason why teenagers are afraid is the nurses' attitudes towards giving teenagers contraceptives. Some nurses were uncomfortable about providing teenagers with contraceptives, as they felt they should not be having sex. They responded to request for contraceptives in a manner that was highly judgmental and unhelpful. The girls describe it as harassment (Irin, 2007:1).

Issue of access to health services is a major one for young people in South Africa because of past imbalances. However, service providers have been notoriously unsupportive towards young people seeking reproductive health services, making them feel unwelcomed by scolding them for being sexually active at such young age and refusing to provide them with contraception without their parents' consents (Naidoo, 2005:56).

Nurses in the family planning clinics often provide little information about the different types of contraceptives that the teenagers should use. They do not discuss even the side effects of those contraceptives, but the women of all ages are frequently scolded by them. (Methai, 1997:15). Because of poor education by health staff, girls in Limpopo province reported only using contraceptive pills when partners visited them, using half the number of pills to reduce weight gain or stopping contraceptive use altogether due to side effects such as amenorrhea according to Woods and Jewkes, (2006) in Panday, at al, 2009:56)

2.3.15. The Desire for a Child

According to Musick (1993:109), if the adolescent did not want babies, they would not have them, but they do want them. Indeed, many seem to fear infertility, craving pregnancy and motherhood. This desire to become pregnant and to have a child makes the prevention of adolescent childbearing a formidable task. Although it is not the primary cause of adolescent motherhood, it is one of the strongest threads in the fabric

of early fertility. A teenage girl, sometimes, fall pregnant because she wants to give her child what she did not get as a child, she hopes she can redo the past, master its pain and loosen its hold over her life. Now she will have someone of her own, someone whose childhood she will happier than hers was, and someone who will return her love.

Some teenagers fall pregnant because they want to obtain the emotional sustenance they didn't get when they were children, extend their dependent bond with their mothers through identification with their babies, whom they fervently hope their mothers will love and care for, find opportunity for competence in a new and highly valued role around which they can reorganize themselves, developing new identity through the process of becoming a parent, and fulfill their mother's spoken and unspoken desire for the "second chance" provided by grandparenthood (Musick, 1993: 111).

2.3.16. Planned Pregnancy

Some girls admit that getting pregnant is a planned strategy which enables them to avoid sex. If sex is seen as unpleasant but unavoidable activity, if their boyfriends treat them as their sexual possession, free to use them sexually anytime it pleases them, then being pregnant is a way of buying some status as well as temporary freedom (Moore & Rosenthal, 2006: 200).

There are teenagers that have babies in order to show their maturity. Sometimes they use motherhood to achieve both an identity and a feeling of being loved and needed. Other teenagers may use pregnancy to escape from unhappy home situation (Gouws, at al 2008:208).

For some girls, the decision to fall pregnant out of wedlock is based on the desire to escape from a very poor home situation. Hancock (1982:130) mentions that the girl thinks that she may use the pregnancy to trap the boy into marrying her so that she can escape the incestuous demands, physical abuse or dangerous psychotic parents she faces everyday. Often the girl fails to get the boy to marry her and she is thus saddled with the additional problem of looking after the child alone. Hancock (1982:130) further

points out that there are those girls that fall pregnant out of wedlock because of the desire to have someone to love who will love them back.

2.3.17. The Influence of the Media

Media may function as a super-peer in terms of pressuring teenagers into having sex earlier than expected (Strasburger, Wilson and Jordan, 2009:226). According to Singh (2005:25) televisions, films, videos, magazines, advertisements and novels, today, are full of sex and love. According to the researcher the media portrays the glamorous side of sex in such a way that teenagers perceive sex as something in fashion. Many teenagers, especially girls, rely on magazines as an important source of information about sex, birth control and health related issues (Strasburger, 2009:237). They ignore the consequences of sex such as unplanned pregnancy and sexually transmitted diseases.

Greathead (1998:95) stated that the media portrays sex as something exciting without risk. Heavy doses of television may accentuate teenagers' feeling that everyone is doing sex except them, and more teenagers engaged them to sexual intercourse earlier. (Strasburger, at al, 2009:226). Messages from the media often convey the concept that abstinence is outdated. Coupled with the fact that teenagers seldom think of long-term consequences of their behavior, teenagers may engage in sexual behaviours to gain immediate feeling of acceptance and self-worth (Bullocks 1992:479).

Singh (2005:25) further stated that the results from an American study in 1987 as cited by The Westside Pregnancy Resource Centre (2004) showed:

- Afternoon soap operas contained thirty-five instances of sexual content per hour.
- High school girls who saw commercials that emphasized sex were more likely to say that beauty characteristics were more important for them to feel good about themselves and to be popular with men.
- Pregnant unmarried girls were twice as never pregnant girls to say that the boy-girl relationship on the television were similar to real life relationships.
- High school learners who were addicted to daytime soap operas were far more likely than light viewers or non-viewers to overestimate the number of social occurrences of illegitimate pregnancies or the occurrence of rape.

- Student who watch a greater amount of ‘sexy’ television were more likely than light viewers to become sexually active.
- Teenagers reported that television is equally or more encouraging about sex than their best friends.
- Students who were heavy viewers of sexually suggestive music on MTV had more permissive attitudes about sex than the light viewers.
- Teenagers who were shown a set of ten music videos were more likely to find premarital sex acceptance than a companion who did not see the videos.

2.3.18. Peer Pressure

Parents spend more time at work, and their concern is about shelter and food. Therefore they neglect their children’s emotional needs and development. This often leads to children spending more time with their peers and then copying them and older gang members or negative role models in the community (Bezuidenhout & Joubert, 2008: 32)

According to Varga (1999:25), peer pressure has multiple dimensions. She stated that there appears to be a trend of young people to incorporate sex much earlier into their social lives than in the previous generations, to engage in multiple partnerships and for young men to feel pressurized in terms of their expectations of their sexual conduct.
Kansumba (2002:23), further stated that peers play a measure role in the transfer of sexual knowledge. This is/ has been viewed as problematic in that peers are seen as less reliable , or as providing less accurate information than teachers or health professionals.

Moore and Rosenthal, (1993:67) agrees that these days there is a shift in adolescents as compared to the past years. Peers today have become more important in forming teenager’s beliefs and regulating their behavior. Peer influence and pressure is often cited as one of the most influential factors affecting adolescents’ sexual decisions. Presumably, peer influence can operate in a number of ways. Teenagers can obtain information about sex from their friends, which may serve to guide decision-making about sex. This information is not always accurate, as reflected in long-standing teenage myths such as that a person cannot get pregnant the first time she has sex.

Secondly, adolescents can accept peer attitudes about sexuality. These can be implicitly reflected in peer behavior, which the teenager may use as a model for his or her own behavior, or they can actively proselytised through discussion, questioning, teasing, dare, shaming, etc. The stronger desire of many young people to be like their admired age-mates and part of the group can lead them to engage in the sexual behaviors, and express the sexual attitudes, that they perceive as characteristic of a particular 'hero' or group (Moore & Rosenthal, 1993:67).

2.3.19. Cultural factors

Macleod (1999:9) pointed out that cultural factors are divided into two ways. Firstly, the **breaking of traditional** values and **sexual control measures** is seen as contributing to sexual behavior conducive to unmarried teenage pregnancy. Secondly, the cultural value placed on fertility is believed to encourage teenage pregnancy.

2.3.19.1 Breakdown tradition.

Initially there were some sexual control traditional practices that were practiced by African societies. These practices include initiation ceremonies, where adolescents were instructed about sexual matters. A certain amount of sex play (mostly intercrural sex) was expected and allowed after initiation. Vaginal inspection was performed to ensure virginity in young women, and a special token to the parents of young women if she was found to be virgin after marriage. Peer groups played a large role in sexual education and control.

Macleod (1999:10) stated that urbanization and industrialization has led to the decline of institution such as the initiation school and virginal inspection. Formal schooling has arrested education from the hands of parents who are now seen as ignorant and uneducated by their children. There is an erosion of the patriarchal structure of the family as well as the traditional respect for elders. The influence of Western culture has led to psychological isolation.

2.3.19.2. The cultural value placed on fertility

In certain cultures, teenage pregnancy is accepted and welcomed. According to Macleod (1999:19) there is a high cultural value placed on fertility, and because marriage and birth have become separated, young women are more prone to conceive early. Teenagers fall pregnant early because men want assurances of fertility before marriage. They believe that bearing a child is an essential part of being a woman and achieving success as women.

Power imbalances in sexual relationships between men and women make the men to hold sexual decision-making power and little room to negotiate contraceptive use with partners. However, respectability among men is still strongly tied to their right to make decision about when, where and how happens, to be highly sexually active and have multiple partners (Panday, at al, 2009:70)

2.3.20. Major causes of teenage pregnancy

Moore and Rosenthal (1993:258) stated that the causes of teenage pregnancy are divided into four major categories: **Physiologically, Psychologically**, **social** and **cognitive abilities.**

Physiological: During adolescence, youth are experiencing physical growth and hormone changes that prompt sexual feelings. The sex organs are maturing and by the end of puberty, both males and females have the ability to procreate. One way that adolescents try to negotiate the change from childhood to adulthood is through sexual activity. By the time the most teenagers graduate, half of them would begin having sex. Many teenagers see sexual activity as a way to develop their adult identity, to test their future roles.

Singh (2005:16) stated that many teenagers look to their friends, especial the opposite sex, for validation and approval of the changes that their bodies are undergoing. Singh (2005:16) go on saying that many teenagers' sexual behavior provides means of challenging parents who seem to stand in their way to independency. Sometimes while testing their adult roles an unwanted pregnancy may occur. This forces them to mature faster since they have to cope and handle responsibility they never experienced before.

Moore and Rosenthal (1993:258) suggest that it is possible for the young girls to fall pregnant because of the improvements in the general health. Improved nutrition and health care have contributed to an increase in the potential for the young girls to fall pregnant.

Psychological: Moore and Rosenthal (1993:258) stated that sometimes pregnancy is the result of a teenager's conscious or unconscious desire to get pregnant. These researchers also found that the psychoanalytic model is pre-eminent in psychological explanations of adolescent pregnancy. Ego strength and family relationships are the most commonly cited reasons. Low ego strength or low sense of personal worth is said to lead to sexual acting out or use of sex as an escape. Highly dependant girls with a great need for affection and those experiencing social or psychological stress are more likely to become pregnant.

Family situations or problems which have been linked to the incident of teenage pregnancy include the following: closeness to father, lack of closeness to mother, unstable family relationships, father absence accompanied by resentment of the mother, and feelings of rootlessness (Mckenry et al (1979), as cited by Moore and Rosenthal (1993:258).

Macleod (1999:6) stated that teenagers that have a poorly defined sense of identity and low self image and self-confidence, they (the pregnant teenagers) experience themselves as inadequate and inferior and are plagued by the feeling of insecurity. Therefore there is an association between poor self-esteem and teenage pregnancy.

Social: According to Mckenry et al (1979), as cited by Moore and Rosenthal (1993:258) poverty influences pregnancy rate. Insufficient economy and social resource may lead to pregnancy. Pressure from peers and the influence of the media are also social precursors to pregnancy during adolescence.

Cognitive Abilities: Another major cause concerns young girls' lack of the knowledge and maturity required to prevent unwanted conceptions. One must possess the cognitive ability to foresee the consequences of sexual activity. Moore and Rosenthal (1993:259)

indicate that some teenagers believe that they are too young to become pregnant or that their sexual encounters are too infrequent. There are some teenagers that do not believe that they can fall pregnant during a single act of intercourse. Others are unable to relate risks of pregnancy to their menstrual cycles or are too menstrual irregular to use such information properly.

Cognitive model views adolescents' pregnancy as resulting from some cognitive deficit, such as poor problem-solving skills, inability to plan for the future, or lack of knowledge about contraception. There is evidence that many teenage mothers have undetected learning problem that makes it difficult for them to succeed academically
Jafte (1998:380).

2.4. THE EFFECTS OF PREGNANCY ON TEENAGERS

2.4 1. Physical Effects

Teenage pregnancies involve significant risk for both the babies and the young mothers. When a teenager realizes she is pregnant, the tendency is to try and hide the condition until it becomes obvious. For this reason few babies born to teenage mothers receive adequate prenatal care (Bullock, 1992: 477).

According to Genobaga (2004:138) teenage mothers are more likely to get complications during pregnancy such as pre-eclampsia, increase in blood pressure and early labor. Teenage mothers are more likely to have poor diet and that makes them less likely to gain the proper weight during their pregnancy, and because of poor nutrition they are more likely to have anemia and low bone-mineral content, which can lead to weak bones in later life.

Teenage mother are also likely to have sexually transmitted diseases which can also be passed to the baby. A young teenager is more likely to give birth to an unhealthy, low birth weight infant because the girl's body may not be ready to support pregnancy (Martin, 2003:51)

2.4.2 Inadequate mothering

According to Macleod (1999:15), mothering is a topic that has been thoroughly researched within psychology, sociology, social work etc. He further stated that teenagers found mothering to be difficult, be unclear about as to what their children's emotional 'needs' are, and have irrational thoughts and feelings. Most teenagers display high levels of parenting stress and are less responsive and sensitive in interaction with their infants than adult mothers. This is caused by the lack parental skills.

2.4.3 Social and Psychological Effects

The pregnant teenagers find it difficult to reveal their pregnancy to parents or other authority figures. Therefore they undergo psychological stress from negotiations with parents, revelations to the unborn child's biological father, peer rejection, leaving the school and fear. The anticipated perceptions of insensitivity of health profession towards her pregnancy may also be stressful to the adolescent. Coddington's research reveals that pregnant adolescents experience significant stress which could negatively impact their physical state if it went unmanaged (Jones & Battle, 1990:97).

Teenage mothers are more likely to have poor parental skills and may find it difficult to cope with the pressures of taking care of a child 24 hours a day. They are also less likely to have regular people to help them take care of the baby, such as a boyfriend or parents who are supportive (Genobaga, 2004:138). The pregnant girl experiences isolation from peers. Emotions experienced as a result of the extreme difficulty of coping with pregnancy may lead to disappointment, anger, depression, and feeling of being trapped, loneliness, anxiety and insecurity. The suicide rate for pregnant teenagers is ten times that of the general population. Girls born to teens mother are up to 83% more likely to become teen mothers themselves, teen sons of adolescent mothers are up 2.7 times more likely to go to jail than those born to mums who were over 20 (Greathead, 1998:158).

A young mother, particularly a single mother, will have less time to socialize, develop as an individual, and learn how to develop health interpersonal relationships (Naidoo, 2005:56). Married adolescent mothers are more likely to experience divorce than those married women who postponed childbearing until their 20s (Loila-Nuahn, 2004:11)

2.4.4 Disruption of schooling and socio-economic disadvantage

A pregnant teenager's education is likely to be ended by her pregnancy and those adolescents dropping out of school are also more likely to have repeated pregnancies. Teenage fathers may find themselves forced to leave school and enter the job market earlier than expected. If the couple decides to get married, they may face economic problems because the father probably has not completed his schooling, and he does not have a fixed employment. The teenage mothers from low socio-economic spheres often have to rely on social services for support, either medically or financially (Gouws, at al, 2008: 210). Child bearing during adolescence is perceived as a trap that propels young mothers on a downwards spiral in socio-economic terms (Naidoo, 2005:56).

According to Greathead (1998:157), the pregnant girl's secondary and tertiary education may be limited. Approximately only one half of the girls who give birth before the age of 18 complete schools, in that case life span and career goals are disrupted. This result to fewer job opportunities, and then usually for lower-paid jobs - the girls earn half as much as one who did not fall pregnant. Pregnant teenagers are more likely to live in poverty or be financially dependant on family members, or public assistance. As they drop out of school early, they may lack job skills and may find it difficult to find or to keep a job (Genobaga, 2004:138). Teenage mothers are less likely to finish high school, in other words some dropout school, and that lead to lower paying jobs and limited job skills. They are more likely to be financially dependant upon their family or social grant.

The younger the mother, the more likely the children are to have learning problems. Children that have been raised by teenage mothers are 50% more likely to repeat a grade. This is because these children perform worse on cognitive development tests and are more likely to drop out of secondary school (Helen, at al, 2006:50).

2.4.5 Education of School-Aged Mothers and Their Possible Return to Mainstream Schooling

Some teenage mothers may be reluctant to return to school after having babies. The reason is that they may wish to remain at home with the new baby. Sometimes it happens that there is nobody at home to look after the child. There are teenage mothers that are reluctant to leave their baby with someone else. Therefore the lack of suitable child care is often a problem for a young mother to return to school (Helen, at al, 2006:50).

Some teenage mothers are also reluctant to return to school because of negative attitudes of school staff. Peer pressure and criticism are also a problem. Some young mothers feel that the reaction of their peers may be unfavorable. Most of them have poor attendance at school. What the researcher has observed is that teenage mothers have many reason that lead them to absence from school. Some of the reasons are that, the child is sick and the teenage mother has to take the child to the clinic, there is nobody to leave the child with at home, teenage mother has gone to receive a child support grant, etc. (Helen, at al 2006:70).

The other problem that leads to school drop out is that teenage mothers feel that they are more grown-up than their peers. The feeling of being a school girl is no longer appropriate when they are mothers (Helen, at al 2006:70).

2.4.6 The Teenage Father

The teenage father is not often forgotten, because the family members often direct their anger towards him for the pregnancy. He is viewed as the “responsible” party and the provision of maintenance must be decided. Eventually, his education decreases if he is working to provide maintenance. The decrease in education leads to the decrease in occupational opportunities (Greathead, 1998:158). He becomes frustrated and feels inadequate if he is unable to provide adequately. The emotions he experiences may include anger, resentment, guilt and anxiety. He has no legal rights regarding the mother and the child if his baby is born out of wedlock, but ended up not knowing whether to get married or not (Greathead, 1998:158.)

According to Panday, at al, (2009: 78), there are some factors that affect the young father’s wellbeing and participation in parenting. These factors are:

- The cultural measures of responsibility equated with money.
- Young men's view money dominant over practices and qualities
- Rejection by the mother child's family
- High unemployment rate
- Multiple concurrent partners amongst young men
- Ignorance about basic biology and contraception
- Foreshortened view of the future
- Parents hijacking young fathers responsibility
- Geographical separation between father and child
- The failure of services and sex education

2.4.7 The Baby

The teenagers that fall pregnant under the age of fifteen, less than 36 percent of them seek prenatal care within the first trimester. This puts the infant at risk of being premature and having a low birth weight. Macleod (1999:4), states that 22% of mothers aged 17 years and younger at the King Edward Hospital give birth to infants weighing less than 2.5kg. Cameron, Richter, McIntyre, Dhlamini and Garstang (1996) compared teenagers less than 17 years old with teenagers with the age between 17- 19 years old and older women with the age between 20-29 delivering at Baragwaneth Hospital in Soweto. The offspring of young teenage mothers were significantly smaller than those of mothers over 19 years of age (Macleod 1999:4).

The lack of prenatal care also increases the incident of neurodevelopment problems including cerebral palsy, seizure disorder, and mental retardation. Congenital impairments such as blindness and deafness are also common, as is the increased risk of infant mortality (Bullock, 1992:477).

Babies born to teenage mothers are generally small and there is a high frequency of more than one baby, for example, twins. The baby is subject to the problems related to a single parent family as well as to insecure, young parents. Sometimes the child is frequently abused because of parental discontent, as the anger is focused on him/her. He/she may suffer social or legal discrimination, neglect or abandonment (Sapire, 1986). Once more, babies from teenage mothers would potentially become 'football' children,

being passed from one relative to another with no opportunity of bonding with any one individual. There are some cases where the children are abused because their families may be reluctant to receive illegitimate children into their families Macleod (1999:6).

According to Teal (2007:2) children born to teenage mothers are often sicker, poorer, and less educated as a group then those born to parents in their 20's. These children tend to have more behavioral problems because they are raised by teenagers that frequently lack the ability to master parenting skills. Statistically, they perform worse on standardized tests and are more likely to repeat grades in school. Apart from problems I have mentioned above, these children are the most likely group to become teenage parents and repeat the cycle.

Infant mortality (infant death during the first year) is the most serious consequence of medical complication that may arise with the offspring of adolescent mothers. Many studies have revealed a strong relationship between young maternal age and infant mortality. In a related sense, however, the infants of teenage mothers are more frequent among the socio-economically disadvantaged segment of the population. This is important since the survival and quality of life of an infant during its first year is a result not only of its heredity (nature), but also of its social, economic, health, and maternal environment (nurture) (Jones & Battle, 1990:94).

2.4.8 Relationship difficulties

According to Macleod (1999:7) children born to teenage mothers use to experience difficulties in the relationships in different ways. They may have difficult relationship with the family of origin, father of the child and peers. The majority of parents react negatively to the news of the pregnancy. This may be because they are embarrassed or because in poor communities the addition of another family member stretches the family's economic resources. Therefore the feeling of anger and distress are sometimes extended to the child.

2.4.9 Maternal mortality

Death of the mother is one of the most serious consequences of adolescent pregnancy. Complications (other than illegal abortions) most commonly leading to maternal mortality include toxemia, hemorrhage and infections (Jones and Battle, 1990: 93). This is caused by the fact that, in most cases, pregnant teenagers attend prenatal clinics late or irregularly (Macleod, 1999:5).

2.4.10. Teenage abortion

According to Gouws, at al (2008:211) abortion is the termination of pregnancy before the foetus is able to live outside the uterus. Some teenagers when they fall pregnant do not want to keep their babies, therefore they decide to abort their babies. Abortion in South Africa is legal according to the choice of termination of pregnancy Act (Act 92 of 1996), but there are some teenagers that may not have easy access to legal abortion clinics. Those teenagers have to face unsafe back street abortion. Some girls carry the baby to term and then simply abandon the baby in hospitals, in open fields or in other convenient places. Back street abortions contain the following risks and problems:

Physical risk: Infections, bleeding, future miscarriages, future premature deliveries and low weight babies, ectopic pregnancies, placental complications, sterility.
Psychological problems: Depression, anger, fear of punishment, nightmares, preoccupied with the baby's birthday or age, grief and regret, thwarted maternal instincts and loss of interest in sex.

2.5. CONCLUSION

The literature has revealed a wide variety of possible causes of teenage pregnancy, ranging from the individually based factors such as risk-taking behaviors to social based factors. Rape, ignorance, not wanting to use contraceptives, proving womanhood, desire to hold on to a boyfriend, poverty- sex in exchange for security, money , roof over ones head, transport to school are all factors that contribute to the rise in the teenage pregnancy. Through urbanization, some traditions have been broken down. Most of the parents are working and do not have time to talk about sex to their teenager, and the teenagers ended up getting incorrect information from their peers or their boyfriends.

These factors do not justify the high rise of teenage pregnancy among the teenagers of Ilembe District. The next chapter will explain the empirical research conducted.

CHAPTER 3
PRESENTATION OF RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter gives an overview of the research design and will concentrate on the findings that arose from the analysis and interpretation of data. The information at hand was primarily assembled through sets of questionnaires. The questions were structured in relation to the objectives of the study, so as to achieve the desired results.

3.2 SAMPLING

For the purpose of this study ten high schools with pregnant and teenage mothers were selected at Mandini ward at Ilembe District. From each of the ten high schools, ten girls were randomly selected at random. Some of them were pregnant and some were teenage mothers. All those girls were given questionnaires to answer. The girls remained anonymous to observe the ethics of research and to honor the promise between the researcher and the respondent. In as much as we had ten girls in ten high schools, some of them did not respond fully on the questionnaires. Therefore other questions do not add up to hundred.

3.3 ADMINISTRATION OF THE QUESTIONNAIRES

The researcher personally delivered questionnaires to the selected schools in the Ilembe district and collected them after completion. Administering the questionnaires was possible because the sample was manageable. In most schools the Life Orientation educators selected girls that were going to be part of the study. The research was done during break time in order to meet all the girls.

This study investigates the high rate of teenage pregnancy in high schools in the Ilembe district. This chapter concentrates on the findings that arose from the analysis and interpretation of data. All questionnaires were structured in relation to the objectives of the study, so as to achieve the desired results.

The questionnaires were delivered to ten high schools at Ilembe district, and were given to ten respondents at each school. The researcher was personally involved in the administration of the instrument in order to clarify possible misunderstandings. The questionnaires were handed to each pregnant girl or teen mother individually. In the schools where the girls asked to complete their questionnaires at home or in their spare time, the researcher agreed and collected them on the following day from their Life Orientation educators.

The questionnaires are found on appendix A. The respondents were pregnant teenagers and teenage mothers. The respondents shall remain anonymous to observe the ethics of the research.

3.4 RESTATEMENT OF OBJECTIVES AND HYPOTHESIS

It is important at this stage to restate objective and hypotheses so as to provide direction for analysis. Objectives give guidelines and focus on interpretation of the data process.

The questionnaire queried biographical attributes of the respondents, perceptions regarding teenage pregnancy and reasons for teenage pregnancy (sections A-C of the questionnaire found on Appendix A). The raw data was computerized and analyzed by an expert.

The sections are linked to the research aims and objectives of the study. Aims and objectives of the research (as described in the documentation provided) are to:

- establish if poverty in Ilembe district leads to higher pregnancy
- establish if the child support grant acts as motivation to fall pregnant
- establish whether teenagers are exposed realistically about pregnancy.
- establish whether poor guidance by parent and schools increase pregnancy
- establish the effect of alcohol and drugs on increased pregnancy
- Ascertain whether ignorance and incorrect use of contraceptives affect pregnancy rate amongst teenagers.

The analysis strategy was followed with the aim of addressing these issues and is listed in the next section of the report. A description of each methodology, analysis of results and interpretation of each step are presented in subsequent sections.

All analyses were performed using the Statistical Analysis System (SAS) statistical software package, version 9.1.3. SAS Institute Inc., Cary, NC, USA. Additional references to the package and components used:

3.5 STEPS IN THE ANALYSIS STRATEGY

- One way frequency tables and composite one-way tables on biographical attributes
- Composite frequency table on questionnaire items of section B and C of the questionnaire.
- Scale reliability testing/ Item analysis on suggested pregnancy perception-dimensions (section 2) and calculation of perception scores
- Non-parametric analysis: Pearson's chi-square tests on composite frequency tables of section B and C of the questionnaire
- Parametric approach: Analysis of variance on perception-construct scores of section B, and Bonferroni Multiple comparison of means tests.

3.5.1 One-way frequency table on biographical characteristics

One-way tables were calculated on the biographical attributes of age, gender, pregnancy status, where the respondents live, occupation, working status and educational level of both parents, number of siblings in the family, cultural perspective on sexuality and information sources on sex. The frequency distributions are presented in Table 3.1. The frequency distributions were used to describe the sampled population. The description is presented, along with table 3.1.

The one-way frequency distributions also acted as guideline in identifying biographical attributes to be considered, in further analyses, as probable influential effects that might affect respondents' perceptions of the various pregnancy aspects probed in section B of the questionnaire. Biographical variables considered for inclusion have to comply with

the requirement of response-representativeness per category of the biographical variable. (For example gender proved to be unbalanced – only females were questioned – thus the variable was excluded in further analyses.) If representativeness is not taken into account analysis results may be biased and result in unreliable findings. Biographical variables suitable for inclusion will be indicated in section 3.1

One way frequency tables for the subset of questionnaire items where respondents had to supply multiple responses (q 9) were also calculated and are presented as a single table in Table 3.1a.(such a combined one-way frequency tables of subsets of questionnaire-items is referred to as a composite table in this report).

The frequency tables presented in Section 3.1 also serve the purpose of confirming **data validity** (the frequency distributions reflects, along with the specified categories for each attribute (such as 'male'-, female-categories for gender) also data-responses which were incorrectly recorded as numerical values outside the defined set of category values or Likert scale agreement values of 1 to 5. (The incorrectly captured data entries can then be followed up, and corrected, or replaced with a 'missing' indicator if uncertainty exists as to the exact value of the response that should have been)

The tables also provide an initial, **overall impression of the biographical background against which the study was conducted.**

Table 3.1 One-way frequency tables for biographical attributes				
Age				
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
13-14	10	10.31	10	10.31
15-16	26	26.80	36	37.11
17-18	28	28.87	64	65.98
19-20	25	25.77	89	91.75
>20	8	8.25	97	100.00
gender				
female	99	100.00	99	100.00
status				
pregnant	38	38.38	38	38.38
been pregnant	61	61.62	99	100.00
parents				
Both parent	23	23.47	23	23.47
Divorced, live mother	35	35.71	58	59.18
Divorced, live father	6	6.12	64	65.31
Divorced, live e.g. grandparents	23	23.47	87	88.78
Live, friends	11	11.22	98	100.00
Occupation, Farther				

Table 3.1 One-way frequency tables for biographical attributes				
Age				
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Professional	6	13.64	6	13.64
Business	6	13.64	12	27.27
Skilled worker	4	9.09	16	36.36
Clerical	1	2.27	17	38.64
Factory worker	19	43.18	36	81.82
Home maker	8	18.18	44	100.00
Occupation, Mother				
Professional	9	11.25	9	11.25
Business	2	2.50	11	13.75
Farming	4	5.00	15	18.75
Clerical	1	1.25	16	20.00
Factory worker	19	23.75	35	43.75
Housewife	45	56.25	80	100.00
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Education level , Father				
no schooling	6	13.04	6	13.04
primary school	9	19.57	15	32.61

Table 3.1 One-way frequency tables for biographical attributes				
Age				
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
completed primary	1	2.17	16	34.78
secondary school	11	23.91	27	58.70
completed secondary	11	23.91	38	82.61
tertiary qualification	8	17.39	46	100.00
Education level, Mother				
no schooling	11	12.50	11	12.50
primary school	21	23.86	32	36.36
completed primary	12	13.64	44	50.00
secondary school	17	19.32	61	69.32
completed secondary	13	14.77	74	84.09
tertiary qualification	14	15.91	88	100.00
Siblings in family				
1	18	19.15	18	19.15
2	18	19.15	36	38.30
3	22	23.40	58	61.70
4	17	18.09	75	79.79
5	7	7.45	82	87.23
6	4	4.26	86	91.49
7	3	3.19	89	94.68

Table 3.1 One-way frequency tables for biographical attributes				
Age				
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
8	2	2.13	91	96.81
9	3	3.19	94	100.00
***C*ultural approach to sexuality**				
yes	23	23.96	23	23.96
no	73	76.04	96	100.00
Work status of parents				
Both work	19	21.84	19	21.84
Mother home, father work	26	29.89	45	51.72
Father home, mother work	21	24.14	66	75.86
Neither work	21	24.14	87	100.00

Table 3.1 a Information sources on sex issues			
Information sources	**Indicated as source**		
Frequency Cell Chi-Square Row Pct	**not indicated**	**indicated**	**Total**
Television	33 18.015 33.00	67 38.281 67.00	100
Parents	82 2.8824 82.00	18 6.125 18.00	100
Friends	51 4.25 51.00	49 9.0313 49.00	100
Teachers	63 0.3676 63.00	37 0.7813 37.00	100
Physicians	99 14.132 99.00	1 30.031 1.00	100
Magazines	66 0.0588 66.00	34 0.125 34.00	100
Radio	82 2.8824 82.00	18 6.125 18.00	100
Total	476	224	700

Deductions:

As mentioned in a preceding paragraph the biographical attribute of gender was excluded in further analyses since only female respondents were included in the study (n=99, 1 missing value)

General deductions

The frequency distributions in Table 3.1 indicated that (except for gender) all categories of the biographical variables were reasonably well represented. (The clerical category of both the father's and the mother's occupational categories proved problematic – the category was excluded in further analyses, but occupation did not prove to be of any significant effect in further analyses. The same applied to the single entry in the primary school category of the educational level attribute of the mother).

Sample description

In total 100 respondents participated in the study, however, not all respondents responded to each and every question on the questionnaire – reflected in 'missing value' statistics indicated in some of the tables in this report, or reflected in total not adding up to 100).

The data revealed that most teenage mothers and pregnant teenagers live with their mothers, and some live with their grandparents. Therefore there is a possibility that those that live with their grandparents do not reveive proper sexual education. Adolescents that get proper sex education are less likely to have engaged in sexual intercourse than the adolescent that do not (Arnold, Smith, Harrison & Springer, 2000: 488).

Nearly half the sampled respondents indicated that their fathers were factory workers (43%) and 56% reported that their mothers were house wives. It is clear that in most household it is only fathers that are working; therefore all the needs of the family are not met. Thirty five per cent of the mothers and 50% of the fathers had either no schooling or primary school education. Parents with lower education level are afraid to talk with their

children, more especially, with sex. Therefore it becomes much easier for the teenagers to double cross their parents. This is also difficult for the teenagers to get proper guidance. There are a number of parents that are not working at all. This indicates the high level of poverty. Undoubtedly, this may lead to teenage pregnancy because teenagers are not exposed to life where all their needs are met.

Eighty percent (80%) of the households represented by the respondents had between two and five children in the family (including the respondent). Quite a substantial proportion of respondents indicated that their culture do not condone pre-marital sex. Television, magazines, friends and teachers proved to be teenagers' source of information on sex affairs to a great extent.

In summary the frequency tables on biographical properties described a sample representing a target population of communities with a poorer economic background. In spite of the poor economic background, 69 % of the respondents disagree that they fell pregnant because of the child support grant, but they agree on the fact that people believe that child support grant leads to teenage pregnancy.

3.5.2 Composite tables

The two tables presented in section 3.2 reflect the agreement distribution of respondents on their perceptions regarding teenage pregnancy matters (section 2) and their impression of the most probable causes of teenage pregnancy in the community (section3).

Questionnaire design at this stage in the analysis required different approaches for sections 2 and 3 of the questionnaire (Even though both sections captured responses as agreement ratings). Questionnaire design aimed at probing perceptions in section 2. The purpose of section 2 was to evaluate teenagers' perceptions on a few broader aspects of pregnancy; as opposed to section 3 which served the purpose of establishing which issues from a list of issues provided, teenagers regarded as the most probable reason for teenage pregnancy: thus a rating of reasons for pregnancy from the most probable to the least probable.

An ordinary composite frequency table of all reasons probed in section 3 would therefore provide the answer as to the most and least probable reasons for pregnancy.

On the other hand, the composite frequency table on all perception issues listed in section 2 gave an initial cursory impression of respondents' perceptions, but did not succeed in providing the crux of respondents' perceptions in a compact and concise way. Perception questionnaire items were therefore grouped into subsets of questions that addressed broader aspects of pregnancy. Three aspects or constructs were identified, namely, motivation for falling pregnant, influence of the boyfriend in falling pregnant and perceptions regarding contraception. According to Greathead (1998:233), the problem with the contraceptives in teenagers, is that young people believe that planning and talking to partners about contraception takes away the romance and spontaneity of the moment. Therefore adolescents frequently use their own do-it-yourself method.

Based on the research findings, teenage mothers and pregnant teenagers fell pregnant because of the pressure from their boyfriends, and it was hard for the teenagers to say no to sex. Many female adolescents lack power in their relationships. Males are likely to pressure them into unwanted or unprotected sexual relations (Rathus, 2008:492). Harrison, Xaba & Kunene (2001: 63), stated that a lack of decision-making autonomy within relationships constrained girls' ability to practice safe sex.

There it is only twenty one percent of the respondents that agreed that they were motivated by the child support grant to fall pregnant. This means that child support grant is another factor that leads to the high teenage pregnancy at Ilembe District.

It was argued that the research question on reasons for pregnancy could be answered from the results of the composite frequency table displayed below Table 3.2.2 (section 3 of the questionnaire), but additional analyses were required to answer research questions on respondents' *perceptions* regarding, teenage motivation, influence of a boyfriend and contraception/ prevention of pregnancy. Once a measure of perception of the three pregnancy aspects had been established and verified, the effect of biographical attributes on these perceptions could be further investigated (for example

does culture and age affect respondents' perceptions of contraception?) . The analysis results of this approach are discussed in section 3.3 of the report.

3.5.2.1 Perceptions regarding Teenage pregnancy

Table 3.2.1
Perceptions regarding teenage pregnancy

Perception of cause of escalation in teen pregnancy)	Agreement rating)					
Frequency Cell Chi-Square Row Pct	Disagree++	Disagree	Undecided	Agree	Agree++	Total
Ambition, finish school	5 15.602 5.00	3 16.642 3.00	5 5.2638 5.00	10 6.7345 10.00	77 201.54 77.00	100
Baby, metric harder	21 0.2869 21.88	19 0.2583 19.79	11 0.2695 11.46	17 0.8856 17.71	28 7.3962 29.17	96
Pre-marital sex ok	47 23.195 48.96	18 0.5251 18.75	12 0.0578 12.50	11 5.016 11.46	8 4.6403 8.33	96
Pregnancy planned	41 12.824 42.71	28 2.0727 29.17	16 0.7657 16.67	7 9.6434 7.29	4 9.7899 4.17	96
Friends have babies	38 7.3191 38.00	33 5.2087 33.00	6 4.0848 6.00	10 6.7345 10.00	13 1.1758 13.00	100
Not planning pregnancy	22 0.0534 23.40	17 0.7289 18.09	9 1.0256 9.57	28 2.4093 29.79	18 0.1385 19.15	94

Table 3.2.1 Perceptions regarding teenage pregnancy						
Perception of cause of escalation in teen pregnancy)	**Agreement rating)**					
Frequency Cell Chi-Square Row Pct	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
No access to contraceptives	19 0.5085 20.88	17 0.5175 18.68	18 2.7668 19.78	20 0.0028 21.98	17 0.0674 18.68	91
Incorrect use contraceptives	13 4.5921 13.68	13 3.1254 13.68	18 2.1838 18.95	21 0.0007 22.11	30 10.672 31.58	95
Forced unprotected sex	18 1.3297 18.75	16 1.3398 16.67	14 0.1007 14.58	24 0.3294 25.00	24 3.0445 25.00	96
Myth pregnant,1st intercourse	31 2.5015 32.63	19 0.2139 20.00	6 3.5563 6.32	20 0.06 21.05	19 0.3274 20.00	95
Baby is cool	46 19.276 46.46	17 1.1425 17.17	14 0.0409 14.14	10 6.5575 10.10	12 1.6581 12.12	99
Ignorance, contraceptives	12 5.5217 12.63	20 0.06 21.05	16 0.8412 16.84	24 0.3911 25.26	23 2.4087 24.21	95

Table 3.2.1

Perceptions regarding teenage pregnancy

Perception of cause of escalation in teen pregnancy)	Agreement rating)					
Frequency **Cell Chi-Square** **Row Pct**	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Popular if pregnant	33 3.9818 34.74	19 0.2139 20.00	14 0.1271 14.74	20 0.06 21.05	9 3.525 9.47	95
Pregnancy strengthens love	29 0.999 29.59	20 0.1475 20.41	16 0.6274 16.33	19 0.357 9 19.39	14 0.5922 14.29	98

Perceptions re teenage pregnancy

Perception of cause of escalation in teenage pregnancy)	Agreement rating)					
Frequency **Cell Chi-Square** **Row Pct**	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Boyfriend's wish	26 0.1942 26.80	24 0.2737 24.74	15 0.3091 15.46	24 0.273 7 24.74	8 4.7765 8.25	97
Child grant motivates me	35 4.9366 35.71	33 5.7634 33.67	9 1.299 9.18	15 2.117 3 15.31	6 7.2848 6.12	98

Table 3.2.1 Perceptions regarding teenage pregnancy						
Perception of cause of escalation in teen pregnancy)	**Agreement rating)**					
Frequency Cell Chi-Square Row Pct	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Fear clinic	16 2.9982 16.00	29 2.0565 29.00	8 2.1747 8.00	29 2.0565 29.00	18 0.012 18.00	100
Liquor abuse	15 3.2828 15.46	19 0.3063 19.59	13 132E-8 13.40	32 5.0428 32.99	18 0.057 18.56	97
Boyfriend sex education	12 5.7033 12.50	18 0.5251 18.75	18 2.0526 18.75	33 6.3597 34.38	15 0.201 15.63	96
Lose boyfriend	21 0.3401 21.65	22 0.0086 22.68	16 0.6944 16.49	25 0.5453 25.77	13 0.9475 13.40	97
Side effect contraceptives	19 0.8125 20.00	19 0.2139 20.00	22 6.7546 23.16	22 0.0362 23.16	13 0.8058 13.68	95
Lose boyfriend, not sleep	32 2.4108 32.32	19 0.413 19.19	13 0.0052 13.13	24 0.1789 24.24	11 2.3337 11.11	99

Table 3.2.1
Perceptions regarding teenage pregnancy

Perception of cause of escalation in teen pregnancy)	Agreement rating)					
Frequency Cell Chi-Square Row Pct	Disagree++	Disagree	Undecided	Agree	Agree++	Total
Baby, marriage promise	15 3.4324 15.31	25 0.472 25.51	11 0.3455 11.22	31 3.8899 31.63	16 0.0825 16.33	98
Way out of school	21 0.3401 21.65	36 9.6527 37.11	10 0.6906 10.31	21 0.0151 21.65	9 3.7756 9.28	97
Curiosity	17 1.3958 18.48	28 2.7799 30.43	25 13.032 27.17	18 0.2955 19.57	4 9.1296 4.35	92
Love, not no to sex	15 2.9897 15.79	11 4.8533 11.58	6 3.5563 6.32	41 18.697 43.16	22 1.7084 23.16	95
Teens can be mother	25 0.0828 26.04	25 0.6247 26.04	17 1.3314 17.71	22 0.0199 22.92	7 5.7496 7.29	96
Teens can care, babies	24 0.0067 25.00	25 0.6247 26.04	10 0.6368 10.42	24 0.3294 25.00	13 0.8755 13.54	96

Table 3.2.1 Perceptions regarding teenage pregnancy						
Perception of cause of escalation in teen pregnancy)	**Agreement rating)**					
Frequency Cell Chi-Square Row Pct	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Sisters with babies	31 1.8225 31.31	30 2.8961 30.30	11 0.3864 11.11	16 1.643 5 16.16	11 2.3337 11.11	99
Total	712	644	388	644	508	2896
Frequency Missing = 104 Probability (Chi-square = 629.13) <0.0001* **						

Deduction

The Chi-square test indicated that statistically significant different perceptions do exist regarding some of the aspect of teen pregnancy. (The probability associated with the F statistic is less than 0.0001 which is highly significant)

To gain an overall impression of perceptions at this stage is difficult however: The sheer volume of information seems to obscure results. Section 3.3 strives to present perceptions on pregnancy in a more compact and precise way.

3.5.2.2 Probable reasons for teenage pregnancy

Table 3.2.2 Section C Probable reasons for teenage pregnancy						
Possible reasons for pregnancy	**Agreement rating**					
Frequency **Cell Chi-Square** **Row Pct**	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Some say, child grant	20 1.8825 20.00	18 2.7037 18.00	7 2.8429 7.00	26 0.071 3 26.00	29 6.2454 29.00	100
Mandini Ward, child grant	26 8.6152 26.00	26 0.0079 26.00	18 1.8298 18.00	19 2.574 2 19.00	11 2.9166 11.00	100
Schools to blame	18 0.799 18.18	46 14.978 46.46	10 0.6811 10.10	21 1.382 7 21.21	4 11.007 4.04	99
Teenagers/schools/parents/government	6 5.1769 6.00	22 0.751 22.00	21 4.7587 21.00	35 2.109 2 35.00	16 0.2908 16.00	100
Ilembe, Schools	19 1.3356 19.19	38 5.3221 38.38	20 3.8071 20.20	17 3.778 9 17.17	5 9.5035 5.05	99
Ilembe, parents	20 2.0094 20.20	41 8.3703 41.41	17 1.2505 17.17	14 6.350 2 14.14	7 6.8277 7.07	99

Table 3.2.2 Section C Probable reasons for teenage pregnancy						
Possible reasons for pregnancy	**Agreement rating**					
Frequency **Cell Chi-Square** **Row Pct**	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Ilembe, government	19 1.2355 19.00	30 0.4743 30.00	20 3.6298 20.00	22 1.0636 22.00	9 4.7317 9.00	100
Ignorant realities	11 0.9461 11.00	13 6.8452 13.00	7 2.8429 7.00	45 11.308 45.00	24 1.7702 24.00	100
Economic background	7 4.0593 7.00	11 9.031 11.00	6 3.8508 6.00	32 0.7729 32.00	44 36.058 44.00	100
No hope future	10 1.5208 10.00	30 0.4743 30.00	17 1.1587 17.00	27 0.0058 27.00	16 0.2908 16.00	100
Fear of clinics	8 3.0774 8.00	20 1.5762 20.00	9 1.285 9.00	32 0.7729 32.00	31 8.8002 31.00	100
Secret contraceptives	10 1.5208 10.00	21 1.1258 21.00	19 2.6534 19.00	29 0.0937 29.00	21 0.3961 21.00	100

Table 3.2.2 Section C Probable reasons for teenage pregnancy						
Possible reasons for pregnancy	**Agreement rating**					
Frequency **Cell Chi-Square** **Row Pct**	**Disagree++**	**Disagree**	**Undecided**	**Agree**	**Agree++**	**Total**
Sex forced, boyfriends	11 0.9461 11.00	23 0.4519 23.00	11 0.3377 11.00	37 3.3651 37.00	18 0.0052 18.00	100
HIV ignorance	31 17.959 31.00	32 1.161 32.00	4 6.3245 4.00	21 1.4941 21.00	12 2.173 12.00	100
No clinics	11 0.8817 11.11	31 0.8822 31.31	16 0.7066 16.16	24 0.3598 24.24	17 0.0697 17.17	99
Sugar Daddy	8 2.9739 8.08	20 1.4643 20.20	7 2.7497 7.07	36 2.9045 36.36	28 5.3814 28.28	99
Total	235	422	209	437	292	1595
Frequency Missing = 5 **Probability(Chi-sq = 286.14) <0.0001*** **						

Deductions

Inspection of the table seem to indicate that respondents did not regard all reasons listed equally important – they seemed to regard some more important than others. The trend is verified by a Chi-square test that was conducted on the frequency distribution of the table as an entity.

(Chi-square tests determine whether – in this instance – the same response pattern exists over every row of table – in other words whether respondents' regard reason as equally important / or probable. If significance can be attached to the test - that is the Chi-square statistic calculated, in this instance 286.14) - the deduction can be made that respondents did not rate all reasons as equally important – they rate importance of some questions/ or reasons significantly different from others)

The probability of less than 0. 001 associated with the Chi-square statistic of 286.14 is highly significant in this instance – which implies that respondents did not rate all reasons equally important – some issues were perceived (statistically) significantly differently from others. For example 64% of respondents rated sugar daddies to contribute towards pregnancy ((38+26)/99) more so than inadequate school guidance to be a culprit which only 25% ((4 +4)/99) of respondents rated important. In this way probable reasons can be ranked from most probable to least probable (see Table 3.2.3) Thus by adding the frequencies of the agree and strongly agree categories of Table 3.2.2 the most probable to least probable reasons for teenage pregnancy can be identified as in Table 3.2.3.

Table 3.2.3
Section C Probable reasons for teenage pregnancy

Possible reasons for pregnancy	**%**
Economic background	76
Ignorant realities	68
Sugar Daddy	64
Some say, child grant	55
Sex forced, boyfriends	55
Teenagers/school/parents/government	51
Secret contraceptives	50
No hope future	43

Table 3.2.3 Section C Probable reasons for teenage pregnancy	
Possible reasons for pregnancy	**%**
No clinics	41
Fear of clinics	33
HIV ignorance	33
Ilembe, government	31
Mandini Ward, child grant	30
Schools to blame	25
Ilembe, Schools	22
Ilembe, parents	21

3.6. SCALE RELIABILITY TESTING

Scale reliability was conducted to establish internal consistency reliability of pregnancy perception constructs probed in section b of the questionnaire

Calculation of perception scores.

The composite tables presented in section 3.2 presents the frequency distributions of questionnaire items associated with a few broader perception constructs such as the influence of the boyfriend on pregnancy, motivational forces behind pregnancy and pregnancy and contraception. Although the table provides an initial exploratory overview of respondents' perceptions regarding a large number of pregnancy issues, the tables do however, not reflect **summative perception-measures** of the broader pregnancy concepts. In a sense the sheer amount of information presented in the composite table seems to obscure the evaluation of perceptions on the broader aspects which it actually purports to evaluate.

An important step in the analysis strategy therefore centers on the development of a rule (or summative perception measure or scale) that measures how each respondent perceived each of the three broader pregnancy aspects mentioned. To this effect, the calculation of a 'rule' or perception-measure is based on the responses of subset of questionnaire-items associated each of the broader pregnancy constructs.

It stands to reason that the applicability of these proposed rules or scales, or perception measures - as indicators of respondents' perceptions on the various aspects - have to be evaluated. A form of reliability testing, referred to as internal consistency reliability, is therefore conducted on the response ratings of the questionnaire items associated with a specific pregnancy perception construct (e.g. effect of boyfriends). If internal consistency reliability is established for each perception-construct, it implies that all questionnaire-items within a pregnancy aspect contributes towards explaining perceptions regarding the particular aspect; and therefore, that the rule, or measure , or scale, calculated from these agreement-responses, measures what it purports to measure. Internal consistency reliability therefore contributes towards the integrity of the research and ensures that valid and reliable analyses are performed and deductions made from reliable perception measures.

Scale reliability testing can also be described as follows: it is a valuable statistical technique that is often applied to determine whether responses to subsets of questionnaire items, which have been grouped together to describe a construct/ or aspect of the topic under investigation, truly contribute towards explaining that aspect.

The analysis technique of internal consistency reliability (also referred to as item-analysis) calculates a coefficient, Cronbach alpha, as part of the analysis output. The value of the Cronbach alpha-coefficient acts as indicator of internal consistency reliability. A value in the region of (0.6), or greater than 0.7, is regarded as indicative of internal consistency reliability. Summary results of scale reliability testing conducted on the agreement scores of the subsets of questionnaire items associated with each of the three perception constructs are presented in Table 3.3.1

Once internal consistency reliability is established for the subset of questionnaire-items explaining a particular construct, a measure, or **scale of perception can be calculated**.

The scale/ or measure is usually calculated for each respondent as the mean value (average) of agreement-ratings for the subset of questionnaire items within a particular aspect. The calculated means of respondents are referred to as scores. The advantage of using the average value of agreement ratings for each respondent as perception-measure is that the agreement **rating scale used in the questionnaire applies to the score values well. Analyses conducted on the score values and commented on in subsequent sections are then easy to interpret according to the Likert agreement protocol. On the scale a rating of 1 indicated strong agreement, up to a rating of five indicates strong disagreement. The interpretation will be applied to the mean perception scores calculated in table 3.1 and Mean score of Table 3.4 to follow.**

Item analyses were duly performed on each of the subsets of agreement ratings for the questionnaire-items of sections 3 to evaluate perceptions (excluding of course questions 1-17). The results of which are reported in Table 3.3. Table 3.3 also presents the mean scores for each construct.

A summary of the three analyses are presented in the table below:

Table 3.3

Scale reliability testing.

Summary results of scale reliability testing conducted on the perception constructs defined. Cronbach alpha coefficients, questionnaire items describing each perception construct, construct mean scores and standard deviations are reported in the body of the table

Perception dimension/ construct	Questionnaire items		Cronbach alpha coefficient	Grand mean perception score	N	Standard dev. mean score
	included	reversed				
Motivations re pregnancy	nb1 b3 b4 b5 b12 b14 b17 b25-b26	b1	0.61	2.49	100	0.58

	b27 b28-b30					
Contraception	b6-b9 b20 b18-b19 b22 b27	-	0.69	3.17	100	0.74
Influence of boyfriend	b15 b16 b11 b21 b23-b24		0.63	2.77	100	0.81
A question-item with a 'n' pre-fix (b1 for example) indicates that the rating scale for that particular item has been inverted to comply with assumptions of scale reliability testing. (To align with other subset questionnaire items which had all been stated either positively or negatively)						

Conclusions:

Cronbach alpha coefficient all proved to be in the region of 0.7, ranging from 0.61 to 0.69. A reasonable indication of internal consistency reliability could thus be established for all constructs. This implies that all questionnaire items within a particular construct contributed towards explaining the particular aspect of teen pregnancy probed in the questionnaire. This result further implies that perception scores (which are calculated for each respondent as the mean response of all responses within a particular subset of questionnaire-items) for each respondent can act as reliable indicators or evaluators of the perception of respondents to each aspect (or construct) of teen pregnancy. The construct scores thus calculated reduced the perception measures from 30 to three, which assists interpretation of results immensely.

The mean scores indicated in the third to last column serve the purpose of reflecting the general perception trend expressed by respondents regarding each construct. For example the general score mean for the aspect of *motivational drivers in increased* pregnancy rate under teenagers was calculated as 2.49. This implies that respondents expressed a 'disagreement' rating – or negative perception regarding '*driving forces to become pregnant'* – respondents were not convinced that these so-called motivational factors 'inspired' teenagers to fall pregnant. On the other hand the mean score for the contraception construct was 3.17, moved more to the uncertain/ positive agreement side

of the rating scale. This implies that respondents perceived the issue of contraceptives to be more influential on increased pregnancy rates than '*motivational forces*. The mean perception rating score of 2.77 can be similarly interpreted and is therefore more positive..

Once the reliability of the summative measures (scores) of the perception construct had been verified, further analysis was performed to investigate and describe the nature of perceptions on pregnancy in more detail.

3.7. ANALYSIS OF VARIANCE

An analysis of variance (anova) to describe the nature of perceptions in more detail and to identify biographical effects that affect perceptions on pregnancy was done and is presented here**.**

Once the internal consistency reliability of the various perception constructs had been established - as described in the preceding section - separate analysis of variance was performed on each of the sets of perception construct scores to identify biographical effects that significantly affected respondents' perceptions on the three pregnancy aspects. Table 3.4.1 presents the results of the analyses of variance. The biographical attributes of age, culture, teachers as reference sources of sex issues, where respondents live, and the work status of their parents and the interaction effects of these attributes were entered into the final anova models. (The effect of the biographical attributes that proved not to be significant was added to the error term of the anova model).

Table 3.4.1 reflects that general significance was established for each anova model on at least the 5% level of significance. Attention could subsequently turn to the statistical significance of individual biographical effects and their interactions on perceptions. Significance of these effects as established in the various anovas are indicated in Table 3.4.1. A significance legend is included in the table.

Table 3.4.1

Analysis of variance (anova) summary results table indicating significance level of identified biographical attributes.

Each row of the table represents a separate analysis of variance performed on the pregnancy perception scores. The constructs are listed in the first column of the table. The general anova F statistic and associated probability is listed in the second column of the table. F-probabilities associated with the individual biographical attributes and F statistics are reported in columns 4-9 of the table.

Construct	General F statistic (F-prob.)	Significance attached to biographical effects to identify influential biographical in anova						
		Age	Culture	q9 Info source Teachers	q9 Info source, Physician	Live with parents	Work status parents	Inter-action
Motives for teen pregnancy	1.87 (0.0350*)	-	-	-	-	0.0254*	0.0774?	0.0830?
Perceptions re contraception	4.61 (0.0004***)	0.0218*	-	0.0041**	-	0.0690?	-	-
Perception re boyfriend	4.41 (0.0003***)	0.1058?	0.6334	<0.0001***	+-	-	-	-

Significance legend: + The effect proved not to be representative of every

? : 10% level of significance category of the attribute and the effect was thus removed

* : 5% level of significance

** : 1% level of significance

*** : 0.1% level of significance

Deduction

The probabilities associated with the general F statistics calculated for each of the 3 analyses of variance summarized in Table 3.4.1 were significant on at least the 5% level of significance (second column of the table). Once general significance was established for each perception construct, attention could turn to the significance of biographical attributes on perception. Biographical effects identified as significant were thus regarded as valid and further investigated. Perception of *motivational forces to fall pregnant* was significantly affected by where respondents lived, and to a lesser extent the work status of their parents. (The nature of the effect on perceptions will be explained in the next table). *Perception on contraception was again affected by* respondents' age, whether the teacher was a source of information on sexual issues and to a lesser extent where they lived. Perceptions on the influence of the boyfriend in increased incidence of teen pregnancy were again affected by whether teachers served as source of information on sexual matters and to a much less extent the age of the respondents.

The nature of the effect of statistically significant biographical attributes on perceptions is described in Table 3.4.2 which reports on the construct score means calculated according to the significant attribute categories

Bonferroni Multiple Comparisons of means

Table 3.4.2

Table of perception score means arranged according to categories of biographical effects identified as significant influential effects on perceptions regarding aspects of teen pregnancy

Bonferroni least significant differences are indicated for each biographical effect. Category mean scores of a biographical attribute suffixed with different small letters indicate means that differ significantly from one another.

Construct	General F statistic (F- prob.)	Category-mean perception scores for the biographical attributes indicated as statistically significant influential affects on the perceptions of the various HIV/AIDS aspects/ constructs.				
		Teacher info	Physician info	Live with parents?	Work status	Age

		source	source		parents	
Motives for teen pregnancy	1.87 (0.0350*)			friends:2.97a grand p:2.52ab mother :2.50ab father :2.31ab both :2.24 b	M h, F w: 2.58a F h, M w: 2.47ab M w, F w :2.47ab No work:2.30 b	
Perceptions re prevention/con-traceptive	4.61 (0.0004***)	yes: 3.48 a no : 2.99 b				
Perception re boyfriend	4.41 (0.0003***)	Yes: 3.19a No : 2.51 b	yes: 4.00a no : 2.75b			13-14: 3.62 a 15-16: 3.41ab 19-20: 3.03ab 17-18: 2.96ab >20: 2.90 b

Significance legend:
? : 10% level of significance
* : 5% level of significance
** : 1% level of significance
*** : 0.1% level of significance

In the preceding analyses of variance results, the analyses only identified those biographical attributes that significantly affect perceptions on the various pregnancy aspects. Bonferroni Multiple Comparisons of means tests, subsequently conducted,

determined the nature of the effect that the biographical attributes exerted on perceptions.

In Table 3.4.2 the results of the Bonferroni multiple comparisons of means tests are reported with the mean scores of the perception constructs. The perception construct means are arranged according to the categories of the biographical attributes identified as significant. For example, in Table 3.4.2, mean perception scores on respondents' '*motives for teen pregnancy'* are reported according to the categories of *working status of parents'. For the categories M h, F W: mother at home, Father Works; F h, M w: Father at home, mother works; M w, F w: both parents work; no work: neither the father nor the mother works.*

Each set of category mean perception scores are compared in a Bonferroni multiple comparisons of means tests against a measure referred to as an 'lsd' – which is an abbreviation for the term 'least significant difference' - to establish which category perception mean/s differ significantly from other category means. Category mean perception scores that differ significantly from one another are suffixed with different small letters. (For example, Table 3.4.2, first row indicate that the *Motives for pregnancy perc*eption score means for 'f*riends* 'and 'both' categories of the *where do you live* attribute differ significantly from one another since different small letters suffix their perception score means of 2.97 and 2.24. Keep in mind that the scores are evaluated against the agreement rating scale where a rating of '1' implies '*strongly disagree'*, up to an agreement rating of '5' which signifies 'Strong agreement'. This implies that respondents living with both parents were less convinced that motivational forces impacts on increased pregnancy under teens, whereas respondents living with friend were more undecided on this issue.

Deductions

The '*motivational forces behind teen pregnancy'* example used in the preceding paragraph serves to illustrate that deductions regarding the nature of perceptions on the different HIV/AIDS constructs can likewise be made by studying the results of the multiple comparisons of means tests on category perception means:

Looking at table 3.4.2, there is a big difference between the teenagers living with parents and teenagers living with friends. Motivation for teenage pregnancy is high to teenagers that live with friends as compared to the teenagers that live with both parents. Motivation towards teenagers that live with their mothers or their grand parents is more or less the same. This implies that mothers or grandparents may not give proper sexual education to the teenagers.

Most teenagers agreed that educators are the source of the information regarding contraceptives whereas some of them got information from other sources. It might happen that information that they get from other sources is not correct. Teenagers between the ages of 13-16 years agreed that they were being influenced by their boyfriend. It seems that because they are young and struggle to make their own decision. So they are easily influenced by the people older than them.

Teenagers with the age of 17 upwards were not influenced by their boyfriends. They have grown up, and they are able to make their own decisions. In other words, motivation towards pregnancy to them is not caused by their boyfriends influence.

3.8. CONCLUSION

This chapter has described and analyzed the results of the questionnaires that were given to the high school girls of Ilembe district. It is quite noticeable that, teenage pregnancy is very high at Ilembe district, and the fact that the respondents have a variety of reasons behind the teenage pregnancy, but there is no big difference between the reasons. The teenagers are faced with high rate of pregnancy, but it seems like some teenagers do not know why they fell pregnant. This is indicated by the areas where the respondents did not respond at all.

According to the analysis of the data, some teenagers fell pregnant because they do not get correct information from their parents but they get from their educators, friends, boyfriends and the media. Some teenagers are influenced by their boyfriend, more especially the teenagers that are sixteen years and younger. Family structures also have an impact on teenage pregnancy, for example, teenagers that live with grandparents or their mothers only, fall pregnant more easily as compared to those that live with both

parents. The environment at which the teenagers live also contributes to high pregnancy. It means that there is a lot of work that need to be done in order to minimize the high rate of pregnancy.

The next chapter will round off the study by giving an overview of what the study entails. It will generally look at how the objectives were achieved, and also reflect whether the hypotheses were rejected or accepted. It will also state some recommendations that can help to reduce teenage pregnancy at Ilembe district.

CHAPTER 4
CONCLUSION AND RECOMMENDATIONS

4.1 INTRODUCTION

Teenagers do not live in a vacuum. They live in a changing physical world and carry on their lives as their personalities and internal world change, all the time being influenced by many social factors such as their peers, media, etc. (Fong, 2007:93). Teenage pregnancy is a very big social problem that is growing each and every day. Teachers, parents and the community cannot sit down, relax and wait for the problem to solve itself. But they have to find the solution to the problem.

The Minister of Basic Education, AM Motshekga, stated that teenage pregnancy is a battle that requires the active involvement of all stakeholders, if it is to be well fought. These stakeholders include other government departments, key organizations in the non-governmental sector, the research community, religious sector, community leaders and more importantly the parents and the learners themselves (Panday, at al, 2009: 3)

4.2 SUMMARY OF THE STUDY

The study is divided into four chapters, orientation to the study chapter, literature review chapter, findings and interpretations chapter, and conclusion and recommendation chapter. All these chapters had specific roles to play in the completion of study.

4.2.1 Orientation of the study

This chapter is based on the orientation of the study, as it presented the objective of the study, statement of hypothesis and research methodology, which provided guidelines of how the study will be conducted. Furthermore, this chapter defines the concepts that would be dealt with in the study. These concepts are adolescents and teenage pregnancy.

4.2.2 Literature review

This is an important chapter of study. It provides the historical overview of teenage pregnancy, the effects of pregnancy in teenagers and the factors that contributes towards teenage pregnancy. This chapter provided alternative paradigms to the study by reflecting what other scholars have said in relation to the topic. Amongst other important things, this chapter provided the possible causes of teenage pregnancy and their effects on teenager's lives.

4.2.3 Findings and interpretations chapter

One of the key chapters of the study was the presentation of the research findings chapter. This chapter is based on the presentation of the findings and the interpretations of the results. In this chapter the data was presented in quantitative form only. Figures and tables were used to give more clarity to data presented. There were some deductions after each and every table that summarizes the finding on the table.

The presentation of findings chapter also looked at causes of high rate of teenage pregnancy at Ilembe district. Teenagers at the Ilembe district do not get enough sexual information from their parents, but television, magazines, friends and educators serve as the source of information. Due to poverty in the area, sugar daddies contribute towards teenage pregnancy. The findings chapter also provided the basis upon which the statement of the hypothesis could be tested. That is why this chapter is considered as the most important chapter.

4.2.4 Conclusions and recommendations for the study

The final presents the findings of the literature study as well as empirical research findings and will provide valuable recommendations regarding the research question proposed in chapter 1.

4.3 RECOMMENDATIONS

4.3.1. Sexuality Education

According to the South African Medical Research Council (MRC), education is fundamental and they recommend that sexuality education at school should be implemented before the age of 14. The following should be included in such education programs:

- Information on avoiding sexually transmitted diseases.
- Detailed information about contraception and its side effects.
- Any relevant information on adolescent sexuality.

While some have voiced out that sex education increases sexual activity, studies show that this is not the case. In fact, effective sex education programs can decrease sexual activity and increase contraceptive use among those already sexually active. Successful programs have a number of similar components. They maintain a narrow focus on reducing specific sexual risk-taking behaviors, they provide accurate information about sexuality; they build interpersonal and communication skills to resist sexual pressures; they address both social and media influences on sexual behaviors; they reinforce individual values and group norms linked to responsible behavior and decision-making; and finally, they involve students in the learning process through small group discussion, role-play, interviewing parents, and other activities (Christensen and Rosen, 1996:2).

4.3.2. Recommendations to Teenagers

All teenagers need encouragement to postpone sexual involvement and information on pregnancy prevention before and when f they become sexually active (Christensen and Rosen, 1996:5)

According to Seifert & Hoffnung (2000:524) programs to prevent teenage pregnancy must be responsive to adolescents' developmental needs and life contexts. Teaching abstinence appears to be most effective in dealing with pre-teenage and young adolescents, while providing information and access to contraceptives works well with older adolescents. For teenagers who are at high risk because of their life circumstances, programs that include comprehensive, developmentally oriented services, medical care and contraceptives services, social services, family and educational support, and school-linked parenting education appear to be most effective.

Greathead (1998: 226) go on saying that, no method is completely effective, except the total abstinence. Therefore there is a risk involved when using any method. Abstinence is an important option for those adolescents who are not ready for the sexual intercourse with its risks of pregnancy, STD or emotional hurt.

Peer groups can be established in schools where teen mothers may talk to their peers in order to provide information as well as the impact that teenage pregnancey has on their lives and the responsibilities that parenthood brings.

4.3.3 Recommendations to the educators

The study has shown that most teenagers get information on sexuality education from their educators. Therefore the educator's role is to try to prevent teenage pregnancies. This is the major goal of the most effective sexuality education courses. Educators must also be prepared and able to offer emotional support if an adolescent does fall pregnant or undergoes an abortion (Gouws, at al, 2008:212).

Furthermore, an effort should be made, to all educators, to develop trust, rapport, confidentiality and empathy with learners. This will make it easier for learners approach other teachers on matters regarding sexuality. It will also strengthen learners' relationship with other educators (Naidoo, 2003:66). It is also important for the educators to explore the clinical service in the area and ascertain how confidential the service is and what the clinical hours are (Greathead, 1998:223).

Life Oreintation teachers are in the most favourable position to address sexual education, teen pregnancy, HIV/AIDS and STD's. All of these aspects form part of the life Orientaion Curriculum. Problems related to teen pregnancy, the disadvantages of having a baby at school going age and the responsibilities of parenthood must be addressed. Career choices, education limitations due to early pregnancy must be spelt out for the learners.

4.3.4 Recommendations to the nurses

There should also be better management and training of nurses, so that they can handle adolescent sexuality in a professional way. Adolescents must be informed about, and warned against, the disadvantages and consequences of both pregnancy and abortion. They should be motivated to avoid pregnancy. To achieve this, adolescents must feel good about them and strive for a success and self-supporting future. . (Gouws, at al, 2008:212)

According to Kansumba (2002: 27) nurses in primary health care setting are expected to establish trusting relationships and to confidentially explore the developmental concerns of young people. According to the principles of primary health care, a health service should be accessible to its user, in this case the adolescent. The service should be within geographical, functional and cultural reach of all adolescents.

Clinics and nurses at clinics can establish links with decondary schools and may be invited to talk to adolescents on aspects such as pregnancy, contraceptives, responsible behaviour andSTD's.

4.3.5 Recommendations to parent

A parent, as an adult, is per definition responsible for guiding and accompanying the child towards adulthood. According to the results from the data analysis, most of the teenagers receive sexual education information from their friends, media and educators. This means that parents do not perform their duties well.

Parents are the primary educators, and an effective sexuality education programme needs the support of parents and of the community. Parents form an integral part of sexuality education in schools. Forming a partnership with school will serve to strengthen parents' relationship with learners. Parents need to attend workshops on sexuality education, make contributions towards developing the school policy on sexual education, and provide learners with adequate resource material (Naidoo, 1993: 66)

The nature and quality of relationships shared between adolescent and their parents can have a major influence on the decision that they make about sex. Teenagers whose parents provided a warm, loving and nurturing environment are less likely to engage in

sex. (Cox, 2007: 22). To decrease the high rate of pregnancy in teenagers, parents need to show support, closeness and parental warmth to their teenagers. However, overly strict and authoritarian parenting style is associated with greater risk of teenage pregnancy. (Miller, 1998)

Positive, open and frequent family communication about sex is linked to postponement of sexual activity, increased contraceptive use and fewer sexual partners. Similarly, parent-child communication is vital for the prevention and reduction of teenage pregnancy. Many adolescents concur that it would be easier for them to avoid teen pregnancy if they were able to have more open and honest conversation about these topics with their parents (Panday, at al, 2009:64).

A failure to share a close connection with adolescents often heightens the influence of peers on sexual activity. This could account for the association between or distant parent-child relationships and risky adolescent's sexual behavior. Adolescents who describe their relationships with their parents as coercive or conflictual, for example, are more likely to be involved with deviant peer groups, and the peers become most important and influential (.Panday, at al, 2009: 64)

Parent-child communication is vital for the prevention and reduction of teenage pregnancy (Hollander, 2003). Many adolescents concur that it would be easier for them to avoid teenage pregnancy if they were able to have more open and honest conversations about these topics with their parents (Albert, 2004). Therefore it is very important for the parents to talk about sex to their teenagers.

Low levels of parental supervision and support increase the risk for sexual behavior, but supportive family decreases the risk of initiating sexual activity at a young age. An adolescent's first sexual experience is usually in his or her home or at a friend's house. Therefore, parental supervision is important, because it limits access to the home as a setting in which to engage in sexual behavior (Arnold, Smith, Harrison & Springer 2000:488)

4.3.6 School based/linked health services

Health services can play an instrumental role in sexual and reproductive health of adolescents when services are youth friendly: that is they are accessible, acceptable, appropriate and equitable (WHO (2000) on Panday, et al, 2009: 89).

There should be school-based clinics either on the school premises or located close to the school. Providing contraceptives through school-based clinics and making condoms available in schools do not increase the onset or frequency of sex. Instead when contraceptives are available through school clinic and condoms can be obtained easily and confidentially on school premises, many sexual active students make use of these services. In other words, schools can be an important source of condoms when they are not readily available from other sources in the community (Panday, et al, 2009: 84).

4.3.7 Peer programmes

Peer programs have gained currency over the years as a strategy to intervene with adolescent sexual and reproductive health because it takes advantage of existing networks of communication and interaction, and because peers have been identified as important determinants in adolescent sexuality and a range of adolescent risk behaviors. Peer programs, generally recruit and train a core group of young people who, in turn, serve as a role models, and sources of information and skills development on adolescent sexuality. Peer educators have participated in a number of multi-component programmes- as a complement to teachers in school-based programmes, to distribute condoms outside of health services, to create demand for health services in community-based settings, and in a number of mass media interventions. (Panday, at al, 2009:85)

Peer groups can also be utilised to serve as support groups for adolescents to cope with peer pressure and sexuality development.

4.3.8 Partner communication

Partner communication is regarded as important for good reproduction health. Studies have shown that men and women who have discussed family planning are more likely to use contraceptive methods. Communication between partners is a vital factor influencing contraceptive use (Naidoo, 2005:58)

This could be part of the Life Orientation classroom involvemnet where the aspect of communication between partners/couples regarding pregnancy and protected sex practices be discussed and internalised.

4.3.9. Multi-level approach

While the sexual experiences of youth differ greatly, the fact remains that most will become sexually active during their adolescent years, and many will become pregnant or father a child. Consequently, the goals for programs addressing teenage pregnancy must be threefold: first, directed at delaying the initiation of sexual intercourse; second, directed at preventing pregnancy for youth who are sexually active, and third, directed at ensuring the well-being of young people who do become parents, including the avoidance of additional pregnancies (Christensen & Rosen, 1996:2).

It is clear from the research and discussion of findings that all the levels of sexual behaviour must be discussed by the school, parents and the community.

4.4. FOLLOW-UP RESEARCH

As follow up research the following investigations can be carried out.

- An investigation into why the parents do not talk about sexuality education to their children, more especially teenagers.
- Why there is a poor relationship between the nurses and the teenagers.
- The impact of child support grant on teenage pregnancy.
- The repurcations of teenage pregnancy e.g. how many teenage mothers are found in the streets begging for food, shelter, etc.
- How to effect change in the Life Orientation curriculum ti effectively address the plight of teenage pregnancy.

4.5. FINAL REMARK

The aim of the study was to find the reason behind the high rate of teenage pregnancy in the high schools of Ilembe district. It is hoped that this study will be of a big value to the

teenagers of Ilembe District, to the parents, educators, the department of education and the community. It is also hoped that the recommendations will be implemented and assist all the stakeholders, to minimize the occurrence of teenage pregnancy.

5. BIBLIOGRAPHY

Aggleton P, Ball A & Mane P. (2006). Sex, drugs and young people: International Perspectives. Routledge: London and New York.

Albert, B. (2004). With one Voice 2004: America's adult and teens Sound Off about Teen Pregnancy. Washington, DC: National Campaign to prevent Teen Pregnancy.

Arnold E.M., Smith, TE, Harrison, DF & Springer, DW. (2000). Adolescents' knowledge and beliefs about pregnancy: The impact of "ENABL". Adolescence, Vol.35.no.139. Libra Publishers: PMB.

Bull, S. (1998). When family support fails. The problem of maintainance payment in apartheid South Africa. South African Journal on human rights, 4: 194-206 and 334-354.

Bullock, L.M. (1992). Exceptionalities in children and youth. Allyn and Bacon: United States of America.

Bush, S. (2006 February). Beating the odds: A teen Mother's Story. .

Bezuidenhout & Joubert, S. (2009). Child and Youth Misbehaviour in South Africa: A holistic approach. Van Schaik Publishers: Hartfield Pretoria

Charters, J.J et al. (1993). At Risk Youth:
A Comprehensive Response. Brooks and Cole Publishing Company. Pacific Grove: California. USA.

Christensen, S. &Rosen, N. (1996). Teenage pregnancy. The family connection of St Joseph County, Inc. and Memorial Health System. Page 1-5. Retrieved on 18 June 2008 from http://community.michiana.org/famconn/teenpreg.html.

Cocca C. (2006). Adolescent Sexuality. Praeger publishers: London.

Conger, J.J. (1991). Adolescent and Youth psychological development in a changing world. University of Colorado School of Medicine: Harper Collins Publishers.

Cox, M. F. (2007). Maternal demandingness and responsiveness as predictors of adolescent abstinence, Journal of Pediatric Nursing.

Davids, S. (1989). Pregnancy in Adolescents. American Journal of public health. 75-13-14

Dittus, P.J & Jaccard, J. (2000). Adolescents' perceptions of maternal disapproval of sex: Relationships to sexual outcome. Journal of adolescent health.

Essau, C.A. (2004). Risk-taking behavior among German adolescents. Journal of Youth Studies.

Florsheim P. (2003). Adolescent Romantic Relations and Sexual Behavior. Lawrence Erlbaum Associates Publishers: London.

Fong, D. Surviving teenagers. (2007). Geddes & Grosset: Poland.

Genobaga, J. (2004). Teenage girl: What I want to know without asking. Australia: Signs publishing company.

Gerdes, L. (1998). Bringing up parents and children. University of South Africa: Pretoria.

Ghanaian, Chronicle. (2009). Teenage pregnancy: The onus lies on teenagers. Modern Ghana. Com. Retrieved on 2009 May 19, from http:/www.modernghana.com/blogs/213742/31/teenage-pregnancythe-onus-lies-on-te.

Gouws FE, Kruger N and Burger S. (2008). The adolescent. Heinemann Publishers (Pty) Ltd: Johannesburg.

Greathead, E. Devenish, C. and Funnel, G. (1998). Responsible Teenage Sexuality. Planned parenthood Association of South Africa. Academic Publishers. Pretoria South Africa.

Harrison, A. Xaba, N. & Kunene, P. (2001). "Understanding safe sex: Gender narratives of HIV & pregnancy prevention by rural South African school-going youth". Reproductive Health Matters. 9(17): 63-71.

Hartley- Brewer, E. (2005). Happy Children through positive parenting. Vermilion: London.

Heaven, P C L. (2001). The social Psychology of Adolescence. Palgrave New York.

Helen, S. Holgate, R. and Francisco, K O. (2006). Teenage pregnancy and parenthood: Global perspective issues and interventions. Routledge, Taylor and Francis group: London.

Irin. (2007). South Africa: teenage pregnancy figures causes alarm. Retrieved on 18 June 20008, from http://www.alertnet.org/thenews/newsdesk/IRIN/af27d3c200dc2ce707bf31e03f32771f.htm

Jaffe, M.L. (1998). Adolescence. John Wiley & Sons Inc: New York.

Jewkes, R., Vundule, C., Maforah, F. & Jordan, E. (2000). Social Science & Medicine: Relationship Dynamics and Teenage Pregnancy in South Africa. Volume 52, issue 5. Elsevier Science Ltd: Pretoria.733-744. Retrieved 19 May 2009, from http://www. Science direct .com/science.

Johnston, B. and Christensen, L. (2000). Educational research. Boston: Allyn and Bacon.

Kansumba, GC. (2002). Factors contributing to increase rate of teenage pregnancy amongst high school girls in Mufulira, Zambia. University of the Western Cape.

Lee E, at al. (2002). Teenage sex: What should schools teach children? Great Britain: Hodder and Stoughton.

Loila-Nuahn, H. (2004). Social Support of Pregnant Adolescent in Durban. University of Natal: Durban.

Macleod, C. (1999). Teenage pregnancy and its negative consequences: review of South African research. Part 1. South African journal of psychology, vol 29, Issue 1, Mar.

Makiwane, M. 2010. The Child Support Grant and teenage childbearing in South Africa. In Development Southern Africa. 27 (2): 193-204.

Manzini, N. (2001). Sexual initiation and child bearing among adolescent girls in KwaZulu Natal. South Africa. Reproductive Health Matters. 9 (17): 44-52.

Martin, RC. (2003). Understanding sexuality. Chicago: World Book, inc. a Scott Fetzer company.

Martin, S. (2007). Teen Pregnancy. Retrieved on 18 June 2008, from http://www.associatedcontent.com/article/307371/teen pregnancy.html?cat=49

Maynard, R.A. (1997). Kids having kids: Economic Cost and Social Consequences of Teen Pregnancy. The Urban Institute Press: Washington, D C

Miller, B. (1998). Families Matter: A research Synthesis of family influences on adolescent Pregnancy. Washington, DC: The National Campaign to prevent teen pregnancy.

Miller, K. (2006). Causes of teenage pregnancy. The top ten most beautiful beaches. Retrieved on 18 June 2008, from http:/www.associatedcontent.com/article/100858/causes of teenage pregnancy.html?cat=52

Mkhwanazi, N. (2006). Partial truths: representations of teenage pregnancy in research. Anthropology Southern Africa, vol 29, Issue 3/4. Page 96-104

Mlambo, G.T., & Richter, M.S. (2005). Perceptions of rural teenagers on teenage pregnancy. Health SA Gesondheid. Page 1-3. Retrieved on 19 May 2009, from http: //findarticles.com/p/articles/mi_6820/is_2_10/ai_n28321185/

Molatlhwa, O. 2010. Sowetan, Wednesday, September 1 2010. KZN Edition. www.sowetanlive.co.za.

Morejele, N. Brook, J.S., & Kachieng'a, M.A. (2006). Perceptions of sexual risk and substance abuse among adolescent in South Africa: A qualitative investigation. AIDS Care.

Moore S & Rosenthal D. (2006). Sexuality in Adolescence. Routledge: London and New York.

Musick, J.S. (1993). Young, poor and pregnant. Yale University: London.

Naidoo, H.A. (2005). Factors affecting contraceptive use among young people in KwaZulu Natal. University of KwaZulu Natal Howard College: Durban.

Newman, MB & Newman PR. (2006). Development Through life: a psychosocial approach ninth edition. Thomson Wadsworth: United States of America.

Nolan, M. (2002). Need to know Teenage Pregnancy. Heinemann: Great Britain:

Nzama, A P L. (2004). The effects of teenage pregnancy on the school life of adolescent girls. University of KwaZulu Natal: Durban.

Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). Teenage pregnancy in South Africa- with a specific focus on school-going learners. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria: Department of Basic Education.

Rathus, S.A. (2008). Childhood and adolescence: Voyages in Development. Thomson Wadsworth: Canada

Rice, F.P. (1992). The Adolescent: Developing, relationship and culture 7th edition. Allyn and Bacon: United States of America.

Seifert KL & Hoffnung RJ (2000). Child and adolescents development. Houghton Miffling Company: New York.

Strasburger, VC, Wilson, BJ & Jordan AB. (2009). Children, Adolescent and the Media second edition. Sage: London.

Teal, A. (2007). Teen Pregnancy: The problem and Possible Solutions. The Top ten most beautiful beaches. Retrieved 2008 June 18, from http://www.associatedcontent.com/article/162301/teen pregnancy the problem and possible.html? Cat=52.

Tips on Pregnancy: pregnancy guide. Retrieved on 03 June (2008), from http://www.tips-on-pregnancy.com/coping-with-teen-pregnancy/.

Van den Aardweg, E.M. &Van den Aardweg E.D. (1993). Psychology of education: A dictionary for Students. Pretoria: E & E Enterprises.

Van Rensburg, C.J.J., Landman, W.A. & Bodenstein, H.C.A. (1994). Basic concepts in Education. Halfway House: Orion.

Varga, C.A. (1999). South African young people's sexual dynamics: implication for behavioural responses to HIV/AIDS in: Caldwell. J. C et al. (ads) "Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries." Canberra, Australia: Australian National University, National Centre of epidemiology and population Health, Health Transition Centre. Pp 13-34

Wikipedia, the free encyclopedia. (2008). Teenage pregnancy. Retrieved on 03 June 2008, from http://en.wikipedia.org/wiki/teenage_pregnancy. Pp 1-16.

YCC. (2007). Why is teenage pregnancy so prevalent. The best beach weather in the nation. Retrieved on 18 June 2008, from http:?//www.associatedcontent.com/article/229432/why is teen pregnancy so prevalent.html?cat=25.

6. APPENDECES

APPENDIX A

QUESTIONNAIRE

INSTRUCTIONS **……. Etc** • **All Information will be treated as confidential** • **There are no correct or incorrect responses. Please respond truthfully** • **Please choose only one option unless otherwise indicate by ticking the appropriate box or boxes** • **Section 1 probes biographical info** • **Section 2 ……..** • **Section 3 ……..**	**Official use column** **Serial no:** **1-3** ☐☐☐
SECTION A BIOGRAPHICAL DATA **1.** Age 1. 2. 3. 4. 5. 13-14 | 15-16 | 17-18 | 19-20 | Above 21	☐ 4
2. Gender. Male | Female	☐ 5
3. Pregnancy, Please indicate whether you are: Pregnant | Not pregnant | Been pregnant	☐ 6
4. Parents 1. Living with both parents. ☐ 2. Separated/divorced – Living with mother ☐ 3. Separated/divorced – Living with father ☐ 4. Separated/divorced – living with grand parents ☐ 5. Living with friends ☐	☐ 7
5 What is your parents occupation Father Mother 1. Professional e.g. Doctor. Teacher ☐ ☐ 2. Business ☐ ☐ 3. Farmer or farm occupation ☐ ☐	☐☐ 10

4.	Skilled worker e.g. Plumber		
5.	Clerical		
6.	Factory worker. e.g. waiter, guard		
7.	Home maker/ Housewife		

6. How much of formal education your parents have.

		Father	Mother
1.	Never been to school		
2.	Some primary school		
3.	Finished primary education		
4.	Some secondary education		
5.	Completed secondary education		
6.	University diploma/degree		

12

7. How many brothers and sisters do you have? Number of sibling.

1.	ONE
2.	TWO
3.	THREE
4.	FOUR
5.	FIVE
6.	SIX
7.	SEVEN
8.	EIGHT
9.	NINE

13

8. I belong in culture where sex is permitted before marriage.

1.	YES	
2.	NO	

14

9. I obtain most of my info about sex from following sources: (you may select more than one option)

1.	TELEVISION	
2.	PARENTS/GUARDIAN	
3.	FRIENDS	
4.	SCHOOL TEACHERS	
5.	PHYSICIANS	
6.	MAGAZINES	
7.	RADIO	

21

10. Working status of parents.

1.	Both Parents working	
2.	Mother stays at home and father works	
3.	Father stays at home and mother works	
4.	Neither of your parents have jobs	

22

SECTION B.

Questions relating to perceptions regarding teenage pregnancy

Please indicate your perceptions on each of the statements made below by ticking the appropriate agreements-box according to the agreement-legend supplied.
Please note that statements are worked in such a way as to accommodate responses from students who have not/are/have been pregnant.

Agreement legend

1. Strongly Disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly Agree.

	1	2	3	4	5
1. Finishing High School is important to me					
2. Having a child will make/makes it harder for me to complete my matriculation exams					

3. Sex before marriage is acceptable						
4. I Plan/Planned to became pregnant while still on my teens						
5. My friends have babies and therefore I want/wanted to have my own baby just like my friends						
6.I do/did not plan to became pregnant						
7. Its difficult to get contraceptives.						
8. I am afraid/was afraid to go to the clinic						
9. Incorrect use of contraceptives leads to pregnancy						
10. Forced unprotected sexual intercourse by my boyfriend leads to pregnancy						
11. One can not fall pregnant from her first sexual intercourse						
12. having a baby is cool						

13. Ignorance regarding contraceptives leads to pregnancy					
14. Being a teenage parent makes one more popular					
15. Falling pregnant will make my boy friend loves me more					
16. A boyfriend's wish for a baby is a reason to fall pregnant					
17. Funding from a child support grant is a motivational factor to fall pregnant					
18. Fear of visiting the clinic leads to pregnancy					
19. Liquor abuse leads to pregnancy					
20. Sexual guidance comes from my boyfriend not from my parents					
21. My boyfriend will leave me if use contraceptives					
22. The side effect of contraceptives is something to be afraid of					
23.My boyfriend will leave me if I don't sleep with him					
24.One's boyfriend's promise of marriage on condition of a baby at first motivates to fall pregnant					
25.Pregnancy is a way out of school If you are not interested in school work					
26. Curiosity regarding pregnancy is a motivation for falling pregnant					
27. When you are deeply in love its hard to say no to sex					
28. Teenagers, including myself are responsible enough to became parents					
29. Teenage-Parents are able to care for their babies themselves					
30. Sisters that have babies are a strong motivation to having your own baby.					

52

SECTION C

Questions leading to reason for pregnancy

Please indicate your perceptions on each statement made below by ticking the appropriate agreement-box according to the agreement-legend supplied.
Please note that statements are worded in such a way as to accommodate responses from students who have not/are/have been pregnant

Agreement legend

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

	1	2	3	4	5
1. Some people say the rise in teenage pregnancy is caused by child support grant.					
2. The teenagers of Mandini Ward fall pregnant because of child support grant.					
3. The schools have done enough in teaching the teenagers sex education					
4. The teenagers have to be blamed for escalation of teenage pregnancy at Ilembe district, the teenagers, the schools, parents or the government.					
5. The schools have to be blamed for the escalation or teenage pregnancy at Ilembe District parents or the government					
6. The parents have to be blamed for the escalation of teenage pregnancy at Ilembe District.					
7. The Government have to be blamed escalation of teenage pregnancy at Ilembe District					
8. Some teenagers fall pregnant because they don't know the problems of having a baby while they are very young					

9. Teenage pregnancy is very high under teenagers from poor economic background						
10. Girls fall pregnant because they do not have hope for the school or future.						
11. Some teenagers do not visit the clinic in to get contraceptive because they believe nurses will shout at them						
12. Some teenagers do not use contraceptive because they do not know where to hide from their parents.						
13. Some teenagers fall pregnant because they are being forced by their boyfriends.						
14. All teenagers are aware that HIV/AIDS is the result of unprotected sex.						
Some teenagers fall pregnant because they do not have clinics in their area.						
Teenage pregnancy may sometimes be attributed to dating an older person (Sugar Daddy)						

68

APPENDIX B