EXPLORING THE IMPACT OF TEENAGE PREGNANCY ON DISADVANTAGED ADOLESCENTS IN MPUMALANGA

By

Tebogo Mokoena

Submitted in accordance with the requirements for

the degree of

MASTER OF ARTS

In the subject of

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR:

Ms Keit Shirinda-Mthombeni

November 2018

DECLARATION

I declare that **"exploring the impact of teenage pregnancy on disadvantaged adolescents in Mpumalanga",** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

…………………………… ………………………………..

Signature Date

(Name & Surname) Tebogo Mokoena

Student no: **4108-325-3**

ACKNOWLEDGEMENTS

- Immeasurable appreciation and deepest gratefulness to God Almighty, for without his grace and blessings, this study would not have been possible.
- I would like to thank my UNISA supervisor, Ms Keit Shirinda-Mthombeni for the unwavering support, encouragement and guidance she provided throughout my time as her student.
- I would like to express the deepest appreciation to my parents, Hellen Makoena Mokoena and Sipho Selby Mokoena for all your love and support. Thank you for always believing in me; you are selfless, unconditional people and the sacrifices you continue to make for all your children inspire me.
- To my siblings, Zandile and Sibusiso thank you for being the best sister and brother I could ask for; our paths may change as life continues, but the bond between us will remain strong forever.
- To my daughter, Kutloano, you are the greatest gift of my life, I am so proud to be your mom.
- To my nephew Noah, you are a true inspiration.
- My gratitude to the schools and participants who took the time to share their stories; your personal experiences enriched my life.

ABSTRACT

Teenage pregnancy remains a major social, economic and health challenge in South Africa. The consequences of unplanned teenage pregnancies are devastating. The current study explored the impact of teenage pregnancy on disadvantaged adolescents in Mpumalanga. Fourteen adolescent girls were selected, using the purposive sampling technique. The objectives were to explore the experiences of adolescence, as well as their knowledge of various methods of preventing teenage pregnancy, and how they cope with the pregnancy. The study further explored programmes that are available to assist with teenage pregnancies in the community. Data was collected using in-depth one on one interviews to allow the researcher a platform to ask open-response questions. The data was thematically analysed by carefully categorising and expanding significant themes that emerged from the participant's responses. The study revealed that lack of knowledge about sex and contraceptives, unhealthy coping strategies, lack of support from parents and peer pressure are all effects of teenage pregnancy and the reasons for participating in unprotected sexual activities. Recommendations for overcoming these challenges were provided to the community, schools and government organisations as guidelines in the establishment of youth programmes.

Keywords: adolescent, pregnancy, human immunodeficiency virus (HIV), vulnerable, sexual initiation, risky behaviour, teenage, motherhood, education, peer pressure, support communication, parents, caregivers

TABLE OF CONTENTS

DECLARATION ii
ACKNOWLEDGEMENTS iii
ABSTRACT iv
TABLE OF CONTENTS v
LIST OF TABLES viii
LIST OF FIGURES ix
LIST OF ACRONYMS x
CHAPTER 1: INTRODUCTION AND BACKGROUND 11
1.1 INTRODUCTION 11
1.2 BACKGROUND TO THE STUDY 13
1.3 STATEMENT OF THE PROBLEM 15
1.4 OBJECTIVES OF THE STUDY 16
1.5 THE RESEARCH QUESTIONS 17
1.6 CONCLUSION 17
1.7 OUTLINE OF CHAPTERS TO FOLLOW 17
CHAPTER 2: THE LITERATURE REVIEW 19
2.1 INTRODUCTION 19
2.2 HOW PARENTING MAY AFFECT ADOLESCENT SEXUAL CONSEQUENCES 20
2.3 FACTORS CONTRIBUTING TO TEENAGE PREGNANCY 23
2.3.1 Poverty in rural areas 24
2.3.2 Gender inequality and cultural factors 24
2.3.3 Knowledge about contraceptives 26
2.3.4 Access to health care services 26
2.3.5 Teenage pregnancy and contraceptive use 27
2.4 TEENAGE PREGNANCY AND MOTHERHOOD 30
2.5 THE IMPACT OF TEENAGE PREGNANCY 31
2.5.1 Social influence 32
2.5.2 Psychological impact 33
2.5.3 Educational impact 33
2.6 FEMINIST PERSECTIVES 34
2.7 CONCLUSION 35

CHAPTER 3: RESEARCH METHODOLOGY 37
3.1 INTRODUCTION 37
3.2 RESEARCH DESIGN 37
3.3 SAMPLE DESIGN..38
3.3.1 Purposive sampling..39
3.3.2 Population and sample size 40
3.4 DATA COLLECTION METHODS..40
3.4.1 Instruments..40
3.4.2 Procedure 41
3.5 DATA ANALYSIS..41
3.6 RELIABILITY 42
3.7 PILOT STUDY 43
3.8 ETHICAL CONCERNS 44
3.8.1 Permission..44
3.8.2 Informed consent 44
3.8.3 Voluntary participation 45
3.8.4 Confidentiality 45
3.8.5 Anonymity..45
3.9 CONCLUSION..46
CHAPTER 4: DATA PRESENTATION, ANALYSIS AND FINDINGS 47
4.1 INTRODUCTION 47
4.2 REVIEW OF THE OBJECTIVES..47
4.3 PARTICIPANT’S BACKGROUND INFORMATION 47
4.4 FINDINGS OF THE QUALITATIVE DATA 48
4.4.1 Socioeconomic impact 50
4.4.2 Strained relationships 53
4.4.3 Attitudes towards birth control..56
4.4.4 Attitudes towards prevention..59
4.4.5 Coping strategies..60
4.4.6 Support systems/programmes 61
4.4.7 Conclusion..63
CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS.........................64
5.1 INTRODUCTION 64
5.2 THE EFFECT OF PREGNANCY ON TEENAGERS 64

5.3 REASONS FOR TEENAGERS TO PARTICPATE IN UNPROTECTED SEX.............65
5.4 CONTRACEPTIVES AVAILABLE TO TEENAGERS 66
5.5 A LACK OF KNOWLEDGE CONCERNING PREVENTION OF INFECTIONS............67
5.6 COPING STRATEGIES USED TO COPE WITH CHALLENGES................................68
5.7 SUPPORT PROGRAMMES TO DEVELOP ADOLESCENTS....................................69
5.8 ATTRIBUTES OF THE STUDY..70
5.9 LIMITATIONS OF THE STUDY 70
5.10 CONCLUSION...71
5.11 RECOMMENDATIONS..71
5.11.1 Recommendations for the National Departments of Health and Basic Education.71
5.11.2 Recommendations for future studies..72
REFERENCES 73
APPENDIX A: PERMISSION LETTER...87
APPENDIX B: PARTICIPANT INFORMATION SHEET...88
APPENDIX C: CONSENT FORM FOR THE INTERVIEW AND RECORDING..........................89
APPENDIX D: BIOGRAPHICAL QUESTIONNAIRE...90
APPENDIX E: INTERVIEW SCHEDULE...91

LIST OF TABLES

Table 4.1: Biographical information of participants 48

LIST OF FIGURES

Figure 4.1: Identified themes and sub-themes from qualitative data 49

LIST OF ACRONYMS

CSE	Comprehensive Sexuality Education
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
LARC	Long-acting reversible contraception
LO	Life Orientation
SABC	South African Broadcasting Corporation
SRH	Sexual and Reproductive Health
UNAIDS	The Joint United Nations Programmes on HIV and AIDS
WHO	World Health Organization

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The World Health Organization (WHO) defines teenagers, as young people between 10 and 19 years (Adolescent Health, 2016). Globally, approximately 16 million teenage girls give birth each year, accounting for around 11% of all births. Over 90% of these deliveries occur in low-and-middle-income countries (Cook & Cameron, 2015). Finer and Henshaw (2006) indicate that half of all pregnancies in the United States of America are unplanned. Females in their 20s account for most of these births. The scale of teenage pregnancy births in the United States is higher than in numerous developed countries, including Canada and the United Kingdom (United Nations Statistics division, 2015). According to the National Centre for Health statistics (2015), the national rate of teenage pregnancies in the United States during 2014 was 24.2 births for every 1000 adolescence females (15-19 years). Consequences of unplanned pregnancy include unintended childbirth and abortion, which may be linked with deficient physical and psychosocial health implications for females (McGowan, 2013).

In Western Europe, the United Kingdom has the highest rate of teenage pregnancies and the second highest in developed countries. The United States has the highest teenage pregnancy rate in developed countries (Dickins, Johns & Chipman, 2012). In the United Kingdom and United States, unplanned teenage pregnancy is still a significant public health and social policy field of interest (Hayter, Jones & Harrison, 2016). Despite attempts to reduce teenage pregnancy, this dilemma continues to profusely affect African American, Latino and American Indian communities in the United States (Kost & Henshaw, 2012). Previous research established numerous factors contributing to adolescent childbearing amongst African American females residing in economically deprived communities. These include parental influences, peer pressure, inadequate knowledge and information about sexual intercourse and substances abuse (Killebrew, Smith, Nevels, Weiss & Gontkovsky, 2014).

According to a study by the World Health Organization (WHO) in 2014, 16 million girls aged 15 to 19, and an estimated one million below 15 gave birth annually. Most of these girls are from low-and-middle-income countries. WHO (2014) also indicates that adolescents contribute to a staggering 11% of annual births. If researchers do not conduct studies on teenage pregnancy, it

would be detrimental to millions of children globally. Teenagers would be encountered with the choice to have sex at a young age instead of delaying sexual activity to improve their and their children's lives (WHO, 2014).

Teenage pregnancy continues to make headlines globally. It is perceived as an epidemic and the stigma associated with pregnancy at an early age is a dominant factor in school drop outs, difficulties during pregnancy and unsafe abortions. WHO (2014) establishes that difficulties during pregnancy and childbirth are the second cause globally for the death of girls aged 15 to 19. These statistics are firm indicators that youngsters globally continue to engage in unprotected sexual activities it is caring professionals' responsibility to investigate the reasons why adolescents engage in risky sexual behaviour, and the consequences of such behaviour are.

In Sub-Saharan Africa, adolescent females continue to be overwhelmingly affected by sexual and reproductive ill health (Phillips & Mbizvo, 2016). Each year, around 380 000 young females become infected with HIV. An estimated 80% of young females living with HIV reside in Sub-Saharan Africa (UNAIDS, 2014). Pregnant adolescents are more likely to drop out of school, risking unfavourable pregnancy consequences (Ganchimeg *et al.,* 2014), including unsafe abortions (Shah & Ahman, 2004). These females are more prone to have another pregnancy instantly (WHO, 2012). Teenage pregnancies are more noticeable and destructive in Sub-Saharan African countries, with high poverty rates.

A 2013 study conducted in South Africa, established that most adolescent mothers reported limited contraceptive use, while accessibility to contraceptives was reported as an important barrier (Wilan, 2013). Studies on young females' access to sexual and reproductive health care, revealed similar patterns of negativity from health-care workers. These observations are based on moralistic observations of young females' sexuality, leading to deficient health care and support from the health-care workers (Alli, Maharaj awda, 2013; Holt, Unce & Hargey, 2012). Winters and Winters (2012) observe that teenage pregnancy is a social challenge perceived to be the result of lower education levels, welfare dependency and low-paying jobs with devastating consequences for these adolescents and their babies. The environment in which a child is raised is significant in predicting the vulnerability of an individual teenager to falling pregnant (Cantlay, 2015). Adolescent parenthood is affiliated with impoverished areas and low-income families. It was debated in terms of it being a social exclusion symptom and cause (Macvarish, 2010).

Mpofu (2012) states that thousands of adolescent pregnancy cases were recorded in South Africa between July 2008 and July 2010. Concerns are raised about the consequences of these alarming rates for gender equality in education. Singh and Hamid (2016) confirm that higher determination expressed by adolescent mothers held significance for their future sexual well-being and prevention of unintended pregnancies. They are determined to participate in training, assisting in preventing unplanned pregnancies. Drawing from their experiences, they are willing to be peer educators in health education, aimed at preventing unintended pregnancies. This study therefore serves as a contributing factor in finding effective prevention strategies and urgent intervention required to improve the individual and societal well-being of adolescents, in particular those from rural areas.

1.2 BACKGROUND TO THE STUDY

Engelman (2016) indicates that in Africa, women bear an average of 4.7 children in contrast to the global average of 2.5. The population increases three times faster than globally. He also emphasises that in Kenya, teenage pregnancy deprives a girl's opportunity to complete education, obtain human capital skills vital for a gainful career path, and their autonomy to make significant decisions surrounding crucial development issues (Engelman, 2016). Female adolescents regularly engage in sexual activities at a younger age than male adolescents (Bankole & Malarcher, 2010). In East Africa, 10% of young females give birth by age of 16 (Neal, Chandra-Mauli & Chou, 2015).

Inadequate family planning service delivery is evident in Ghana, where unsafe abortions are responsible for more female deaths than AIDS. Birth rates are alarming at 66 per 1000 girls between the ages of 15 to 19 and 176 per 1000 for young females aged 20 to 24 (Cleland & Ali, 2006; Mayhew & Adjei, 2004). Research conducted in four provinces of South Africa, with 3123 participants, denotes an adolescent pregnancy rate of 19.2%. Of these pregnancies, 6,7% were aborted (Mphatswe, Maise, & Sebitloane, 2016). In 2012, the youth population aged 15-24 years accounted for approximately 20% of HIV infections of six million individuals nationally (National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa, 2011). In Kwazulu-Natal, 16% of pregnant adolescents aged 15-19 are HIV-positive compared to the national rate of 12.7% (NASHSPS, 2011). These findings show that there is an urgent responsibility to study teenage pregnancy and the trend of high-risk sexual activities amongst adolescents (Jewkes, Vundule, Maforah & Jordaan, 2001). A study conducted in the Giyani District of the Limpopo Province,

reported high rate of pregnant learners not attending classes or leaving school early, due to fatigue and other pregnancy complications (Patel, 2011).

The SABC (South African Broadcasting Corporation, 2015) reported that Mashishing Secondary School in the Mpumalanga had twenty pregnant pupils during the 2015 academic year and the article further stated that 3000 pregnancies were reported in the previous year in Mpumalanga. The same article quoted a school governing body member labelling teenage pregnancy as a "disease". Reports also indicate that South Africa has an unintended teenage pregnancy rate of 30%" (Ardington, 2012). Cantlay (2015) suggests that a teenager's background is significant in determining the risk of individual adolescent pregnancy. An increased awareness that pregnant adolescents encounter several difficulties inside and outside school were presented. Adolescent motherhood causes problems both in the education sector as well as society at large (Shefer, Bhana & Morrell, 2013).

Adolescent pregnancy and motherhood have been at the centre of various studies in South Africa over the past few years. Most studies focus on the experiences, challenges and consequences of early motherhood (Bhana & Mcambi, 2013; Shefer, Bhana & Morrell, 2013). The younger the age of the first sexual experience, the higher the risk of unprotected intercourse (Cantlay, 2015). According to Finer and Zolna (2013), more lenient observations towards teenage pregnancy named its causes not to be teenagers' ignorance, but some adolescents' limited access to contraception, ultimately leading to alarming unplanned adolescent pregnancies. Studies support the observation that most adolescent pregnancies are unintended.

Adolescence refers to a transition from childhood to adulthood and it begins with the onset of physiologically normal puberty. The stage ends when an individual accepts an adult identity and behaviour. Therefore, an adolescent is anyone from the age of 10/11 up to or just above age 19. Disadvantaged adolescents are people aged 10-19 who, as a result of factors beyond their control, are excluded from social, financial and educational opportunities enjoyed by other adolescents in their community (Auerswal, Piatt & Mirzazadeh, 2017).

According to Hofmann, Sawyer, Fang and Asnaan (2012) adolescence is a crucial period for the development of emotional skills. Dysfunctional development during adolescence can have severe negative consequences, leading to mental health challenges, risky behaviour and poor social skills. Adolescence is a sensitive period of development, characterized by physical and mental

maturation (Massey, 2013). A teenager refers to a person who falls within the ages of 13 to 19 and it is another word for adolescent.

This study aims to explore the impact of teenage pregnancy on disadvantaged adolescents in Mpumalanga. Massey (2013) established that when the disadvantage is condensed in a geographic area, therefore, the community becomes disadvantaged. The researcher chose to conduct the study in Bushbuckridge because she observed pregnant disadvantaged adolescents here. The adolescents are regarded as disadvantaged because they come from the community with violence, high crime rates, high rate of female-headed households, poverty, high unemployment, broken-down buildings, restricted public resources and high levels of violent crime as identified by (Massey, 2013). The study also seeks to understand the experiences and perspectives of young girls falling pregnant during their adolescent years. It further explores how teenage pregnancy affects these adolescents' emotional, social and academic aspirations. The following section discusses the research problem, purpose of the study, and research questions.

1.3 STATEMENT OF THE PROBLEM

Osaikhuwuomvon and Osemwenkha (2013) identify unintended teenage pregnancy as a complicated concern. It is a significant public health challenge, posing socioeconomic challenges in society. Teenage pregnancy is a global concern and developed and developing countries are searching for solutions to ensure that female adolescents develop into healthy adults, providing decent care for their children (Taylor, Jinabhai, Dlamini, Sathiparsad, Eggers & De Vries, 2014). Teenage pregnancy is frequently associated with deficient psychosocial, socioeconomic and health consequences (Sedgh, Finer, Bankole, Eilers & Singh, 2015).

Teenage pregnancy creates challenges for the parent and the child (Summers, Lee & Lee, 2017). Teenage pregnancy has several disturbing effects, such as higher chances of leaving school, increased risks of contracting sexually transmitted infections (STIs), premature birth and poverty (Kanku & Mash, 2010). Children born to adolescent mothers are more inclined to perform below average academically and leave high school. They encounter more health challenges and are more frequently incarcerated during adolescence. Becoming a young mother leads to a lack of employment opportunities as a young adult (About teen pregnancy, 2016).

In South Africa, research on young females' access to sexual and reproductive health care indicates that adolescents are criticised for being sexually active by health care professionals based on moralistic perspectives of female's sexuality, resulting in insufficient health care and support (Alli *et al.*, 2012). In the South African context, adolescent females' difficulties in negotiating safe sex practices were reported (Singh & Hamid, 2010). Adolescent pregnancy amongst school-going youth is a global challenge. In socially-economically impoverished environments it is an outcome, relating to a complicated pattern of social justice (Woodd & Hendricks, 2016). Gender signifies to be more important in understanding and addressing pregnancy and adolescent mothers (Morrell, Bhana, & Shefer, 2012; Mkhwananzi, 2010). Therefore, it led to an increased focus on adolescent pregnancies and mothers, particularly in the fields of gender inequalities, signifying male power and teenage girls' exposure to HIV that is attributable to intimate relationships (Morrell *et al.*, 2012). Smith and Hamid (2013) in their study about teachers' attitudes towards sexuality and life skills education established that teachers display negative attitudes towards adolescent's sexuality and pregnant learners, instead of encouraging positive sexual health education and guidance.

Unintended pregnancy is a global health crisis (McGowan, 2013). Increasing awareness that pregnant adolescents encounter several difficulties within, and outside school was raised. These include adolescent motherhood as problematic within the education sector and society (Shefer, & Bhana Morrell, 2013). Adolescent pregnancy is a complicated concern with an extension of associated factors, such as poverty, poor educational completion, absenteeism, a low self-image, early sexual initiation and deficient contraception use (Kessel *et al.*, 2014). Deficient consequences are indicated for adolescent parents aged 30 and are more likely to lack qualifications than mothers giving birth at age 24 or older. They are also more likely to be unemployed and single (Kessel *et al.*, 2014).

1.4 OBJECTIVES OF THE STUDY

The objectives of the study are:

- To investigate the experiences of teenagers who are or were pregnant during their adolescence.
- To investigate and identify how they cope with teenage pregnancy.
- To identify programmes to assist with teenage pregnancies in the community.

1.5 THE RESEARCH QUESTIONS

According to Cruz and Tantia (2017), the focal opinion of the qualitative study is the guiding research question stating the purpose of the study, while structuring the literature review and identifying the informants.

The following research questions are addressed to respond to the study's main objectives:

- How did pregnancy at an early age change your life and affect your future?
- What are the reasons for teenagers to participate in unprotected sex?
- Are there any contraceptive methods available to teenagers?
- What are the strategies used to cope with the challenges?
- Are support programmes available to aid adolescents in the community?

1.6 CONCLUSION

Chapter 1 provides a general overview, including an introduction and a background to the study. Aims, objectives and research questions are established, while main terms are identified. Although health care services are available to youths in their communities, they are not used as expected. Clinics provide health care services to the communities, though they do not increase the uptake of contraceptive methods if teenagers are uninformed on the benefits. Teenagers' access to sexual and reproductive health care facilities and their willingness to use them may be affected by criticism from health care professionals resulting in insufficient health care and support, hence the high rate of unintended pregnancy in adolescents. Factors that contributes to adolescent pregnancy were identified and they can be used in helping young people to prevent adolescent pregnancy. This study endeavours to expand on the few existing studies. The following chapter focusses on the literature review.

1.7 OUTLINE OF CHAPTERS TO FOLLOW

- **Chapter 2**

Chapter 2 focuses on the review of the relevant literature.

- **Chapter 3**

Chapter 3 describes the research method used for data collection. It comprises details of the characteristics of participants and issues considered to protect the ethical rights of the participant.

- **Chapter 4**

Chapter 4 presents the research findings of this study and attention is given to the in-depth interviews.

- **Chapter 5**

Chapter 5 discusses the results of the study. Recommendations are made for the Department of Basic Education and the Department of Health to improve their Life Orientation subjects to assist teenagers. The Limitations of this study are also discussed and recommendations for future research are suggested.

CHAPTER 2: THE LITERATURE REVIEW

2.1 INTRODUCTION

This chapter identifies previous research conducted on teenage pregnancy among adolescents. Studies establish that teenage children of adolescent mothers engage in riskier behaviours, linked with teenage pregnancy, than children of adult mothers. Genna and Cornelius (2015) in their study established that adolescent mothers were more likely to abuse substances. Their offspring were more likely to use drugs and become pregnant during adolescence. According to Anastas (2017), in preventing unplanned pregnancy, the choices a young woman makes when she becomes pregnant, giving birth and keeping the baby, how best to support both mother and baby have all been noticeable.

Risky sexual behaviour is defined as inconsistent or non-use of condoms and other contraceptives, whilst engaging in sexual activities with numerous partners (Rashid & Mwale, 2016). Adolescent mothers' substance abuse may contribute to the risk for teenage pregnancy affecting several generations (Genna & Cornelius, 2015).

According to Rashid and Mwale (2016), including sex education in schools will increase awareness concerning reproductive health, ensuring the prevention of sexual risky behaviour and that decline in pregnancies be prioritised amongst adolescents. Earlier research highlights that the type of peers and peer pressure among teenagers is significant in learning and accommodating risky sexual behaviours (Akers & Sellers, 2012). Teenagers who associate with peers who participate in risky sexual behaviour increases the chances to engage in similar activities (Hoskins & Simons, 2015). African American females had constant higher birth rates apart from one ethnic group. The birth rate for African American teenagers ages 15-19 in 2013 was 33 births per 1000 (The National Story, 2016); 45% of female African American teenagers will fall pregnant before the age of 20; 38% from this 45% will leave school because of their pregnancy (National Day, 2015). Honig (2012) establishes that 85% of adolescent pregnancies in the United States are unintended.

2.2 HOW PARENTING MAY AFFECT ADOLESCENT SEXUAL CONSEQUENCES

According to Deputla, Schoeny and Henry (2010) the high-quality relationships between the parent and an adolescent are associated with lower levels of adolescent engaging in unprotected sex and early sexual initiation. Parents who are more willing to communicate about sexual behaviours, are less likely to encounter an irresponsible teenage child who engage in risky sexual behaviour (Biggs *et al*., 2010). Salmon (2011), indicated that the more economically developed countries are interested on the function of parental communication and more focused on supervision in predicting risky sexual behaviour. Guardians may be aware of the challenges associated with adjusting to a new environment during a short period and may monitor adolescents more closely during this time. They are then inclined to decrease their sexual activities (Luke *et al*., 2012).

Parental knowledge, or the parent's extent of awareness of their teenager's activities, whereabouts and peers, is a significant predictor of youth risk behaviour, including risky sexual conducts (McCauley, Shadur, Hoffman, MacPherson & Lejuez, 2015). Smith (2017) suggests that pregnancy desires and subsequent childbearing will decline and be less common amongst teenagers with improved home monitoring. They are inclined to be more committed and invested in their academics and do not engage in alternative peer activities. Research suggests that teenagers who recognised their parents to have greater knowledge were less likely to participate in unprotected sexual activities (McCauley, Shadur, Hoffman, MacPherson & Lejuez, 2015). Increased parental knowledge is also linked to decreased likelihood of participating in unprotected sex (McCauley, Shadur, Hoffman, MacPherson & Lejuez, 2015). Salmon (2011) indicates that it is important to educate parents to successfully guide their children through puberty, build resilience and promote good health and healthy relationships. Affirming parenting behaviours increased social and emotional support and high parent-child relationship quality helps protect the youth from substance abuse and risky sexual behaviour. Conversely, insufficient parental monitoring, deficient supervision and low parental knowledge are associated with higher rates of drug addiction, including more objectifying behaviours and risky sex amongst teenagers (Kalina *et al*., 2013; Killoren & Deutsch, 2014; Kincaid *et al*., 2012; Reynolds, MacPherson, Matusiewiez, Schreiber & Lejuez, 2011).

The approach that can be used to deal with adolescents' risky sexual behaviour is to talk openly with them and encourage parents or caregivers to educate their teenagers about sexual

behaviours (Annang, Lian, Fletcher & Jackson, 2014). Declined parental monitoring due to change in family structure consequent of adolescent pregnancy, could also clarify increased vulnerability for younger siblings (Nichols, Javdani, Rodriguez, Emerson & Donenberg, 2016).

Most parents seem to be anxious when talking about sexual matters because they believe their children are not mature enough for this conversation. They feel awkward and they believe they lack information, which diminish parental esteem to start the conversation (Jerman & Constantine, 2010). According to Mollborn (2010), studies show that adolescent behaviours are shaped by individual and environment-level socioeconomic statuses. Each predicts the risk of early pregnancy independently. Umana-Taylor, Jahromi and Updegraff (2013), established that parenthood comprises various stressors and needs. Teenagers and their mother figure usually attempt to understand whether the extent of their emotional, instrumental or practical companionship changes throughout this period. They try to establish whether the level of social support differs or remains the same in this significant transition period, and this is of particular interest when it comes to pregnancy in teenage mothers

Concerning family, studies suggest that parent and extended family members' conversations with young females concerning morals and beliefs about reproductive health and sexuality, can have a significant influence on their sexual behaviour as well as their positive sexual development (Massey, 2013)

Honest and open conversations between parents and their children about sexual behaviour and consequences are more likely to positively influence adolescents' sexual behaviour (Killebrew, Smith, Nevels, Weiss, & Gontkovsky, 2014). During adolescence, peer pressure has an intense pressure on how teenagers think and the choices they make, specifically regarding risky sexual behaviours associated with early childbearing (Summers, Lee & Lee, 2017). Perceived parental supervision is a crucial determinant of health, within the greater context of social determinants of health, for decreasing sexual risk-taking behaviour (Jones, Salazar and Crosby, 2015).

It has been established that active parenting is significant in ensuring the good health of teenagers (Boudet *et al.*, 2014; Guilen, Roth, Alfaro, & Fernandez, 2015). Media illustrations influence teen sexual activities and glamorous television and magazine images of famous pregnant teenagers sway youth towards engaging in sexual intercourse and becoming pregnant (Honig, 2012). Barn, & Tan (2015); Ottoni-Wilhelm, Estell, & Perdue, (2014) state that parents are responsible for

developing, teaching, counselling and supporting their children emotionally, ensuring they aspire to participate in health promotion activities as they grow. Open dialogue between children and parents makes it easier for a child to disclose strains about pressures for early sex or unwelcome activities by others (Honig, 2012). Youth with open conversations with their parents are more likely to delay the initiation of sexual intercourse, whilst being more likely to use contraceptive methods and to have fewer sexual partners (Honig, 2012).

Deputla, Schoeny and Henry (2010) establish that parents have the potential to protect children against adolescent sexual risk, indicating early sexual behaviour, inconsistent condom use and consequences, such as unintended pregnancy and sexually transmitted diseases. When adolescents receive decent supervision and information by their parents or family members, they are less likely to participate in risky sexual behaviours (Minnis, 2010). Smith (2017) institutes that adolescents who are more connected, committed and involved in their families, schools, friends and central institutions, are less likely to experience early unplanned pregnancy. Honest and open conversations between parents and their children about sexual behaviour and their consequences are more likely to have positive influences on adolescent sexual behaviour (Killebrew, Smith, Nevels, Weiss, & Gontkovsky, 2014). A recent study established that teenagers with a background of pregnancy are less likely to communicate with their parents about the consequences of adolescent pregnancy, further strengthening this need (Killebrew, Smith, Nevels, Weiss & Gontkovsky, 2014).

Longitudinal studies have established that the link between increased parental control, decreased sexual risky sexual engagement and increased using contraceptive methods, does not last over time (Markham *et al.*, 2010). A qualitative study established that parents generally believe that teenagers do not want to engage with them concerning delicate issues such as sex. Adolescents reported that parents usually made premature judgements about their sexual behaviour hence they had challenges discussing sex issues with them. Another study supports findings that authoritative and protective parenting is strongly associated with a decline in teenagers' participation in risky sexual behaviour and a reduced pregnancy rate (Hoskins & Simons, 2015). Healy (2012) establishes that parents generally believe that teenagers are informed about sex, whilst schools in the United States frequently only address biology with minimal or no discussion on sexuality. Mollborn and Everett (2010) reported that parents' assumptions about their children's sexual well-being generally constructed a self-fulfilling commitment to their children's sexual consequences.

Studies established that attitudes of maternal criticism of premarital sex link with less persistent sexual activity and frequent use of contraceptive methods (Annang, Lian, Fletcher & Jackson, 2014). Authoritative and protective parenting develops an awareness of their daughter's behaviour, leading to the opportunity to delay their engagement in risky sexual behaviour (Hoskins & Simons, 2015). African American teenage girls engage in sexual intercourse earlier, reporting higher levels of sexual behaviour during their adolescence than adolescent girls from other racial groups (Dancy, Crittenden, & Ning, 2010). It is important to acknowledge the potential influence of teenager attitudes of their parent's perceptions about sex on their behaviour (Annang, Lian, Fletcher & Jackson, 2014).

The literature recommends that parents should be actively involved in adolescent risk reduction programmes and educate their teenagers about sexual concerns (Annang, Lian, Fletcher & Jackson, 2014). Teenage pregnancy desires will be higher and early pregnancy more common amongst youth who engage in fewer activities; are under less supervision; experience negligent or predominant parenting styles in their families; have poor academic performance and expectations; have more interruptions and flexibility at school; are involved in more romantic relationships; show earlier sexual initiation; show delinquent behaviour and substance abuse with friends (Smith, 2017).

2.3 FACTORS CONTRIBUTING TO TEENAGE PREGNANCY

Alli, Maharaj and Vawda (2012) emphasised that several factors, including individual, socio-demographic, familial and relational characteristics, poverty, cultural and family patterns of early sexual experience and a lack of school or career goals, affect teenage pregnancy. As established, teenage pregnancy in South Africa is driven by several factors such as gender inequalities; gendered expectations of how teenage boys and girls should behave; sexual 'taboos' (for girls) and sexual permissiveness (for boys); poverty; deficient access to contraceptives and termination of pregnancies; inaccurate and inconsistent contraceptive use; judgemental attitudes of health care workers; high levels of gender-based violence; and deficient sex education (Flanagan *et al.*, 2013:11).

2.3.1 Poverty in rural areas

According to Flanagan *et al.* (2013:17), poverty is a contributor and a consequence of early pregnancy. In some cases, it leads to intergenerational sex, transactional sex or sexual relationships that are not ideal but providing some benefits. Poverty decreases a girl's ability to negotiate condom use and can keep her in abusive relationships, creating a further layer of unequal power (Mkhwanazi, 2010).

Ngabaza (2011) establishes that although here is a general decline of teenage pregnancy across South Africa, there are some poorer black communities that are still affected, such as Mpumalanga, Northern Cape, Limpopo and the Eastern Cape, and that is a reflection of historic dividing consequences linked with Apartheid. Ardington (2012) highlighted that rural areas also establish a different trend. He indicates that despite a general trend of declining teenage births, in rural areas the percentage of teenagers who gave birth remained higher over time. Flanagan *et al.* (2013) support this, remarking that unplanned pregnancies were higher in rural areas than urban areas, with 14% of rural teenage girls becoming mothers as compared to 11% in urban areas. The Department of Basic Education suggests that the distinction between urban and rural fertility rates is due to increased access to education, t development and higher levels of access to contraceptive services in urban areas (Flanagan *et al.*, 2013:10).

According to Meshki, Lin and Tsai (2019) growing up in low-income homes and communities increases adolescents' vulnerability to various health threats and challenges. According to Mchunu, Peltzer, Tutshana and Seutlwadi (2012) access to reproductive health services is another element that contributes to teenage pregnancy. Teenagers need to be able to access sexual and reproductive health information at all times, without having to endure public scrutiny.

2.3.2 Gender inequality and cultural factors

Willan (2013) emphasises that teenage pregnancy and being a teenage mother is not about teenagers partaking in unprotected sex, but absorbed in the norms of societies concerning gender, sexual taboos around teenage sex and gender inequalities within societies influencing teenager's participation in sexual activities. Cultural factors also emerged as barriers to service provision. Providers sensed that depending on the age and gender of the provider, clients were

less likely to discuss sexual and reproductive health issues for fear of being disrespectful (Willan, 2013).

South African studies established that Health Care Workers were particularly unfriendly towards unmarried young female seeking obstetric care because they sensed they were immoral in falling pregnant (Alli, Maharaj & Vawda, 2012). Holt *et al.* (2012:288) highlighted that HCWs recognised that “gender dynamics in relationships also plays a role in determining the risk of young women”. Flanagan *et al.* (2013) observe that several studies indicate age gaps partake and are motivated by gender-based inequalities and poverty as females seek financial support from men to meet their basic needs. They continued that peer pressure to participate in sexual activities and the principle of submission to male partners both often lead to unprotected sexual behaviour.

The literature repeatedly emphasises that teenage girls are not always in control, lacking knowledge of whether and how they engage in sexual activities. “In South Africa, studies cite unequal decision-making about sex between partners, where girls lacked autonomy, thus hindering the practice of safe sex” (Flanagan *et al.*, 2013: 15). This finding supports the findings of previous studies that young females have little or no negotiating power with their partners to insist on condoms usage in relationships. This finding might be different in a transactional sexual relationship. Qualitative research findings indicate that females often assert that accepting financial or material assistance from males, means accepting sex on his terms, which often means sex without condoms (Mchunu, Peltzer, Tutshana & Seutlwadi, 2012).

Mkhwanazi (2010:356) comments on the mixed messages circulated between girls. “Gendered norms discourage girls from being ‘sexual’ active and encourage them to be ‘sexually innocent”. Conversely, they are told to be protected against pregnancy and they are the ones to blame when they fall pregnant. They are also expected to be “sexually ignorant” and subject to the observation that keeping condoms threaten a girl’s respectability. Willan (2013) shows more about the resistance in discussing topics generally known to be taboo and which a young woman should not be talking about according to social norms. Therefore, this creates barriers because teenagers are often uncomfortable and shy over being observed by community and family members to be curious about these topics.

2.3.3 Knowledge about contraceptives

The literature presents varied ideas about whether teenage girls know about contraceptives. A body of literature argues that teenage girls have relatively low levels of knowledge about contraceptives. One of these studies argues that knowledge is high. In addition to comprehensive knowledge about contraceptives, concern was raised that several teenagers do not understand how conception occurs, when they are fertile, and the impact of incorrectly or inconsistently using the pill (The National Contraception Policy Guidelines, 2012). This can lead to misunderstandings about how unwanted pregnancy occurs, when teenagers are more likely to conceive, and notions that "if I just have sex once I won't fall pregnant". Such essential information should be the basis of sex education. Hoffman-Wanderer *et al.* (2013) reviewed several teenage pregnancy studies, establishing that pregnant adolescents have low levels of information about modes of contraceptives (Hoffman-Wanderer *et al.*, 2013). A literature review on the topic established that several adolescents similarly lack adequate knowledge on contraceptives (MIET, 2012).

This review supports Panday's observation that while teenagers have high levels of knowledge about contraceptive methods, there are gaps terms of the certainty of their knowledge or skill regarding accurate use of contraception. Incorrect usage can lead to tears in condoms and missed doses of birth control pills can lead to ovulation (Panday *et al.*, 2009:56). The last focus emphasises how several teenagers are ignorant about their fertility cycles. As previously reported, their respondents sensed that the content of the school subject of Life Orientation was inadequate.

While knowledge about contraceptives is presumed to be a first step in stimulating the desire for its use, such knowledge of contraceptive methods alone may be inadequate. Individuals must be aware of establishments to gain access to these services. It must be understood that deficient knowledge of accessibility could lead to low use of contraceptives. Conversely, a more enlightened person may use it, but the less enlightened person may doubt its potency and its benefit and may not find it relevant in terms of use (Adjei, Sarfo, Asiedu & Sarfor, 2014).

2.3.4 Access to health care services

The literature identifies several barriers for teenagers, irrespective of their pregnancy status, in accessing contraceptives. Ibis Reproductive Health conducted a qualitative study in N'wamitwa,

Limpopo Province with teenagers, parents, guardians and community stakeholders, investigating concerns on access to health care services. Access to reproductive health services is another factor that contributes to adolescent pregnancy. Young people want to have access to sexual and reproductive health information and services without being exposed to public stigma (Mchunu, Peltzer, Tutshana & Seutlwadi, 2012).

Young females emphasised that there is lack of confidentiality in the clinic and the clinics close early (clashing with school times). Several reported visiting traditional healers for SRH services because they do not ask them numerous questions. Another reason is that the nearby clinics does not provide the termination of pregnancy services. In the parents, guardians, community stakeholders and young female's groups a concern was raised that there is an unfriendly service delivery for young females in the clinics (No author: Ibis Reproductive Health. Young Women's Reproductive Health Brief Series. 2012). Flanagan *et al.* (2013) also confirmed that even when teenagers visit clinics, they often still encounter limited contraceptive options (injection being most common) and lack of proper counselling.

Clinics are reported to present several barriers to teenagers when they try to access contraceptives. These barriers are: clinic opening hours; waiting long queues at clinics; concerns around confidentiality; staff judging teenagers; limited contraceptive options; limited staff knowledge and poor staff training (Hoffman-Wanderer, 2012; MIET, 2012; The National Contraception Policy Guidelines, 2012).

2.3.5 Teenage pregnancy and contraceptive use

The research established that an alarming percentage of youth do not use contraception (Martin, Sheeran, Slade, Wright & Dibble, 2009). For most young girls, teenage pregnancy remains the main health risk associated with teenage sex (Salmon, 2011). Adolescents report the main boundaries they encounter when pursuing contraceptives to include lack of transport, lack of time after classes and anxiety related to the unknown clinic environment (Patel, Huynh, Alvarez, Jones, Jennings & Snyder, 2016). Previous studies report that early initiation of substance use including alcohol elevates the risk for early pregnancy amongst teenage females. Substance abuse contributed to their behavioural risk-taking, including participating in unprotected sexual intercourse and various sexual partners (Swartzendruber, Sales, Brown, DiClemente & Rose, 2016). Rashid and Mwale, (2016) observe that myths amongst teenagers can be a potential factor

for sexual risk-taking. The risk takers feel detached and safe from any possible outcome and this perception amongst adolescents decreases their fears when it comes to engaging in risky behaviour, including sexual activities, suggesting a shift in focus of risk from one individual to another with teenagers' ignorance to their vulnerability. Luke *et al.* (2012) establish that rural-to-urban migration in Kenya during early adolescence is associated with greater emotional and physical changes linked to adolescence. This could be especially harmful to teen girls, increasing their vulnerability to initiate early sexual activity and get pregnant as teenagers.

Risky sexual behaviour amongst teenagers is customary, resulting in several negative consequences (McCauley, Shadur, Hoffman, MacPherson & Lejuez, 2015). For some, adolescence is also affiliated with risky sexual behaviour, often characterised in research studies as a greater number of sexual partners or not using condoms during intercourse (Schuster, Mermelstein, & Wakschlag, 2013). Participation in unprotected sex and multiple sexual partners increase the risk of spreading STIs, including HIV/AIDS and unintended pregnancies (Rashid & Mwale, 2016). Xu, Mberu, Goldberg and Luke (2013) suggest that improved access and use of contraceptive methods could decrease the risk of early pregnancies, whilst the availability of safe abortion services could reduce the negative consequences of teenage pregnancy. Amongst teenagers, factors of engaging in unprotected sex include low levels of condom use, alcohol abuse, and a lack of contraceptive use (Black,Sun, Rohrbach, & Sussman, 2011; Haley, Puskar, Terhorst, Terry, & Charran-Prochowink, 2013; Khan, Berger, Wells, & Cleland, 2012). Risky sexual behaviour amongst youth, such as engaging in sex without a condom, can lead to serious consequences for the individual, and can be especially significant as a serious public health challenge (McCauley, Shadur, Hoffman, MacPherson & Lejuez, 2015).

In the United States of America, several pregnancy terminations involve teenagers and young females in their 20s (Jones, Finer & Singh, 2010). Alcohol is the most commonly used and abused substance by most teenagers that increases the likelihood of unintended and unprotected sexual intercourse (CDC, 2015). Abortion does not undoubtedly protect young females from difficulties. Conversely, increased risk behaviours are studied in this age group (Coleman, Rue, Spence & Coyle, 2008). Texas is still the state in the USA with the third highest rate of adolescent pregnancies, with several adolescents participating in sexual activity before the age of sixteen. It is essential to increase access to contraceptives for this particular youth population (Patel, Huynh, Alvarez, Jones, Jennings & Snyder, 2016). According to Anastas (2017), adolescent pregnancy and parenting as a defined social challenge, was studied thoroughly from the early 1970s.

Qualitative research, which developed later than quantitative research, typically sought to "give voice" to the young female. In the United States of America, in recent decades, the prevalent discourse about adolescent pregnancy was in terms of it being an "epidemic" and a severe public health challenge that lacked effective preventative efforts.

In Northern Ireland, school pupils of Roman Catholic religion were more likely to obtain information on contraception from their peers, magazines and the media, than pupils from public school (McLaughlin, Thompson, Parahoo, Armstrong & Hume, 2007). A survey conducted in Glasgow, established that 50% of adolescent girls reported being condomised, whilst 4% used emergency contraception; and 21% did not engage in safe sex at their first sexual encounter (Sarkor, 2012). Adolescents may use oral contraceptives less adequately than condoms for pregnancy prevention. This behaviour exposes teenagers' vulnerability to an unplanned pregnancy. More contraceptive methods should be available for these teenagers (Parkes *et al*., 2009).

According to Xu, Mberu, Goldberg and Luke (2013), the high birth rates in Sub-Saharan Africa reveal the lack of accessibility of contraception for females. They indicated that in most of Sub-Saharan Africa, the social and economic consequences of teenage pregnancy occur in the absence of a government social welfare support for poor or single mothers. Religious practices are also vital in accommodating attitudes towards contraception. Adolescent girls were observed to be the only group refusing to use contraception, which would be attributable to cultural and religious beliefs (Watts, Liamputtong & Carolan, 2013). Evidence shows decreases in teenage pregnancy rates linked to decreases in sexual activity and increases in contraceptive use (Santelli, Lindberg, Finer & Singh, 2007).

Austin *et al*. (2008) indicate that child marriage in some Sub-Saharan African countries is seen as a benefit that will offer support and stability for adolescent girls. It is associated with a lack of access to services directed towards youth sexual needs. College students in Kampala, Uganda regarded their peers and the media as channels of information on emergency contraception (Byamugisha, Mirembe, Paxelid, & Danelsson, 2006). In Kenya, rural-to-urban migration occursmostly amongst teenagers in developing countries and could influence sexual activities with consequences for early pregnancy (Xu, Mberu, Goldberg & Luke, 2013).

Xu, Mberu, Goldberg and Luke (2013), ascertain that rural-to-urban migration may cause teenagers from developing countries to pursue new relationships and participate in risky sexual activities, such as more constant intercourse, early sex initiation, decreased condom and contraceptive use, increasing the risk of teenage pregnancy. A lack of knowledge is especially important as it is negatively associated with consistent contraceptive use (Miller & Chung, 2014; Yoo & Hayford, 2014) and is positively linked with teenage pregnancy (Miller *et al.*, 2013).

In South Africa, 11-20% of adolescent pregnancies are reported to be because of rape (Honig, 2012). Rashid and Mwale (2016) institute that teenagers are at an elevated risk for several health consequences associated with early and unsafe sexual activity, including HIV/AIDS, STIs and unplanned pregnancies. Some youth engage in sexual intercourse but have insufficient knowledge about how to access contraceptives to prevent pregnancy, whilst others are influenced by their sexual partners to refrain from using condoms (Honig, 2012). Rashid and Mwale (2016) show that heightened sexual risk-taking behaviour amongst teenager's is based on the theory that lack of knowledge referring to sex and sexuality, provokes teenagers to engage in risky sexual behaviour. Alcohol abuse can lead to teenage pregnancy and alcohol damages the memory system in the hippocampus, critically limiting the ability of the frontal lobes to perform thoughtful and logical thinking (Honig, 2012). Participation in unprotected sex and multiple sexual partners, increase the risk of spreading STIs, including HIV/AIDS and unintended pregnancies (Rashid & Mwale, 2016).

2.4 TEENAGE PREGNANCY AND MOTHERHOOD

The sexual and reproductive health and rights and service needs of pregnant teenagers and teenage mothers differ from those of other teenagers. Pregnant teenagers often fail to access appropriate support during pregnancy for several reasons, including failing to reveal the pregnancy for several months; lack of acceptable and accessible services; and the fear, or actual experience, of stigma and judgement by Health Care Workers for being pregnant. Several teenage mothers reported the difficulties of balancing accessing sexual and reproductive health (SRH) services and schooling following birth. Several communicated their discontent about unsupportive HCWs, lack of information concerning established institutions and clinic hours that clashed with school hours.

Karra and Lee (2012:3) also note that younger mothers were less likely to return home and young teen mothers (women who had their first child at 17 or younger) are about 50 percentage points more likely to drop out of school than non-teen mothers (who are still in school), emphasising that the younger the teen mother is, the higher the risk of not returning to school. This supports the opinion that teenage motherhood impacts younger teenagers more than those 17 years and older. Several studies emphasise both the challenges and rewards of teenage pregnancies and motherhood, as experienced by teenage girls. Chohan (2010) emphasises that the young mothers in the study acknowledged that motherhood was demanding and challenging, especially when the baby was sick, or they had sundry school work. Several of her participants started their day three hours earlier than their peers to prepare themselves and their babies. They all returned to school and achieved academically. In addition, several felt caught in a double-bind. They wanted to stay home and care for their babies, which would reinforce the attitudes of "teenage mothers as reckless because they do not return to school". They also wanted to return to school, though this would intensify the notion that "teenage mothers are not good mothers" as they are accused of prioritising their education over their baby's well-being.

Moore (2013) conducted a critical study of three generations of mothers, noting that ideas of mothering and "good mothering" shifted significantly in South Africa over the last decade. Several mothers express various perceptions on the timing of marriage, function of fathers and "ways of mothering". This shifting observation of mothering comprised the recognition of the importance of being a mother and "nurturing the self" (for which she needed support). "The mother in the younger generation, however, required support from kin caring for her children so that she could work on the project of the self" (Moore, 2013:168). This 'project of the self' is a more modern shift, which often involves furthering her education and career, whilst raising young children, both for her own empowerment and the benefit of her children.

2.5 THE IMPACT OF TEENAGE PREGNANCY

Teenagers encounter issues that require them to make daily costly decisions. Teenage pregnancy is associated with negative consequences for the adolescent parents, their children and society. Children born to adolescents encounter particular challenges. They are also more likely to have poorer educational, behavioural and health consequences throughout their lives, compared to children born to older parents. Below are some of the impacts associated with teenage pregnancy.

2.5.1 Social influence

Flanagan *et al.* (2013) note that fear of adult judgements, peer pressure, uncertainty about parent and boyfriend disapproval and concern for confidentiality were all factors limiting teenage girls' accessing and using of contraceptives. This emphasises that the concerns are not as simple as knowing where to obtain contraceptives and clinic hours.

Hoffman-Wanderer *et al*. (2012) mention the stigmatisation of teenage sex as a significant barrier to accessing contraceptives. Obtaining contraceptives is seen as an obvious admission of sexual activity which is frowned upon by nurses (Hoffman-Wanderer *et al*., 2012:15). Teenagers feel intimidated by health care workers who lecture them about being too young for sexual initiation. They often do not receive any contraceptives, despite visiting the clinic to obtain them (Hoffman-Wanderer *et al*., 2012; Ehlers, 2003; Holt, 2012). Because of this stigma towards adolescent sexuality, they often report a lack of access to SRH services for fear of being reprimanded and stigmatised for sexual involvement (MIET, 2012).

Accessibility: A lack of convenience concerning long travelling distances, inconvenient opening times and costs of services and deficient knowledge of services offered. Acceptability: lack of trust in and confidentiality, the health workers' judgemental attitudes and deficient quality of health services (Flanagan *et al*., 2013).

Health care worker attitudes; moral judgements; deficient knowledge and insufficient training were repeatedly emphasised as barriers. Wood and Jewkes (2006) found, in a study in Limpopo investigating barriers, that "nurses acknowledged problems associated with teenage pregnancy, and still preferred to teach abstinence to adolescents who asked for contraceptives (Flanagan *et al*., 2013:14).

Wood and Jewkes (2006) provide a useful summary of several of the frustrations expressed by teenagers and indicating the relationship between teenagers and nurses as particularly problematic. Teenagers saw nurses as insulting, short-tempered and vulgar and complained that nurses asked sarcastic questions about whether they had boyfriends or why they wore mini-skirts. Teenagers commented that nurses would not allow them to choose the contraceptive method (Hoffman-Wanderer, 2012:15).

Teenage mothers encounter particularly difficult barriers concerning their developing social status. In some ways they are still regarded as school children and treated as such, but in other instances they are mothers and expected to be mature adults, responding to specific responsibilities. This is conflicting for a teenage mother, who is recognized as a child but who still supposed to act like an adult (Chohan & Langa, 2011:88).

2.5.2 Psychological impact

The literature comprises examples of teachers and schools that did not support pregnant teenagers and teenage mothers, as aforementioned. In some cases it was due to an inability and in other cases it was due to judgemental attitudes (Bhana & Ngabaza, 2012). Teacher and school attitudes varied widely, and several teachers and schools did not support either pregnant teenagers or teenage mothers. Teenage mothers reported that they experienced the greatest stigma whilst pregnant, once it was visible.

The literature indicates that pregnant teenagers and teenage mothers also experienced stigma from friends, peers and the community. Several reported this as a barrier for them to remain in school, whilst pregnant and returning following childbirth (Shefer, Bhana *et al.*, 2012). Panday *et al.* (2009) note that this lack of support and shunning can have far-reaching impacts: "Stigma during or after pregnancy can lead to depression, social exclusion, low self-esteem and poor academic performance affecting the prospects of employment in the future".

2.5.3 Educational impact

Teenage pregnancy seems to lead to teenage mothers leaving school across Africa, and especially in South Africa. Evidence suggests delays in completing schooling rather than for them to drop out. Unlike in most other African countries, girls commonly continue their education after giving birth. A situation where only one third of teenage mothers returned to school was observed (Morrell, Bhana & Shefer, 2012:10). School-based sexuality education and HIV prevention is an area of enormous potential for South Africa, but must provide non-judgemental and accurate information, promoting strategies to empower young people to render responsible decisions regarding their SRH. Equally, teachers' personal and professional needs must be included in such strategies (Smith & Harrison, 2013).

2.6 FEMINIST PERSECTIVES

Anastas (2017) emphasises that whilst several feminisms exist, it can be reasoned that all of them attempt to understand the lives of females (and men). Feminism understands that females in most societies are oppressed and marginalised because of profoundly held gender beliefs, identifying several ways in which human and social life are reduced. Feminists often question usual perceptions of social policy, social delivery and how individual problems become social challenges. Feminists are usually interested in empowering females, supporting their activities and execution of qualitative research (Anastas, 2017).

Researchers applying a feminist perspective to understand teenage pregnancy are more prone to support teenage mothers and reduce shame associated with the stigma of teenage pregnancy in society (Kelly, 1996).

Feminist scholar, Deidre Kelly (1996), identified three descriptions on the subject. The first section highlights the fact that something is wrong with the girl, whether attributable to a lack of knowledge concerning preventing an unwanted pregnancy, immature expectations of motherhood, past or present trauma, including sexual abuse. This description locates the problem in the young female, indicating a need for someone to love them, having abusive or traumatic experiences, or making an irreversible decision.

This problem of teenage pregnancy leads to calls for prevention programmes, monitoring and treatment efforts that focusses on individual change. Kelly sums this framework up: The wrong girls are having babies (p. 429). According to Kelly Type A is labelled the stigma story in this study. Kelly's second story is called Type B in this study and it signifies that pregnancy and childbearing result in making the wrong kind of family. This traditional story rests on the idea that the girl's family of origin or her subculture failed to convey good values on sexuality and preferred family norms (e.g., getting married first before having children). The underlying "doubt is often uncertainty over the fate of the nuclear family" (Kelly, 1996, p. 431). An example of an area of inquiry arising from this opinion concerns single teenage motherhood in the teenager's own mothers or sisters.

This normative and moralistic opinion of observation on unmarried motherhood was dominant, historically remaining amongst the norms that teenagers perceive in public and private messages

about teenage pregnancy and motherhood. This is reflected in the middle-class values of professionals assisting these teenagers (Molborn & Sennott, 2014).

The third opinion of observation used in this analysis is the category that Kelly describes as “dissenting views”, significantly advanced from feminist, Afrocentric and other critical views: “An anti-racist, feminist ideology would opinion to the gender and racial subtexts in the dominant discourse about teen mothers” (p. 424). Part of this dissenting story is about how teens bear and rear their children through social structural barriers. An example is school disaffection, which usually starts before pregnancy.

Pregnant teenagers are often aware that pregnancy and parenting become barriers to obtaining a good job (Payne, Anastas, & Ghuman, 2016). Amongst other concerns, these dissenting observations also call for supporting young females’ decisions about sexuality and reproduction, including those who decide to become young mothers. Those telling this story Type C advocate for organisational reforms (schools) and social reforms to address structural barriers and less stigmatisation of these young females. Kelly states the following: “The discourses do not compete as equals; some carry little weight and are marginalized, whereas others are considered authoritative and dominant” (p. 423). Evidence exists that programmes for pregnant and parenting teenagers are informed and based on various perspectives about what is most required. For example, a community programme might emphasise care for the teenagers; another perceives them as problematic mothers and provide better care for babies and parenting classes, whereas others suggest empowerment, such as ‘a drop-in centre’ emphasising support for improved service and policies.

2.7 CONCLUSION

The literature establishes the need to investigate how risky sexual behaviour and the quality of relationships with parents and peers influence adolescent sexual behaviour, particularly those leading to teenage pregnancy. The literature further indicates the link between internal and external environmental factors, such as quality of social relationships and accessibility of social services and support with pregnancy prevalence in adolescent behaviours. The literature also demonstrates the impact of teenage pregnancy, transitioning from teenage hood to motherhood. The influence of parental involvement is discussed to identify behaviours leading adolescents to

disregards safe sex practices and ultimately fall pregnant. The following chapter outlines the methodology used in this research in detail.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Cruz and Tantia (2017) suggest that a qualitative method is the device used to conduct the study, explaining how data are collected and analysed. The research methodology provides an overview of the research design, research instrument, target population, sampling procedure, data collection procedure and data analysis procedure. Although several qualitative methodologies exist, five are identified to be most prominent in the social, behavioural and health sciences literature and are promoted with accurate descriptions of approaches to data collection and analysis, namely narrative inquiry, phenomenology, grounded theory, ethnography and case study (Creswell, 2013; Jones *et al.*, 2013).

3.2 RESEARCH DESIGN

The research approach used in this study is qualitative. It takes people's personal experiences sincerely as the essence of what is real for them (ontology); clarifying people's experiences by engaging with them and paying attention to what participants share (epistemology); and applying qualitative research techniques to collect and analyses data (methodology). The aim of qualitative research methods is to describe a process or experience and create meaning of experiences or phenomena from the information as it develops (Cruz & Tantia, 2017). Creswell (2013) suggests that qualitative research is selected when health science researchers investigate personal stories, conducting a literary, adjustable style, explaining the context or setting of issues, understanding connections in casual theories, and creating theories and when general quantitative statistical analyses do not fit the problem.

Denzin and Lincoln (2011) describe qualitative research as a set of analytical practices that changes the world. According to Gergen, Josselson and Freeman (2015), qualitative approaches improve the field of psychology by increasing perspectives on methods of inquiry and theory, promoting interdisciplinary and offering a variety of solutions, and addressing social change. Colorafi and Evans (2016) establish that qualitative research is particularly favourable to social researchers as it provides actual responses to questions about how people observed a specific period, reasons they have for using features of that period, and factors guiding or prohibiting use.

Qualitative research centres on processes and the adjustable nature of research. It focuses on what, why and how questions instead of numbers as in quantitative research (Ritchie, Lewis, McNaughton Nicholls & Ormston, 2014). Denzin and Lincoln (2011) also indicate that qualitative research transforms the world into a set of representations, including field notes, interviews, dialogues, photographs, recordings and memos. It observes participants in their natural environment, striving to explain phenomena concerning the descriptions people bring to them. The ultimate goal is to understand an experience or how something is perceived in a profound and purposeful way. Qualitative research methods are not a contrast of an experiment but are derived on a different philosophical observation, offering reliance to various ways of knowing (Cruz & Tantia, 2017). According to Moretti *et al.* (2011), the advantage of qualitative research is the depth of compiled data that needs to be represented and coded in a valid and reliable way. The qualitative research approach is observed as a suitable method for this study.

3.3 SAMPLE DESIGN

The practice of selecting cases to study is called sampling. Sampling is the choice of research participants from a total population and includes results about which people, settings, events, behaviours and/or social processes to study. The main objective is to choose a sample that will be representative of the population intended to produce conclusions. Participants are selected because they are presumed to hold significant information that is relevant to the research questions (Cruz & Tantia, 2017). Various types of sampling techniques, such as convenience sampling, purposive sampling and snowball sampling may be used in qualitative research.

The researcher needs to decide which type of sampling would be best to use (Creswell, 2013) and a brief description of the sampling method should be provided (Elo, Kaariainen, Kanste, Polkki, Utriainen & Kyngas, 2014). A researcher's selection of methodology guides the choice of specific methods for collecting, analysing and interpreting data (Jones *et al.* 2013).

Sample selections place a barrier around the conclusions drawn from the qualitative study and affect the confidence of others (Miles, Huberman, & Saldana, 2014). Colorafi and Evans (2016), established that a trademark of the qualitative descriptive approach is the flexibility of any sampling technique (maximum variation where the goal is to collect as different cases or homogenous whereby informants are primarily the same). In qualitative research, natural environments provide the source for the information and informants are selected because of their

unique experiences. The process is called purposive sampling, rather than being selected to substitute a population as in quantitative methods (Cruz & Tantia, 2017).

Purposive sampling refers to methods where researchers exercise their judgement, identifying those that will provide the most relevant information on the phenomenon of interest. They then deliberately invite those experiences into the study (Abrams, 2010). For the current study, purposive sampling was used as the technique suitable to address the aim of the study. A representative sample, including the representativeness of each sub-category of the total population to be researched, is essential (Boddy, 2016).

3.3.1 Purposive sampling

The number of participants is not as important in qualitative research. Rather, it is the quality of their selection and their identity that is more significant (Cruz & Tantia, 2017). Purposive sampling is a nonprobability sampling method, meaning that the study chooses the informants based on awareness about those most forthcoming (Polit & Beek, 2012). According to Elo, Kaariainen, Kanste, Polkki, Utriainen and Kyngas (2014), purposive sampling is appropriate for qualitative studies where the focus and interest are on participants with the best knowledge on the research topic. Creswell (2013) suggests that when using purposeful sampling, choices are needed to identify the sample, the sampling form and the number of participants or sites to be sampled. Elo *et al.* (2014) established that a disadvantage of purposive sampling is that it can be challenging for the reader to determine the trustworthiness of sampling if full details are not provided.

The study used a purposive sampling technique falling under the nonprobability category. Purposive samples are defined as sampling that depends on availability and willingness to be part of the research. It was used in this study to increase the diversity amongst participants concerning age, residence and level of education (Bjorklund, Soderlund, Nystrom & Haggstorm, 2015). In purposive sampling, the purpose is more important than randomness; events, occasions and perceptions, (not individuals) are generally the objects of the sampling (Miles & Huberman, 2014).

3.3.2 Population and sample size

The sample must be suitable and comprise participants who best represent or have knowledge of the research topic (Elo *et al*., 2014). The population in this study is teenagers between the ages of 13 to 18 year who had unplanned pregnancies from Bushbuckridge. The sample comprises of fourteen participants. The number of participants was determined by the number of voluntary participants who willingly took part in the study.

Participants were selected from Magabotse Secondary School in Bushbuckridge. The study aims to interview 15 adolescents, aged 13 to 18 from the Magabotse Secondary School in the Bushbuckridge District. The number of participants is determined by the number of learners who freely volunteer to participate in the study.

3.4 DATA COLLECTION METHODS

Qualitative researchers aim to accurately describe the emotions, experiences, social situations, or phenomena as they occur in the real world and therefore want to study them in their natural setting (Terre Blanche, *et al*., 2010). In qualitative research studies, data collection attempts to investigate "the who, what and where of events" or experiences (Colorafi & Evans, 2016). Data were collected with face-to-face in-depth interviews, with a list of basic interview questions to guide the study. The findings must represent participants' voice and conditions of the study and not the researcher's biases objectives or perspectives (Polit & Beck, 2012). Data collection is most accurate when it is deliberate and methodologically driven (Newman & Clare, 2016).

3.4.1 Instruments

The study uses in-depth interviews as the data collection method. The interviews are semi-structured with open-ended questions and probes each participants' perception (Doyle & Buckley, 2017). In-depth questions during an interview can explain deeper aspects of each participants' experience (Cruz & Tantia, 2017). Interviews allow open-ended questions directed to participants about their experiences as teenage mothers, enabling them to comment on issues about the research problem. "Some common data sources in qualitative research include documents, records and other archival materials; interviews, observations, open-ended survey items,

participant journals, researcher journals, field observes and memos, drawings, photographs and videotapes" (Newman & Clare, 2016).

Across the traditional and developing types of qualitative research, other methods to collect data with rich information about an experience can also be used. They include focus groups and field observations, reflexive journaling and document examination or videotaping (Cruz & Tantia, 2017). Rossetto (2014) states that qualitative researchers must be aware of the possibilities of therapeutic elements in conducting interviews, because it can and should impact participants' reactions, interviewers' approaches, and how researchers can make a difference in people's lives.

3.4.2 Procedure

Semi-structured one-to-one in-depth interviews were used by visiting the respective homes of potential participants and personal contact with participants, ideally in a quiet place, such as an office or study room to minimise interruptions. Interviews could be conversational, unstructured, semi-structured, or highly structured (Newman & Clare, 2016). Interviews were conducted during weekends and school holidays and appointments were scheduled with participants for each interview session. Interviews were sound recorded and transcribed to ensure the accuracy and reliability of the information.

3.5 DATA ANALYSIS

For the current study the researcher applied thematic analysis to identify patterns across participants' responses which are known as themes and answer the research questions. The researcher chose to transcribe the data and familiarize herself with the data and generate themes.

Strachan, Yellowless and Quiley (2015) describe thematic data analysis as a technique, identifying and categorising patterns of meaning in a body of data. The thematic analysis takes on a systematic approach to the recognition of patterns within the information but aims to grasp the context of each data unit and provide hierarchical or other relationships between themes to be acknowledged (Strachan, Yellowless & Quigley, 2015). Themes raised from the participant's experiences of adolescent pregnancy were combined to create a complete representation of their collective experiences. Related themes and record associated patterns were linked to sub-themes

(Malahlela, 2012). Elo *et al.* (2014) suggest that the trustworthiness of content analysis results depend on the availability of rich, sufficient and well saturated data.

Data analysis involved three stages of coding (open, axial and selective) and applying principles, such as purposive sampling and constant analysis across data sources and types (Newman, 2012). Associations between various ideas or components were established that fit together in a significant way when combined. Reflexive journaling is the personal reflection of the researcher about any period of the research process with insight that occurs during data analysis (Cruz & Tantia, 2017).

Qualitative content analysis is one of several qualitative methods available for analysing data and interpreting its meaning (Elo *et al.*, 2014). According to Schreier (2012), if the code descriptions are clear and sub-categories do not overlap, the two rounds of independence coding should create the same results. Not only should an efficient description of the analysis be provided to assist authenticating data, but the limitations of the findings should also readily be discussed (Elo *et al.*, 2014).

Qualitative data obtained from transcribed in-depth interviews and open-ended questions were analysed using a thematic analysis. Since the interviews are recorded, substantial time was spent translating the tapes, perusing the transcripts and categorising the data according to particular themes or recurrent ideas. The themes emerging from the interviews and open-ended questions with respondents are combined to form a comprehensive representation of their collective experience.

3.6 RELIABILITY

The relevance of commonly positivist terms, such as reliability and validity are probed and the term ‘trustworthiness’ is suggested as more applicable Rodham, Fox, & Doran(2015) and Elo *et al.* (2014) established that from the context of establishing credibility, researchers must confirm that research participants are classified and described accurately. According to De Casterle, Gastmans, Bryon and Deneier, (2012), researchers normally struggle with challenges surrounding the trustworthiness of qualitative research findings. Elo *et al.* (2014) suggest that reporting results of content analysis is especially linked to transferability, conformability and credibility.

The assurance of rendering a trustworthy or credible qualitative study is how well it joins its objectives, biases and output for the reader (Edwards, 2016). From the context of trustworthiness, the main question is, how can the reader judge the transferability of the results? Transferability refers to the degree to which the findings can be transferred to other settings or groups (Polit & Beck, 2012). Reliability is maintained in this study to establish the trustworthiness of the work, by indicating that data collection processes and analysis were applied to research questions, in an detailed, honest and accurate manner (Mason, 2012). From the context of validity, it is critical to report how the results were created (Elo *et al.*, 2014). Polit and Beck (2012) established that credibility concerns the objective of the study and confidence in how well the information addresses the intended focus. Enhancing the trustworthiness of content analysis commences with sufficient preparation before the study, requiring advanced skills in data collection, content analysis, trustworthiness discussion and result reporting (Elo *et al.*, 2014).

According to Saldana (2011), qualitative researchers are encouraged to be systematic and well-planned to increase the trustworthiness of the study. If the research methodology is efficiently documented for all stages of the study (preparation, organisation and reporting), and all phases of the trustworthiness criteria were enhanced (Elo *et al.*, 2014). It was debated whether the use of quotations is necessary to indicate the trustworthiness of results (Polit & Beck, 2012).

3.7 PILOT STUDY

A pilot study is a small study contributing to the design of a further favourable study. It may have several purposes, such as data collection and validity (Arian, Campbell, Cooper & Lancaster, 2010). Pilot studies are preparatory studies on small samples, therefore three participants are selected for pilot testing to establish or identify potential challenges with the research design, specifically the research instruments (Terre Blanche *et al.*, 2010).

The pilot study was conducted to measure the feasibility of the research. The researcher began approaching clinics in the Bushbuckridge district and was sent to the district to request access to interview potential participants. The researcher was told the Provincial Health Department in Nelspruit would have to authorize access to patients in clinics and the researcher would have to wait for a response with no guarantee of being granted permission to resume the study. Thereafter the researcher approached schools in the area and was given permission to interview learners at Magabotse Secondary School that met the inclusion criteria.

The pilot study gave the researcher an opportunity to test the questionnaire and establish a time-frame for each interview session. From the pilot study the researcher established that participants were accessible and interested in participating in the study. The researcher handed out consent forms for learners to take home for their parents or caregivers to sign and scheduled a date to officially begin interviews.

3.8 ETHICAL CONCERNS

Given the sensitive nature of the study, ethical concerns are addressed. According to Smith and Rust (2011), it is imperative that research participants were treated respectfully. The fundamentals of anonymity, free and fully informed consent, confidentiality and freedom to withdraw were identified by ethics committees as compulsory (Buckley, 2011; Murray *et al*., 2011). The anticipated risks and anxiety in comparison with the likely benefits for participants in the study were considered as structured. The research ethics regarded in this study were permission, informed consent, confidentiality and anonymity. According to Cruz and Tantia (2017), the four basic standards to be aware of in reports were the statement of need; the guiding question; description of methods and participants; and presentation of analysis and findings.

3.8.1 Permission

Adults are tasked with the responsibility of decision-making on behalf of young people in their care, in addition to granting or denying access to researchers (Morrow, 2004). Permission to conduct the research project in secondary schools around Bushbuckridge was requested at a regional level. In this study, essential formal permission was obtained from the gatekeepers, namely the Department of Education, school principal and parents before conducting the study.

3.8.2 Informed consent

Informed consent is generally interpreted as a crucial focus of ethical research practice across the social sciences (Goredema-Braid, 2010). The significance and integrity of informed consent is based on a partnership between the study conductor and study participants, in the context that research is a privilege, not a right and the goal is to have a signature on the consent form, and a shared understanding and decision-making process (Adams, Prakobtham, Limpattaracharoen, Suebtrakul, Vutikes, Khusmith, Wilairatana, Adams & Kaewkungwal, 2017).

3.8.3 Voluntary participation

Dantzker and Hunter (2012) indicated that researchers should obtain consent and they should also inform participants that participation is voluntary. Consistent with the above, participants were not coerced to receive any form of payment for interviews. They participated voluntarily. Participants were informed that they may withdraw from the research process, despite initially agreeing to participate (Brooks, Cleaver & Ireland, 2009).

3.8.4 Confidentiality

The principle of confidentiality required the researcher to display certain personal and professional attitudes, such as honesty and respectfulness to participants involved in the study (Savin-Baden & Major, 2010). The researcher represented participants accurately, by displaying unlimited respect to those who may be sensitive and emotional, by encouraging them to control their own information (Petrova, Dewing & Camilleri, 2016).

3.8.5 Anonymity

According to Gordon-Braid (2010), anonymity refers to the act of preserving the precise identities of participants involved in the research process, whilst confidentiality is the guarantee that particular details regarding a participant's life will not be shared. Anonymity is an essential concept underlying ethical research, defined as the means through which the privacy and confidentiality of participants is preserved (Doyle & Buckley, 2011). Moore (2012) established that practices differ but generally involve removing names, usually replacing them with pseudonyms and changing identifiable details, such as location or demographic characteristics, either at the transcription phase or more often at reporting phase. Taylor (2015) suggests that these practices are based on the understanding that harm may be inflicted particularly to vulnerable participants when sensitive information or illegal acts are disclosed. It can be eliminated if identities are disguised. This study uses pseudonyms such as "Participant 1" when referring to participants.

3.9 CONCLUSION

The aim of this chapter was to provide a detailed explanation of the research methodology used in this study. The qualitative method and procedure were used to investigate the impact of unplanned pregnancy on disadvantaged adolescents are described. The results of the in-depth interviews were discussed in detail in the following chapter.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND FINDINGS

4.1 INTRODUCTION

This chapter presents the participants and thematic analysis of the research data. The thematic analysis presented an approach for organising and interpreting qualitative data to create a narrative perception, combining the similarities and differences in participants' descriptions of their subjective experiences (Crowe, Inder & Porter, 2015). The biographical questionnaire collected information about participants' family background, challenges associated with teenage pregnancy, the age of sexual initiation, personal experience of teenage pregnancy and suggestions required to bring awareness to those challenges. Representation of themes that developed during data analysis is also discussed and grouped into categories. To secure confidentiality as mentioned in Chapter 3, participants' names were concealed; they were rather referred to as participants, for example Participant 1. Quotations from the interviews are used to elaborate themes.

4.2 REVIEW OF THE OBJECTIVES

Before discussing the results, it is important to review the objectives of the research. The first objective was to investigate the experiences of teenagers who are or were pregnant during their adolescence; the second objective is to establish factors contributing to an adolescent's vulnerability of falling pregnant; and the third objective was to investigate adolescents' knowledge of various methods of contraception and to identify programmes to assist with teenage pregnancies in the community.

4.3 PARTICIPANT'S BACKGROUND INFORMATION

Participants had to meet all the requirements for the study. Fourteen black adolescents, from whom three were pregnant when the interviews were conducted, agreed to participate in the study by sharing their experiences. The chapter commences by presenting brief background information on each participant. Each participant's demographical characteristics are discussed below. About 14.2 % (n=2/14) of participants were in the 13-15 years age group and 85.7% (n=12/14) of participants are between the ages of 16-18 years. 28, 5% (n=4/14) of participants were in Grades 9-10 and 71.4% (n=10/14) were in Grades 11-12. 42.9% (n=6/14) of participants were from single

parent households, 50% (n=7/14) were living with caregivers and 7.1% (n=1/14) were from child headed households. 28.5% (n=4/14) of participants had their first sexual encounter between the ages of 13-15 years, 57.1% (n=8/14) between the ages of 16-18 years and 14.2% (n=2/14) chose not to answer the question. 24.5% (n=4/14) of participants shared that they are still in a relationship with the father of their children, while 71.4% (n=10/14) were not. 14.3% (n=2/14) of participants had two or more children, 64.2% (n=9/14) had one child and 21.4% (n=3/14) were pregnant during the interview. 100% of participants confirmed that there were no support programmes available to teenagers in their community.

Table 4.1: Biographical information of participants

Variable	Item	Number & percentage of participants Total (n=14)
Age	13-15 yrs	14.2% (n=2/14)
	16-18 yrs	85.7% (n=12/14)
Grade	9-10	71.4% (n=10/14)
	11-12	42.9% (n=6/14)
Single parent household	teenagers	50% (n=7/14)
Living with caregivers	teenagers	7.1% (n=1/14)
Child headed household	teenagers	28.5% (n=4/14)
First sexual encounter	13-15 yrs	28.5% (n=4/14)
	16-18 yrs	57.1% (n=8/14)
No answer to question	teenagers	14.2% (n=2/14)
Have two or more children	teenagers	14.3% (n=2/14)
Pregnant during interviews	teenagers	21.4% (n=3/14)

4.4 FINDINGS OF THE QUALITATIVE DATA

The findings of the analysed qualitative interviews are addressed below. The themes that emerged were arranged as follows: socioeconomic impact, strained relationships, attitudes towards birth control, attitudes towards prevention coping strategies and support systems. All the themes and sub-themes are discussed in detail below.

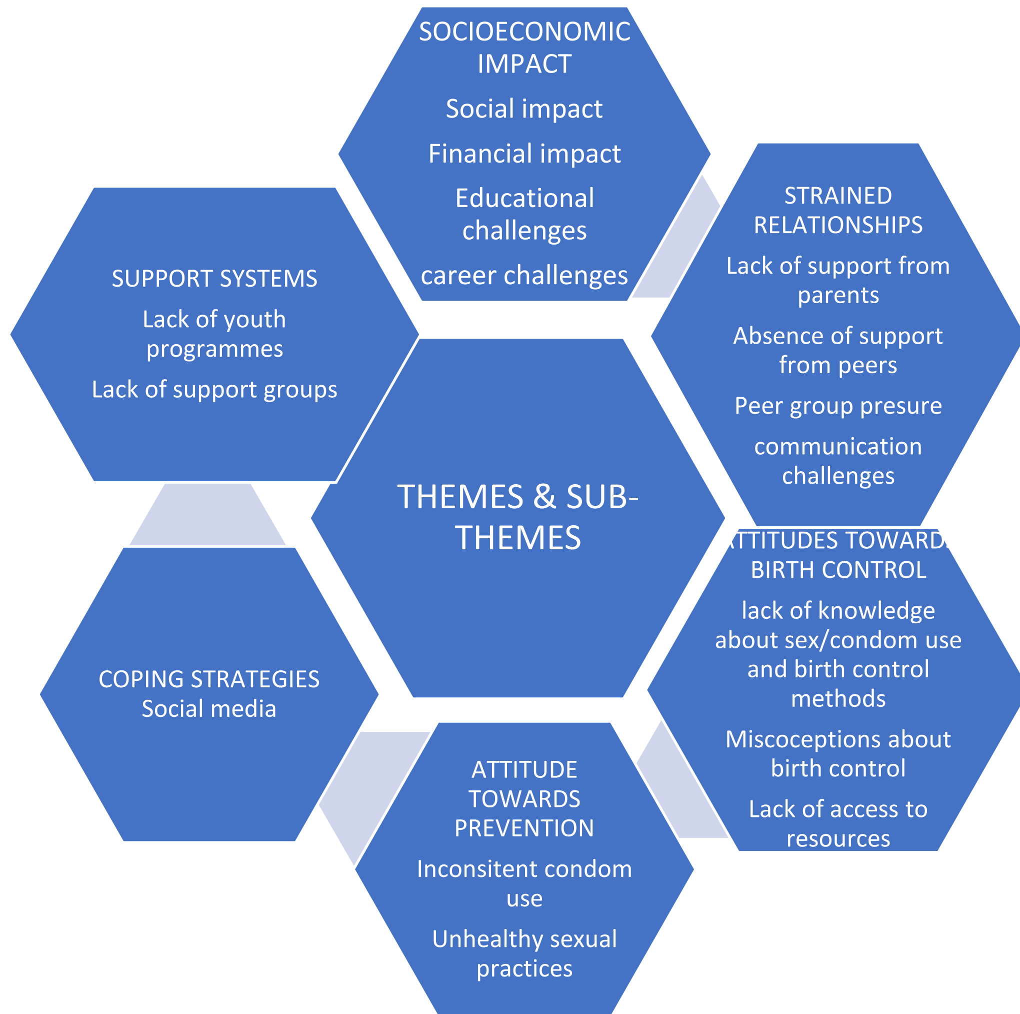

Figure 4.1: Identified themes and sub-themes from qualitative data

4.4.1 Socioeconomic impact

Questions were directed to participants to investigate the effects of teenage pregnancy on teenagers., The main theme that emerged was socioeconomic impact and the sub-themes are discussed below.

4.4.1.1 Social impact

Participants were requested to explain how falling pregnant at an early age changed their life and affected their future. Falling pregnant at an early age had a negative impact on the participant's lives. They indicated that there was little support from their families. All the teenagers in this study were still at school, as were the fathers of their children, they would seek emotional support from their parents. Most participants are from single mother households or living with caregivers, while some are from child headed households and a minority are being raised by both parents.

Some participants commented about a lack of emotional support as follows:

Participant 8: "Treatment at home changed as soon as I had a baby. "

Participant 13: "Being a teenage mother changed my life in a big way, it is difficult when you do not know what to do sometimes when the baby cries I also end up crying or when she is sick…it is really hard.

"Participant 14: "Stop shouting at us (pregnant teenagers) and teasing teenage mothers, their behaviour is hurtful; the community should encourage us."

4.4.1.2 Financial impact

Participants reported that they were extremely stressed about money. They indicated that since both the teenagers and the fathers of their children were still at school, they seek financial help from their parents. It is difficult for their parents to support them financially. Some participants responded as follows:

Participant 2: "My brother does not buy me clothes or provide me money, he says he is supporting my child and is not interested in my needs. I do not live with my parents; they are working in another town. My boyfriend does not have a serious job; I just saw changes to my body, then I denied I was pregnant."

Participant 4: "My boyfriend is still in school."

Participant 5: "Life as a young mother is tough, children are expensive.

Others reflected as follows*:*

Participant 6: "The father of my child is unemployed and still in high school; I was afraid to go to family planning because of what people might say if they saw me at the clinic."

Participant 7: "My father left us in 2009."

It is evident from the participant's experiences that the costs of raising a child affected them psychologically and emotionally. Most participants assumed that their families, although most are raised in broken structured families, would cover all the financial costs and have come to the realisation of the financial burden that a teenage pregnancy brings.

4.4.1.4 Educational challenges

Participants reported that it is difficult for them to go back to school due to the negative attitude that they experience from their peers and the teachers. The lack of emotional support and motivation needed for pregnant teenagers to complete their matric was expressed by the participants. For example:

Participant 5: "I did not stay away from school deliberately, the baby stays up late at night, when the baby is sick and I cannot go to school"

Participant 6: "I cannot concentrate on my schoolwork and my marks have dropped, no support from teachers"

Participant 7:" Falling pregnant when I was young…I did not know what to expect. I cannot attend Saturday classes at school as my grandmother is away on church trips; I failed Grade 10 and I went back to school after giving birth, but I did not get any support from my teachers"

Participant 8: "I could not concentrate in class, during break I had to run to the crèche to breastfeed my baby."

Participant 13: "Having a baby meant that I had to bunk school to take her to the clinic when she was sick"

It is evident from all the participant's responses that early pregnancy interrupts a female adolescent's schooling, eventually leading to adolescent mothers dropping out or delaying their education.

4.4.1.5 Career challenges

To gain access to a college or institution of higher education, learners need to have completed their matric (Grade 12), and the careers participants have noted below require high pass marks for acceptance. It is therefore, important to suggest that teenage mothers need programmes to assist them to stay motivated and support for them to stay in school and achieve academic success. Some participants commented about career challenges as follows:

Participant 2:" I wish my parents would provide me advice about school, I wish they guide me to further my studies and I wish they would take care of my child while I go off to university"

Participant 3: "I wanted to be a Chartered Accountant when I finish matric. 'Participant 8:" I wanted to become a social worker or a policewoman; I will not be able to attain that because I have failed matric a lot of times"

Participant 12: "I wanted to become a pilot…I still believe I can do it, it is just harder when you have children and need someone to take care of them.''

Participant 14: "Falling pregnant meant I could not go to university, I had to stay home for two years raising my child."

It is evident that young motherhood decreases the likelihood of adolescents furthering their education. Young females need to have cultural resources (ideas and knowledge) on what steps to take to prevent unwanted pregnancy and motherhood.

4.4.2 Strained relationships

Participants were requested to answer questions to investigate the reasons why they participate in unprotected sex. They indicated that the relationships with their loved one are strained. The following sub-themes emerged:

4.4.2.1 A lack of support from parents

Participants also reported that a lack of support from parents is another reason they became involved in unprotected sex. A lack of support leads teenagers to engage in unprotected sex, since they receive support from their peers. All the teenagers and the fathers of their children in this study therefore seek support from their peers. One approach of addressing teenagers' sexual risk is to encourage parents or other primary guardians to discuss with and educate their children about sex. Participants in this study stated that it is not easy to communicate with their parents about sex. Some reflected as follows:

Participant 2: " I do not speak to my parents about sex; I do not know how to speak about sex with anyone besides my boyfriend. "

Participant 3: " I do not talk to anyone about sex; I wish I had someone to talk to about having sex. "

Participant 4:" I was too scared to tell my mother I had a boyfriend. "

Participant 5: "My mother is too strict to talk to"

Participant 6:" I did not talk to anyone about sex…I feel like that topic is taboo; I wish my mother had spoken to me about sex."

Participant 7: “I do not talk to my mother about sex”.

Other participants commented as follows:

Participant 11: " It is easier speaking to my mother, my father is not understanding, he is short-tempered and has a lot of anger; " I wish there was support for teenagers at home, we do not understand a lot of things and we need guidance."

Participant 12: " I talk to my friend about sex, she gives me good advice." Participant 9: “My family always reminds me of what I have done and call me names like ‘stupid’ and add on my stress.

Participant 13: "Black parents do not talk to their children about sex, I know it is not an easy topic however mothers should still sit their children down and have the conversation."

It is evident from the shared experiences that adolescents do not disclose their pregnancies to their parents and caregivers until there are forced to do so; either due to illness or where the conditions may be life threatening. Such is proof of a lack of trust and communication between them.

4.4.2.2 Absence of support from peers

All participants in this study were subjected to some form of humiliation from their peers at school which can be stressful and can lead expectant teenagers to produce deficient grades, have low self-esteem and become isolated. Some participants reflected as follows:

Participant 4: “some of my school mates stare at me, ask me questions (tease) and then laugh…it hurts me”

Participant 5: “There was an incident at our school where two teachers laughed at a pregnant learner in front of her classmates”

Participant 13: “It was a painful experience being pregnant at school, the learners would gossip about me especially when they approach me and ask how it feels being a child having a child”

It appears that all the humiliation and bullying from peers began when participants' bellies started growing and their pregnancies become visible. Participants have shared about this amount of mental and emotional stress in addition to the physical challenges that pregnant teenagers have to endure. Lack of support from peers has resulted in teenagers leaving school or not completing their secondary educations, delaying their academic aspirations.

4.4.2.3 Peer pressure

Participants were requested to explain their reason for participating in unprotected sex. Some of them indicated that they got pregnant due to peer pressure and some participants responded as follows:

Participant 6: "Sometimes we used condoms, but at times I failed because the sex would be unplanned"

Participant 2: "my friends were conducting it, so I decided to do it to fit in the discussions"

Participant 11: "I wanted to experience what my friends told me that sex is cool"

Some participants indicated that they got pregnant the first time because they did not understand the risks involved in what they were doing. They responded as follows in this regard:

Participant 10*: "I did not understand how pregnancy happens"*

Participant 4 "I had sex once and did not know that I will be pregnant"

Participant 8*: "I was afraid to lose my boyfriend if I do not have sex with him and we did not have condoms".*

It is evident from the responses above that peer pressure played a role in teenagers' decision to have unprotected sex. They decide to have sex to impress their peers and to fit in the groups they associate with. It indicates that teenagers usually do not have control over when and how to have sex.

4.4.2.4 Communication challenges

Challenges in communicating with parents were reported by some participants as another reason for teenagers to participate in unprotected sex. They fear that if they disclose that they are in a relationship, parents will not approve, and hence they do not want to carry condoms. Communication breakdown is reported by some of the participants who only told their parents that they were pregnant after some complications. Participants reflected as follows: *Participant 10: " I had to tell my family I was pregnant because I was sent to the hospital for high blood pressure, Participant 8: "my parents only new that I was pregnant when they accompany me to the clinic, I was told that my body was too small to carry twins and I was going into labour at any moment."*

Another one said: Participant 11:" I never spoke to anybody about sex, I just wrote things down then my mother found my book and then we sat down and told me what would happen if I had unprotected sex."

It is evident from the responses that they identify a lack of communication between parents and their teenagers. It is important for parents to initiate the conversation about sex with their teenagers as they may perceive them as being too strict or only talk to them after they have fallen pregnant in the case of participant 10, where the conditions may be life threatening.

4.4.3 Attitudes towards birth control

The results indicated various contraceptive methods available to teenagers. Challenges are associated with their use and knowledge. Questions were directed to participants concerning the availability of contraceptives and the following sub-themes emerged:

4.4.3.1 Lack of knowledge about birth control methods

Participants in this study indicated that they lack information about birth control methods. They reflected as follows:

Participant 2:" I was preventing, I was using the injection then stopped when I did not see my periods, I do not know of any other contraceptives I know of the pill and condoms. "

Participant 3:" I fell pregnant after having my first injection; I have heard of the pill, but I do not know anything about it"

Participant 5: "I never used any contraceptives before falling pregnant".

Others said: *Participant 7: I do not know of any contraceptives Participant 8: I know of pills and the 1-year contraceptive."*

Participant 13: " I do not know any contraceptives."

From participants' shared experiences, it is evident that birth control and safe sex methods should be taught to teenagers. They are not provided with the incorrect information by their peers, boyfriends and families.

4.4.3.2 Lack of knowledge about sex

Some of the participants indicated that they do not have knowledge about sex. They responded as follows:

Participant 1: "I started having sex at the age of 13.''

Participant 11: " I fell pregnant at the age of 14, I continued to go to school and eventually I had to drop out. It affected my future because I must look after my baby, but I plan to go back to school."

The researcher observed that the age of initiation, as reported by participants, is below the required age to legally consent to any sexual activity and the age of child-bearing shows that the adolescents were not aware that unplanned pregnancy was a possible outcome.

4.4.3.3 Lack of knowledge about condom use

Adolescents need access to a reliable source of information about condoms and other contraceptive methods and risky sexual behaviour. *One participant reflected as follows:*

Participant 13: “Adolescents have unprotected sex to please their boyfriends and mostly alcohol is to blame.”

The implementation of school programmes directed specifically at pregnant teenagers are needed to provide the psychosocial support pregnant teenagers need to finish school and become more engaged in school activities.

4.4.3.4 Misconceptions about birth control

Participants in this study identified some misconceptions or false information concerning birth control methods. Some participants lamented:

Participant 1: "I spoke to my mother and aunt, my mother told me to look at my body, the injection was making my stomach big and my schoolmates said I looked pregnant”

Participant 4: "My aunt and mother advised me to stop using the injection because I was not getting my period and was getting fat around my stomach area. When I stopped getting the injection I got blood clots and my stomach went back to normal, as well as my periods”

Participant 8: “I asked my mother if I could continue with the injection and she refused, I told her I have a boyfriend and we are sexually active, she said I must not worry, because the injection was still in my bloodstream”

Other participants reflected as follows:

Participant 9: “My mother said I must not use contraceptives because they will ruin my womb and I will not be able to have children."

Another one said: Participant 11: " I stopped using contraceptives when my family told me to stop because it was ruining my body."

It appears from the responses above that teenagers received false information from others, hence they usually take wrong decisions concerning pregnancy protection. They would need to become educated on these methods to make good decisions.

4.4.3.5 A lack of access to resources

A few positive experiences reported by participants at their local clinic, however several participants had negative experiences as noted below.

Participant 2:" I am treated well at the clinic. I have not told anyone I am not on contraceptives; my family thinks I am still on the injection. "

Participant 5: "The clinic does not provide quality medicine, I still have to buy medicine at a pharmacy after visiting the clinic; The nurses at the clinic are harsh especially if you are teenager taking your baby for immunizations; they shout at you, I am not using contraceptives because of the treatment at the clinic, I once went to the clinic with my friends those that were brave enough to go in were requested if they thought the clinic was a school and if they were sent by the school principal; I cannot ask the nurses any questions because they are too harsh."

Some reflected as follows: Participant 6:" Sometimes I get the help that I need at the clinic, the service is slow, they do not care, they go off on long lunch breaks and I end up getting home late."

Participant 10: " There are some nurses that are friendly, others just shout at me and I just keep quiet."

Participant 13*: " The nurses do tell us about sexually transmitted diseases and do not encourage us to come back for family planning."*

It may be assumed that the negative experiences reported are shared amongst teenagers in the area and would scare teenagers away from visiting the clinic. Conditions such as depression will then not be treated. The clinic also serves as a reliable source for teenagers to obtain accurate information on contraceptives, sexually transmitted diseases and making healthy decisions.

4.4.4 Attitudes towards prevention

To investigate the knowledge of teenagers on the prevention of sexually transmitted infections, questions were directed to participants. In addition to the sub-themes that are discussed below, the main theme, of *attitude towards prevention* emerged.

4.4.4.1 Inconsistent condom use

Participants in this study showed that they do not have knowledge about the prevention of infections. They believed that the contraceptives that they are using could also prevent sexually transmitted diseases. Some participants reflected as follows: Participant 1: *"My boyfriend and I*

were using condoms until we went and got tested for HIV, the results came back negative. I asked him not to cheat on me, then we stopped using condoms because they hurt me. "Participant 5: I overdosed on pills to abort my child. Participant 6: Peer pressure and friends saying condoms will hurt me. Participant 3:" My boyfriend and I were not using condoms because I was using the injection. 'Participant 8: "I did not want to break my virginity with a condom, I wanted the experience to be 'real'.

4.4.4.2 Unhealthy sexual practices

Adolescence and peer pressure place intense pressure on how teenagers think and the choices they make, specifically regarding risky sexual behaviours. Some participants reported that they were pressurised to participate in unhealthy sexual practices. They reflected as follows:*" Participant 12: "Sometimes boyfriends trick us, they say stuff like they cannot eat a banana with the peel on it." Participant 13: " I have a boyfriend…we are not using any contraceptives."* Contraception at school clinics may enable students to overcome these challenges and begin to pursue contraception consistently.

4.4.5 Coping strategies

Some of these strategies are unconscious, others are skills consciously mastered to reduce stress whilst others are learned behavioural patterns used to cope with the situation. Below are some of the coping strategies used by participants in this study.

4.4.5.1 Social media

He indicates that people are not always able to cope with the difficulties that they encounter, as not all coping mechanisms are equally effective. These are some of their comments: *Participant 4: "When I am stressed, I talk to my mum via Facebook or over the phone and she comes home once a year" (in December). Participant 7: "When I am stressed, I listen to music; I am scared to talk to anyone at home because I am afraid they will judge me.*

Participant 14: "sometimes I talk to my friends on WhatsApp and Facebook, and I feel good".

Participants’ responses established the need for teenagers to be taught basic life skills where they will learn skills to cope with the stresses of being a young mother for them to form healthy relationships as adults.

4.4.6 Support systems/programmes

Participants were requested to answer questions about the availability of support systems or programmes in their communities; the following themes emerged:

4.4.6.1 Youth programmes

The function of youth programmes is to provide adolescents with a sense of community and a safe place where sensitive information is shared and serves as a reliable source of information about sexual reproductive health. Participants reflected as follows:

Participant 3:" There is an organisation that visits the school, but they do not talk to us who are pregnant”

Participant 7: "There are no programmes available here (in the community)."

Participant 8: "Some guys think if you ask them to use condoms you do not love them, you are hiding something, or you are cheating on him I have never seen any organisations in my Community.

Participant 10*: "Sometimes there are advantages and disadvantages of unprotected sex. Sometimes we (girls) believe our boyfriends have tested for HIV then realize later that everything was not right”*

Some of the participants reflected as follows: ‘Participant 12: *"There are no programmes in the Community.*

‘Participant 13: " If there were programs to assist adolescents in the community there would not be any pregnant teenagers. I would like the nurses to go door to door like you are doing;" boys

also need to be educated, programmes need to go deeper into adolescent issues and educating the youth."

It is clear from these findings that no programmes are available to assist the youth in the community. Informative programmes would provide the youth with an environment to be creative, engage with their peers in a positive way and assist them in rendering educated decisions regarding sexual behaviour.

4.4.6.2 Lack of Support groups

Most participants indicated that there are no support groups for teenage mothers in their area. Participants commented about support group availability as follows:

Participant 4*: "there are no support groups in the community".*

Participants 6*: "I do not know of any support group in the area", Participant 10: "I fell pregnant because nobody loved me".*

Participant 12*: I do not know where to find a support group".*

The findings indicated that there are no support groups available to assist teenagers in the community.

4.4.7 Conclusion

The results of this study were presented in this chapter. The chapter provides detailed information on the impact of teenage pregnancy on disadvantaged adolescents. The effects of teenage pregnancy were identified as were reasons for not using contraceptives. The findings also shed light on the challenges of staying in school that teenagers encounter and also comprised communication breakdown between parents and adolescents. The findings also revealed the ineffective coping mechanisms adopted by teenagers. The support systems required by the teenagers were emphasized. The findings of this study are discussed in the following chapter. Recommendations were suggested, based on the findings of the study. These recommendations will be forwarded to the community, schools and government organisations as guidelines in the establishment of youth programmes.

CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Adolescent pregnancy and early motherhood are still perceived as important public health and social challenges. Teenage pregnancy, whether planned or not planned, has negative effects at the individual, community and societal levels (Anastas, 2017). Doku (2012) establishes that most sexually active youth do not use contraceptives. A third of them are aged 12-18 and they did not use any form of contraceptive during their most recent sexual intercourse. In the distinct case of condom use, factors that increase the chances of youth in various African environments include sex education in school, school attendance, perceived social norms, good morals and a confident outlook on life. These aspects were identified to predict the intention to use protection. Besides the knowledge divergence, research established that contraceptive use is influenced by young females feeling reserved and embarrassed to seek family planning services or because contraceptives are not easily accessible (Adjei *et al*., 2014; Apanga & Adam, 2015).

If most adolescent pregnancies are unplanned, this raises the question about why the youth are not protecting themselves (Krugu, Mevissen, Munkel & Ruiter, 2017). The current study attempted to investigate the experiences of teenagers who are or were pregnant during their adolescence. The study endeavoured to establish factors contributing to teenage pregnancy and the reasons why adolescents engage in risky sexual activities. The study further investigated various methods of preventing teenage pregnancy and identified ways they cope with their challenge. Finally, the programmes available to assist with teenage pregnancies in the community were investigated and are discussed below.

5.2 THE EFFECT OF PREGNANCY ON TEENAGERS

Studies established that all the teenagers in this study as well as the fathers of their children were still at school, therefore they seek emotional and financial support from their parents. That was a challenge because parents or their families also struggled financially. According to Gyan (2017) financial support can only be helpful to teenagers if they have access to other forms of resources. The participants experienced that the financial costs of raising a child affected them psychologically and emotionally. Cook and Cameron (2015) identified that adolescents with babies are less likely to complete school; are unable to cope with challenges as adults and are

more prone to have children with behavioural, educational and health challenges over the course of their lives. The findings of this study established that participants shared several similar experiences. All participants shared their experience of being humiliated and isolated by their peers and some members of their community. Participants initially hid their pregnancies from their parents and caregivers and described the experience has terrifying and shameful. Some participants were subjected to verbal abuse from their parents and forced to drop out from school to raise their children as a form of punishment.

According to Ehiemua (2014), the education of the girl-child has endured several setbacks. The experiences reported by participants' findings above supports Ehiemua's (2014) statement that participants' education was delayed, or they dropped out because of teenage pregnancy. Finer and Philbin's (2013) also bring up the notion that teenage pregnancy may result in termination of education and lower chances of employment amongst females. All participants disclosed the lack of emotional, financial and social support from their parents and expressed the desire to talk about issues of sexuality with their parents before engaging in sexual activities. All participants expressed psychological distress bought by the experience of being ridiculed by their peers at school and leaving school and becoming single mothers during their adolescence. Sentse *et al.* (2015) agree with the findings, indicating that female teenagers regularly reported significant challenges and negative consequences, such as lower levels of social acceptance and self-esteem, and more internalising problems, anxiety, depression and suicidal ideation, than boys.

5.3 REASONS FOR TEENAGERS TO PARTICPATE IN UNPROTECTED SEX

Numerous studies were conducted on the factors linked with teenage pregnancy. The factors include low socioeconomic status, broken family structure, unsuccessful bonding between parent and child and other family factors (Lehti, Sourander, Niemela, Sillanmaki, Piha, Kumpulainen, Tamminen, Moilanen & Almqvist, 2011). The findings revealed that some teenagers participated in unprotected sex and they fell pregnant due to peer pressure. Others mentioned that they did not understand how pregnancy happens or did not think about risks involved in engaging in unprotected sexual intercourse which could explain the high number of unwanted pregnancies.

The literature repeatedly refers to teenage girls who are not always in control of whether and how they engage in sexual activities: "In South Africa, studies cite unequal decision-making about sex between partners, where girls lacked autonomy therefore, hindering the practice of safe sex"

(Flanagan *et al.*, 2013: 15). These findings are consistent with Holt *et al.* (2012:288) mentioning that HCWs established that “gender dynamics in relationships are also crucial in determining young female’s risk”. They continue to observe that peer pressure influence teenagers to have sex and the “culture of submission to male partners” often led to unprotected sex. The study established that a lack of communication and support from parents financially, was also a challenge.

Research also associates a lack of financial support as one of the contributing factors of early teenage sexual engagement, pregnancies and motherhood (Domhnail, Hutchinson, Milev & Milev, 2011; Gyeson & Ankomah, 2013). Several studies established that communication about sexuality with parents is relatively rare (Riggio, Garcia & Matthies, 2014). Annang, Lian, Fletcher and Jackson (2014) emphasise deficient communication, often found between teenage girls and their mothers: “for example when mothers take their daughters for family planning but do not discuss sex or why the daughter might need family planning” (Holt *et al.*, 2012:288). Hoffman-Wanderer *et al.* (2013) also interviewed Heath Care Workers and again they stressed their belief that teenage girls do not have enough information to adequately protect themselves. Parental support links with improved sexual health behaviours, such as delaying sexual initiation and safe sex practices (De Graaf *et al.*, 2011). Studies suggest that teenagers who regularly communicate with their parents about sexual topics, report higher rates of positive attitudes and emotions towards sexually-related topics and well-being (Klein, Becker & Stulhofer, 2018).

5.4 CONTRACEPTIVES AVAILABLE TO TEENAGERS

The findings revealed that various contraceptive methods are available to teenagers, but there are challenges associated with their use and knowledge. Several participants indicated that they do not know how to use these methods. A strong association between education and contraceptive use was anticipated based on previous studies. The complexity surrounding the use of some methods has resulted in a wrong perception about its use, which sends wrong signals to individuals who never used contraceptive methods to avoid using any method. The use and operation of some methods are poorly understood by several participants.

Several scholars have emphasised the education of the function of contraceptive use. Manlove, Welti, Barry, Schelar and Wilsmith (2011) establish that a greater understanding of the influences associated with contraceptive use amongst adolescents, can assist developing policy and

programme efforts to improve reproductive health consequences amongst this population. Ochiogu, Miettola, Llika and Vasilampi (2011) suggest that providing teenagers with the correct reproductive health information is key in preventing unplanned pregnancies and abortion and its challenges, such as STIs and HIV/AIDS.

Non-use of contraception, use of less efficient methods and irregular use of contraception add to a high unplanned pregnancy and to discrepancies in unplanned pregnancy (Finer & Zolna, 2011; Jones, Mosher and Daniels, 2012; Martinez, Copen, & Abma, 2011). It is evident from the responses above that contraceptive knowledge influences contraceptive behaviours, including the probability of engaging in unprotected sex, the efficiency of methods used, and consistency of contraceptive use (Frost, Lindberg, & Finer, 2012; Rocca & Harper, 2012). Access to youth-friendly health services is crucial for establishing the sexual reproductive health and well-being of adolescents (Denno, Hoopes & Chandror-Mauli, 2015).

5.5 A LACK OF KNOWLEDGE CONCERNING PREVENTION OF INFECTIONS

According to Adegun and Amu (2017), adolescence is a stage of promiscuity and experimentation in the area of sexual relationships. Social habits such as alcohol intake and cigarette smoking put adolescents at risk of planned and unplanned injuries, unwanted pregnancies, infections from sexually transmitted diseases including human immunodeficiency virus (HIV)/AIDS and a variety of other adjustment and mental health problems.

The National Contraception Policy Guidelines, (2012:18) note four crucial challenges facing adolescents in preventing unplanned pregnancies. Some participate in risky behaviours due to peer pressure to be sexually active or to conceive and demonstrate their fertility. Teenagers receive inaccurate information about conception, reproduction and contraception. Another challenge has to do with negative and judgemental health care provider attitudes towards teenagers who are sexually active and clinics that are not open after school or are not youth-friendly. Others feel embarrassed to be seen at the clinic by their community. Unanticipated sex and sexual coercion were also identified as challenges.

Prevention of sexually transmitted diseases and unplanned pregnancies amongst adolescents though consistent contraceptive use is a global health challenge and has been given priority (Welti, Wildsmith & Manlove, 2011). Knowledge about contraception is a crucial factor contributing

to contraceptive use (Craig, Dehlendorf, Borrero, Harper & Rocca, 2014). It is clear from participants' experiences that they lack crucial knowledge of birth control methods, how to engage in safe sex, and how to terminate pregnancies in a safe environment. According to Patel, Michaela, Alvarez, Jones, Jennings and Snyder (2016), adolescents report that crucial barriers in obtaining contraception include a lack of transportation to clinics, a lack of time after school, and discomfort linked with an unfamiliar clinic setting.

Some studies of Health Care Workers also reflected low levels of knowledge amongst teenagers. Holt *et al*. (2012) in their work with Health Care Workers emphasised that some of the Health Care Workers they intervened with sense that the level of knowledge was insufficient. Teenagers do not have sufficient information about the consequences of sex and the importance of prevention. Wood and Hendricks (2016) suggest that although teenagers' observation of parenthood whilst they study has a negative influence on their life goals, the prevention lessons taught by educators and other adults do not consider the needs and lifestyles of teenagers within their specific social context.

5.6 COPING STRATEGIES USED TO COPE WITH CHALLENGES

Thoits (2011) defines coping mechanisms as the strategies people employ to deal with the minor or major stress, trauma, pain and natural changes that they experience in life. Some of these strategies are unconscious, while others are skills that are consciously mastered to reduce stress, whilst yet others are learned behavioural patterns used to cope with the situation. People cannot always cope with the difficulties that they encounter, as not all coping mechanisms are equally effective. Hedge, Sianko and James (2016) indicate that coping is a combination of social relationships and interpersonal skills. Professional help may be the most efficient source of support, known to provide protection against several mental health risks (Baskin *et al*., 2010). Adolescents hardly seek any assistance for their problems and are particularly unlikely to seek expert assistance (Hedge, Sianko & James, 2016).

The findings in the current study revealed that teenagers cannot always cope with the difficulties that they encounter. They listen to music or communicate with their friends through social media, which is not an effective coping strategy. Social media can cause even more damage than expected. Teenagers need to be taught basic life skills and learn to cope with the stresses of being a young mother for them to form healthy relationships as adults. This is consistent with the

findings by Persike and Seiffge-Krenke (2016), indicating that the way in which adolescents cope with stress may be significant for further relationship development in young adulthood. Adolescence is a stage generally characterised by initiation and experimentation with risky behaviours, such as substance use and rule-breaking (Plenty, 2018). These behaviours guide several causes of preventative ill health and well-being during adolescence (Mokdad *et al.*, 2016). In the current study, participants did not indicate that they use substances to cope with their challenges.

5.7 SUPPORT PROGRAMMES TO DEVELOP ADOLESCENTS

Findings in this study revealed a lack of youth programmes to assist teenagers in their community. Youth programmes are required to provide adolescents with a sense of belonging and a safe place where sensitive information and sexual reproductive health is shared. Constructing a protective environment to reduce the risk of substance use and reckless behaviour during adolescence is critical in improving the health and well-being of the youth (Eisman, Lee, Hsing-Fang & Zimmerman, 2018). According to Wood and Hendricks (2016), most school-based prevention interventions in South Africa are adult-designed and informed, with the voice of the adults ignoring the youth.

The findings further revealed a lack of support groups for teenage mothers in the community. This factor is of concern as teenagers need support from adults for them to manage their future with courage. Adolescence is a challenging period of development, marked by hormonal, cognitive, social and psychological challenges that usually lead to emotional distress, particularly depression (Stone, Hankin, Gibb & Abela, 2011; Teunissen *et al.*, 2011). Eisman, Lee, Hsing-Fang and Zimmerman (2018) established that the encouragement of positive peer and adult interactions is a mechanism that can assist in ensuring that organised activity participation reduces risks of negative consequences. Participants were requested to identify support systems and programmes available in their communities.

According to Killebrew *et al.* (2014), notes an increased risk for pregnancy amongst teens lacking parental closeness, peers with children and who consumed alcohol and used drugs prior to sexual intercourse. Francis (2010) established that programmes affect the youth in obtaining positive knowledge, positioning them as experts concerning issues that affect their lives. Wood and Hendrik (2016) established that there is a need to create a platform for young people at the centre

of this phenomenon (teenage pregnancy), ensuring they apprehend teenage pregnancy, and considering developing more youth-friendly and contextually relevant prevention strategies.

Killebrew, Smith, Nevels and Weiss (2014) established that it is beneficial to identify adolescent school pupil mothers and create support groups for these young females. P10's response suggests that isolation is a factor in teens engaging in risky sexual behaviours. Support groups will provide a sense of belonging to the youth. A lack of counselling to assist in combating the stigma associated with teenage pregnancy, misunderstandings and pressure from teachers and fellow learners, lead teenagers to prefer isolation, engaging in risky behaviours. Clowes and D'Amant (2012) emphasise that pregnant learners and teenage mothers experienced various challenges, with most reporting at least some experiences of discrimination and "pressure to leave school" during the pregnancy. Some principals who did not support pregnant teenagers remaining at school, framed time off for pregnant learners as desirable, necessary and legitimate" (Clowes & D'Amant, 2012:41).

5.8 ATTRIBUTES OF THE STUDY

The study is of value in the disciplines of research, education, health and psychology. The use of a qualitative method allowed collecting more detailed information to describe sensitive issues, whilst providing multiple methods for obtaining more information on complex topics. Emphasising the experiences of rural African teenage girls should improve awareness and remove judgement for other pregnant teenagers encountering similar experiences, whilst simplifying the shortcomings of social challenges in rural communities.

Participation in the study was a form of therapy and the sharing of experiences in a safe environment gave participants an opportunity to reflect on their challenges and also think of innovative solutions to their problems. Participants were provided with information about long distance learning institutions, services provided at the local library, and the roles of nongovernmental organisations in the area.

5.9 LIMITATIONS OF THE STUDY

Despite the noteworthy strengths and recommendations, a few notable limitations were established in this study. The limitations were as follows:

1. The study was time consuming; it took four weeks to interview 14 participants from four villages.
2. By applying the qualitative approach, the sample size was limited. Only 14 adolescents were interviewed, therefore the finding of the study may not be generalised.
3. Interviewing adolescents was challenging. It was observed that participants were not communicative about their partners in fear of causing them distress (trouble).
4. Accessibility to clinics was challenging. Initially participants would be recruited from local clinics. A visit to the district office in Mkhuhlu and thereafter the provincial office in Nelspruit was required. These processed delayed the completion of the study.

5.10 CONCLUSION

This review confirms the reality of multiple influences when it comes to South Africa's high levels of teenage pregnancies. Evidence indicated that a multi-pronged approach was needed at a structural and individual level to reduce unplanned teenage pregnancies. Gendered norms and gender inequalities between girls and boys needed to be addressed to enable girls to have autonomy and decision-making over their own bodies. Poverty, race-based inequalities and residing in rural areas were additional factors played a role, contributed to unplanned teenage pregnancies. These concerns need to be addressed.

5.11 RECOMMENDATIONS

The study presented the following recommendations, representing its perception of the derived information.

5.11.1 Recommendations for the National Departments of Health and Basic Education

It was recommended that organisations, specialising in programmes, should facilitate Life Orientation classes, aimed to reduce teenage pregnancy, whilst promoting sexual reproductive health. Improving access to contraceptives, clinics need to ensure they are accessible (open) after school hours with shorter waiting periods. These classes should provide the youth with accurate information, whilst having a positive developmental impact on education, health and psychosocial support.

Teenage programmes should be designed to suite their unique demands. Potential programmes should consider the needs and lifestyle of teenagers within their specific social context. Life Orientation classes would close the gap but may be lacking in the curriculum. They equip adolescents with social skills, enabling decision-making that will enhance their well-being. Programmes are needed to inspire young girls, enabling decision-making concerning appropriate sexual intercourse (when and how). These initiatives can be integrated into school-based comprehensive sexuality education (CSE) sessions, expanding several excellent community-based programmes to empower young girls and boys. Some may involve critical collaboration with parents also.

South Africa embraces sexuality education in schools, delivered through Life Orientation (LO) classes. This review recommends that the programme needs to expand to become a comprehensive sexuality education (CSE) to increase effectiveness. It needs to engage more effectively in gender relations and norms. Increased access to support grants enables teenage mothers to pay for childcare and return to school.

5.11.2 Recommendations for future studies

It is anticipated that some of the issues raised in this study will form a foundation for future studies on concerns related to teenage pregnancy. Some of the participants' reported experiences could be used as a basis for social and health services for pregnant teenagers, advocating state involvement in reducing teenage pregnancy rates. It is recommended that future research focus on the following aspects:

1. Exploring the association between social support and teenage pregnancy in rural communities.
2. Exploring perceptions and the participation of adolescent boys in preventing teenage pregnancies in rural communities.
3. Exploring the psychosocial challenges of children born from teenage mothers in rural South Africa.

REFERENCES

Abrams, S.L. (2010). Sampling 'Hard to Reach' populations in qualitative research. Qualitative Social Work, 9(4), 536-550.

Adams, P., Prakobtham, S., Limpattaracharoen, C., Suebtrakul, S., Vutikes, P.

Adjei, D., Sarfo, O.J., Asiedu, M., & Sarfo, A.I. (2014). Social cognitive factors affecting contraceptive usage: A case of unmet needs in Ghana. European Scientific Journal, 10(15), 84-93.

Adolescent Health. (2016). Retrieved from http://who.int /topics/adolescent health/en.

Akers, R., & Sellers,C. (2012). Social learning theory, In Field,B., & Bishop,D.(Eds). The Oxford handbook of juvenile crime and juvenile justice. Oxford. Oxford University Press.

Alli, F., Maharaj,P., & Vowda, M. (2013). Interpersonal relations between healthcare workers and young clients: Barriers to accessing sexual and reproductive health care. Journal of community health, 38 (1), 150-155.

Anastas, J.W. (2017). What's the story? observations of pregnant teens in qualitative research. Journal of female and social work, 3(2), 133-170

Annang, L., Lian, B., Fletcher,F., & Jackson, D. (2014). Parental attitudes about teenage pregnancy: Impact on sexual risk behaviour of African American youth. Sex Education, 14(2), 255-237.

Apanga, A. P., & Adam, A. M. (2015). Factors influencing the uptake of Family Planning services in the Talensi District, Ghana. Pan African Medical Journal, 20(12), 1-9.

Arain, M., Campbell, M.J., Cooper, C.L., & Lancaster, G. (2010). What is a pilot or feasibility study? A review of current practice and editorial policy. BMC Medical research methodology, 10, 67.

Ardington,C., Branson,N., Lam, D., Leibbrandt, M., Marteleto, L., Menendez, A., Mutevedzi, T. & Ranchold, V. (2012). Revisiting the 'Crisis' in Teen Births: What is the impact of teen births on young mothers and their children? A Southern African Labour and Development Research Unit Policy Brief. UCT.

Auerswal,C.L., Piatt,A.A.& Mirzazadeh,A. (2017). Research with disadvantaged, vulnerable and/or marginalized adolescents. Innocenti Research Brief,4,1-17.

Bankole, A., & Malarcher, S. (2010). Removing barriers to adolescents' access to contraceptive information and services. Stud Fam Plann, 41(1), 117-124.

Barn, R., & Tan, J.P. (2015). Foster youth and drug use: Exploring risk and protective factors children and youth services review, 56, 107-115; doi:http://dx.doi.org/10/016/j.childyouth.2015.07.

Benett,A.E., Cunningham, C., & Johnston, M.C. (2016). An evaluation of factors which can affect the implementation of a health promotion programme under the schools for health in Europe framework evaluation and program planning, 57, 50-54.

Bhana, D. And Ngabaza, S. (2012) Teacher responses to pregnancy and young parents in schools. In Morrell, R., Bhana, D and Shefer, T. (eds). (2012). Books and Babies: Pregnancy and Young Parents in Schools. Cape Town: HSRC Press, 49-62

Bjorklund, O., Sunderlund, M., Nystrom, & Hoggsrom, E. (2015). Unemployment and health: experiences narrated by Finnish men. American journal of men’s health, 9(1), 76-85.

Boddy, C. R. (2016). Sample size for qualitative research. Qualitative market research (19), 4, 426-432.

Boudet, H., Ardoin, M.M., Flora, J., Armel,K.C., Desai, M., & Robinson, T.N. (2014). Energy behaviours of Northern California girl Scouts and their families. Energy policy, 73, 439-449.

Brooks, H., Cleaver, I., & Ireland, E. (2009). Researching young people’s lives. London: Sage.

Bryman, A. (2012). Social research methods 4th ed. Oxford: Oxford University press.

Buckley, C.A. (2011). Student and staff perceptions of the research-teaching nexus. Innovations in Education and Teaching International, 48(3), 313-322.

Bymamugisha, J., Mirembe, F., Paxelid, E., & Danielsson, K. (2006). Emergency contraception and fertility awareness amongst university students in Kampala, Uganda. African Health Sciences Journal, 6(4), 194-200.

Cantlay, A. (2015). Managing teenage pregnancy. InnovAiT.8 (9), 524-542.

Centers for Disease Control & Prevention (2012). Unintended pregnancy statistics. United States Department of Health & Human Services.

Centers for Disease Control and Prevention (2015). Youth risk behaviour surveillance- United States. Retrieved May 1, 2016 from https://www.cdc.gov/mmmwv/volumes/65/55/556506a1.htm.

Centers for disease control and prevention. (2011). Adolescent pregnancy and childbirth- United States, 1991-2008 (MMVR), 60, 105-118. Atlanta,GA.

Centers for disease control and prevention.” sexually transmitted diseases data and statistics”.www.cdc.gov/std/stats/default.htm.

Charmaz, K. (2013). Constructing grounded theory (2nd Ed.) Thousand Oaks: Sage.

Chohan, Z and Langa, M. (2011). Teenage Mothers Talk About Their Experience of Teenage Motherhood. Agenda, 25(3), 87-95

Chohan, Z. (2010). Deconstructing Teenage Pregnancy: Teenage Mama's Talk About the Self. (MA), University of the Witwatersrand

Christofides, J.N. (2013). Adolescent pregnancy: Risk factors and consequence-a-longitudinal study in the Eastern Cape, South Africa. Retrieved from Dissertation Abstracts International: Section B. Sciences and engineering, 73,12. 2013-99120-282.

Cleland, J., & Ali, S. (2006). Sexual Abstinence, contraception, and condom use by young African female: A secondary analysis of survey data. Lancet, 368(1), 1788-1793.

Coleman, P., Rue, V., Spence,M., & Coyle,C. (2008)."Abortion and the sexual lives of men and female: Is sexual behavior more appealing and more common after abortion? "Journal of Studies on Alcohol, 67(2), 195-203.

Colorafi, J. K., & Evans, B. (2016). Qualitative descriptive methods in health science research. Health Environments research and Design Journal, 9(4), 16-25.

Colorafi, J.K., & Evans, B. (2016). Qualitative descriptive methods in health sscience research. Health Enviroments research and Design Journal, 9(4), 16-25.

Connolly, J. C. Heifetz, M., & Bohr, Y. (2012). Pregnancy and motherhood amongst adolescent girls in child protective services: A metasynthesis of qualitative research. Journal of public child welfare, 6,614-635.

Constantinou, S. C., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation in qualitative interviews. Qualitative research, 1, 1-18.

Cook, S. M. C., & Cameron, S. T. (2015). Social issues of teenage pregnancy. Obsterics, gynaecology & reproductive medicine, 25(9), 243-248.

Creswell, J. W. (2013). Qualitative inquiry and research design: Choosing amongst five approaches. Thousand Oaks, CA:Sage.

Creswell,J.W. (2013). Qualitative inquiry and research design: Choosing amongst five approaches. Thousand oaks, CA: Sage.

Crosnoe, R., & Johnson, M.k. (2011). Research on adolescence in the twenty-first century. Annual review of Sociology, 37, 439-460.

Cruz, F.R., & Tantia, F.J. (2017). Reading and understanding qualitative research. Am J Dance Ther, 39, 79-92.

Cruz, F.R., & Tantia, F.J. (2017). Reading and understanding qualitative research. Am J Dance Ther, 39, 79-92.

Dancy, C., Crittenden, S., & Ning, H. (2010). African American adolescent girls' initiative of sexual activity: Survival analysis. female's health issues, 20(2), 146-155.

Dantzker, M.L., & Hunter, R.D. (2012). Research methods for criminology and criminal justice. 3rd edition. Ontario: Jones and Bartlett.

Dantzker, M.L., & Hunter, R.D. (2012). Research methods for criminology and criminal justice. 3rd edition. Ontario: Jones and Bartlett.

De Casterle, B., Gastmans, C., Bryon, E., & Denier, Y. (2012). A guide for qualitative data. International journal of nursing studies, 49(3), 360-371.

De Genna, M.N., Larkby, C., & Cornelius, D.M. (2011). Puberty timing and early sexual intercourse in the offspring of teenage mothers. Journal of youth adolescence, 4, 1315-1328

De Genna,M. N., & Cornelius, D.M. (2015). Maternal drinking and risky sexual behaviour in offspring. Health, education & behavior, 42(2), 185-193.

Denzin, N.K., & Lincoln, Y.S. (2011). The Sage handbook of qualitative research, 4th edition.London.Sage.

Deptula, D.P., Schoeny, E.M., & Henry, D.B. (2010). How can parents make a difference? Longitudinal associations with adolescent sexual behavior. Journal of family psychology, 24(6), 731-739.

Dick, B., & Ferguson, B. J. (2015). Health for the world's adolescents: A second chance in the second decade. Journal of adolescent health, 56(1), 3-6.

Dicksins, T., Johns., & Chipman, A. (2012). Teenage Pregnancy in the United Kingdom: A behavioural ecological perspective. Journal of social, Evolutionary and Cultural Psychology, 6(3), 344-359.

Doku, D. (2012). Substance use and risky sexual behaviours amongst sexually experienced Ghanaian youth. BMC public health, 12, 1220.

East, P., & Khoo., T. (2005). Longitudinal pathways linking family factors and sibling relationship qualities to adolescent substance use and sexual risk behaviours. Journal of family psychology, 19(4), 571.

Edwards, J. (2016). Editorial: Is there such a thing as qualitative research? The arts in psychotherapy, 47, A1-A2.

Elo, S., Kaariainen, M., Kanste, O., Polikki, Utrian, K., & Kyngas, H. (2014). Qualitative content analysis. Sage journals, 4(1), 1-9.

Engelman, R. (2016).Six billion in Africa. Scientific American Journal, 314(2), 56-63.

Finer, L.B., & Zolna,M.R. (2013). Shifts in intended and unintended pregnancies in the United States. American Journal of Public Health. 104(1), 43-48.

Flanagan, A., Lince, N., Durao de Menezes, I and Mdlopane, L. (25 February 2013). Teen Pregnancy in South Africa: A Literature Review Examining Contributing Factors And Unique Interventions. Ibis Reproductive Health

Genna, N., & Cornelius, L. (2015). Maternal drinking and risky sexual behavior in offspring. Health, Education and Behavior, 42(2), 185-193.

Gergen, K.J., Josselson, R., & Freeman, M. (2015). The promises of qualitative inquiry. American Psychologist, 70,1-9.

Goeredema-Braid, B. (2010). Ethical research with young people. Journal of Early Childhood Research, 6(2), 48-52.

Guillen,N., Roth, E., Alfaro, A., & Fernandez, E. (2015). Youth alcohol drinking behavior: Associated risk and protective factors. Revista iberoamericana de Dsicologia y Salud, 6(2), 53-63.

Gyan, E.S., Ahorlu, C., Dzorgho, D., & Fayorsey, C. (2016). Social capital and adolescent girls' resilience to teenage pregnancy in Begoro, Ghana. Journal of Biosocial science, 49,334-347.

Ha, Y., Narendorf, S.C., Santa Maria, D., & Bezette - Flores, N. (2015). Barriers and facilitators to shelter utilization amongst homeless young adults. Evaluation and program planning, 53, 25-30.

Haas, L.M., McArthur, B.A., Burke, T.A., Olino, T.M., Alloy, L.B. & Abrahamson, L.Y. (2019). American Psychological Association, 19(4), 563-572.

Hallmark, K. (2006). Orphan hood, poverty and HIV risk behaviors in Kwazulu-Natal, South Africa. Paper presented at the annual meeting of the population association of America, Los Angeles. 30 Mar-1st April

Hayter, M., Jone, C., Owen, J., & Harrison, C. (2016). A qualitative evaluation of home-based contraceptive and sexual health care for teenage mothers. Primary Health Care Research & Development, 17(1), 287-297.

Hoffman, S., & Maynard, R. (2008). Kids having kids: Economic costs and social consequences of teen pregnancy (2nd Ed). Washington DC: Urban Institute Press.

Hoffman-Wanderer, Y., Carmody, L., Chai, J and Rohrs, S. (2013). Condoms? Yes! Sex? No! Conflicting Responsibilities for Health Care for Professionals under South A Ibis Reproductive Health: Young female's Reproductive Health Brief Series.frica's Framework on Reproductive Rights. Cape Town: The Gender, Health & Justice Unit, University of Cape Town

Hofmann, S.G., Sawyer, A.T., Fang, A., & Asnaan, A. (2012). Emotion dysregulation model of mood and anxiety disorders. Depression and anxiety, 29, 409 -416.

Holt, K.., Lince, N., Hargey, A., Struthers, H., Nkala, B., McIntyre, J., Gray, G., Mnyani, C. and Blanchard, K. (2012). Assessment of Service Availability and Health Care Workers' Opinions about Young's Sexual and Reproductive Health in Soweto, South Africa. African Journal of Reproductive Health, 16(2), 283-294

Honig, S. A. (2012). Teen pregnancy. International Journal of Adolescence and Youth, 17(4), 181-187.

Hoskins, D., & Simons, L. (2015). Predicting the risk of pregnancy amongst African American youth. Testing a social contextual model. Child Family Studies, 24, 1163-1174.

Imamura, M., Tucker, J., Hannaford, P et al. (2007). Factors associated teenage pregnancy in the European Union countries, a systematic review. European Journal of Public Health, 17,630-631.

Jerman, P., & Constantine, N. (2010). Demographic and psychological predictors of parent - adolescent communication about sex: A representative statewide analysis. Journal of youth and adolescence, 39(10), 1164-1174.

Jones, J., Salazar, F.L., & Crosby, R. (2015). Contextual factors and sexual risk behaviors amongst young black memn. American journal of men's health, 11(3), 508-517.

Jones, R., Finer, L., & Singh, S. (2010).Characteristics of US abortion patients, 2008. New York: Guttmacher institute.

Jones, S. R., Tornes, V., & Armino, J. (2013). Negotiating the complexities of qualitative research in higher education; fundamental elements and issues (2nd Ed). New York: Routledge.

Juma, M., Askew, I., & Ferguson, A. (2007). Situation analysis of the sexual and reproductive health and HIV risks preventing needs of older orphaned and vulnerable children in Nyanza Province, Kenya. Nairobi: Population council and Constella Futures.

Kanku, T., & Mash, R. (2010). Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung.South African family practice,52,563-572.

Karra, M and Lee, M. (March 2012). Human Capital Consequences of Teenage Childbearing in South Africa. Research Brief. USA: Population Reference Bureau

Kelly, D. M. (1996). Stigma stories: Four discourses about teen mothers, welfare and poverty. Youth & Society, 27, 421-449

Kessel,A., Buckley, E., Hoskins, A., Bracebridge, S., Olivier,I., Bradley,N., & Brooks,F.(2014). Achieving success in reducing teenage pregnancy in Hull. Perspectives in Public Health, 134 (5), 292-296.

Khusmith, S., Wilairatana, P., Adams, P., & Kaewkungwal, J. (2017). Ethical issues of informed consent in malaria research proposals submitted to a research ethics committee in Thailand: a

Killebrew, A.E., Smith, M.L., Nevels,R.M., Weiss,N.H., & Gontkovsky, S.T.(2014).

Knotek, S. E. (2012). Utilizing culturally responsive consultation to support innovation implementation in a rural school. Consulting psychology journal. Practice and research, 64, 46-62.

Koffman, O. (2012). Children having children? Religion, psychology and the birth of the teen pregnancy problem. History of the human sciences, 25, 119-134.

Kramer, M., Rowland-Hogue, J., & Gaydos, L. (2007). Noncontracepting behavior in female at risk for unintended pregnancy: What's religion got to do with it? Annuals of Epidemiology, 17(5), 327-334.

Krugu, K.J., Mevisson,F., Munkel, M., & Ruiter, R. (2017). Beyond love: a qualitative analysis of factors associated with teenage pregnancy experience in Bolgatanga, Culture, Health and Sexuality, 19(3), 293-307.

Lachance, C.R., Burrus, B.B., & Richmond-Scott, A. (2012). Building an evidence base to inform interventions for pregnant and parenting adolescents: A call for rigorous evaluation. American journal of public health, 102, 1826-1831.

Lee, J. O., Hill, K. G., Hartigan, L. A., Bogen, J. H., Gutmannova, K., Kosterman, R.,... Catalano, R.F. (2015). Unemployment and substance use problems amongst young adults: Does childhood, low socioeconomic status exacerbate the effect? Social Science and medicine, 143, 36-44.

Li, J., Haung, J., Zhaung, J., & Li, Y. (2016). A home-based, nurse-led health program for postoperative patients with early stage cervical cancer: A randomized controlled trial. European Journal of oncology nursing, 21, 174-180.

Luke, N., Xu, H., Mberu, U. B., & Goldberg, E.R. (2012). Migration experience and premarital sexual initiation in urban Kenya: An event history analysis. Studies in family planning, 43, 115-126.

Macleod, C. I., & Tracey, T. (2010). A decade later: Follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. South African journal of psychology, 40(1), 18-31.

Macvarish, J. (2010). Understanding the significance of the teenage mother in contemporary parenting culture. Sociological Research online, 15 (4), 3.

Malahlela. M.K. (2012). The effects of teenage pregnancy on the behaviour of learners at secondary schools in the Mankweng area, Limpopo (Masters Dissertation).

Maly, C., McClendon, A.K., Baumgartner, N.J., Nakyanjo, N.J., Ddaak, G.W., Serwadda,D., Nalugoda, K.F., Wawer, J.M., Bonnevie, E., & Wagman, A.J. (2017). Perceptions of adolescent pregnancy amongst teenage girls in Rakai, Uganda.Global qualitative nursing research, 4, 1-12.

Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Menacter, F., Kirmeyer, S., & Matthews, M.S. (2009). Births: Final data for 2006.National Vital Statistics Reports, 57(7).Retrieved from hhtp://www.cdc.gov.za.

Mason, J. (2012). Qualitative researching (2nd Ed.). London: Sage.

Massey, D.S.(2013). Inheritance of poverty or inheritance of place? The emerging consensus on neighborhoods and stratification contemporary sociology: A Journal of Reviews, 42(5), 690-695.

McCauley, L. K., Shadur, M.J., Hoffman, M.E., & Lejuez, C.W. (2015). Adolescent callous-unemotional traits and parental knowledge as predictors of unprotected sex amongst youth. Behavior modification, 40(1-2), 70-96.

McGowan, J. (2013). Improving access to emergency contraception under the Scottish Sexual Health Strategy: can rates of unintended pregnancy be reduced? female’s Health, 9 (5), 435-442

Mchunu, G., Peltzer, K., Tutshana, B, & Seutlwadi, L. (2012). Adolescent pregnancy and associated factors in South African youth. Journal of African Health Sciences, 4, 426-434.

McIsaac, J. L. D., Mumtaz, Z., Veugelers, P.J., & Kirk, S. F. (2015). Providing context to the implementation of health promoting schools: A case study. Evaluation and program planning, 53, 65-71.

McLaughin, M., Thompson, K., Parahoo, K., Armstrong, K., & Hume, A. (2007). Inequalities in the provision of sexual health information for young people. Journal of Family Planning Reproductive Health Care, 33(2), 99-105.

Meshki, C., Lin, Y., & Tsai, M. (2019). Dietary behaviors mediate the association between food insecurity and obesity among socioeconomically disadvantaged youth. Journal of Appetite, 132,275-281.

MiET Africa. (2011). Literature Review: Youth-friendly Health Services, September 2011.

Miles,M., Huberman,M., & Saldana, J. (2014). Qualitative data analysis: A methods source book (3rd ed). Thousand Oaks: CA :Sage.

Miller, W. B., Barber, J. A., & Gatney, H. H. (2013). The effects of ambivalent fertility desires on pregnancy risk in young female in the USA: Population studies. A journal of demography, 67, 25-38.

Micheael, R.S. 2012. Sampling Procedures, Y520: Strategies for Educational Inquiry, (2): 2-17.

Mkhwananzi, N. (2010). Understanding teenage pregnancy in a post-Apartheid South African township. Culture,health and sexuality,12(4),347-358.

Molborn, S., & Sennot, C. (2014). Bundles of norms about teen sex and pregnancy. Qualitative Health Research, 25, 1283-1299.

Mollborn, S. (2010). Predictors and consequences of adolescents' norms against teenage pregnancy. Sociological quarterly, 51, 303-328.

Mollborn, S., & Everett, B. (2010). "Correlates and consequences of parent-teen incongruences in reports of teen's sexual experience. Journal of sex research, 47(4), 314-329.

Moore, E. (2013) Transmission and Change in South African Motherhood: Black Mothers in Three-Generational Cape Town Families. Journal of Southern African Studies, 39:1, 151-170

Moretti, F., Van Vliet,L., Bensing, J., Deledda, G., Mazzi, M., Rimondini, M… Fletcher, I. (2011). A standardized approach to qualitative content analysis of focus group discussions from different countries. Ptient education & Counselling, 82, 420-428.

Morrell, R., Bhana, D and Shefer, T. (2012). Pregnancy and Parenthood in South African Schools. In Morrell, R., Bhana, D and Shefer, T. (eds). (2012). Books and Babies: Pregnancy and Young Parents in Schools. Cape Town: HSRC Press, 1-30

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. Journal of counseling psychology, 52,250-260.

Mphatswe, W., Maise, H., & Sebitloane, M. (2016). Prevalence of repeat pregnancies and associated factors amongst teenagers in Kwa-Zulu Natal, South Africa. International Journal of Gynecology & Obstetrics, 133(2), 152-155.

Mpofu, M. (2012). Teenage pregnancies on the rise. Feminism and psychology, 11,493-510.

Murray, L., Pushor, D., & Renihan, P. (2011). Reflections on the ethics approval process. Qualitative Inquiry,18(1), 43-54.

National Day. (2015). Retrieved hyttp://thenationalcampaign.org/event/national-day.

Newman, D. S. (2012). A grounded theory study of supervision of pre-service consultation training. Journal of educational and psychological consultation, 22, 247-279.

Newman, S. D., & Clare, M. M. (2016). School psychology as a relational enterprise: the role and process of qualitative methodology. Contemporary school psychology (20), 327-335.

Ngabaza, S. (2011). Positively Pregnant: Teenage female's Experience of Negotiating Pregnancy with Their Families. Agenda, 42-51

Nichols, S., Javdani, S, Rodriguez, E., Emerson, E., & Donenberg, G. (2016). Sibling teenage pregnancy and clinic-referred girls' condom use: The protective role off maternal monitoring. Journal of child family studies, 25, 1178-1187.

Oleke, C., Blystand, A., Moland, K., Rekdal, O., & Heggenhagen, K. (2006). The varying vulnerability of African Orphans: The case of Langi, Northern Uganda.Childhood,13(2),267-284.

Oman, R.F., Vesley, S.K., Aspy, C.B., Tolna, E.B., Gvin, L., Bensyl, D. M., …Fluhr, J.D. (2013). A longitudinal study of youth assets, neighbourhood conditions, and youth sexual behaviors. The journal of adolescent health, 52, 779-785.

Osaikhuwuomvon, J., & Osemwenkhakha, P. (2013). Adolescents' perspective regarding adolescent pregnancy, sexuality and contraception. Asian Pacific Journal of Reproduction, 2(1), 58-62.

Oye, C., Ovre, N.S. & Glasdam, S. (2016). Qualitative research ethics on the spot: Not only on the desktop. Nursing ethics, 23(4), 455-464.

Patel, L. (2011). Successful Social protection floor experiences. Center for Social Development in Africa: University of Johannesburg.

Patel, P., Huynh, M., Alvarez, C., Jones, D., Jennings, K., & Snyder, R. (2016). Postpartum teenagers' observations or providing contraception in school-based health clinics. Journal of female's Health, 25(1), 32-37.

Payne, N. A., Anastas, J. W., & Ghuman, S. (2016, January). The mental health needs of low-income pregnant teens: A nursing-social work partnership in care. Poster presentation at the Annual Meeting of the Society for Social Work and Research, Washington, DC.

Petrova, E., Dewing, J. & Camilleri, M. (2016). Confidentiality in participatory research: Challenges from one study. Nursing ethics, 23(4), 442-454.

Polit, D.F., & Beck, C.T. (2012). Nursing research: Generating and assessing evidence for nursing practice (9th ed). Philadelphia, PA: Walters Kluwer Health.

Rashid, S., & Mwale, M. (2016). The effects of sex education on the sexual behavior of school going adolescents: A case study of Mbenjere secondary, Ntaja and Nsanama community day secondary schools. Psychology and developing societies, 28(1), 126-138.

retrospective document review. BMC Medical Ethics,18,50-69.

Richardson, L., DeBeck, K., Feng, C., Kerr, T., & Wood, E. (2014). Employment and risk of injection drug use initiation amongst street involved youth in Canadian setting. Preventive medicine, 66, 56-59.

Rijsdijk, L. E. Bos, E. A., Lie, R., Ruiter, C. A., Leerlooijer, N. J., & Kok, G. (2012). Correlates of delayed sexual intercourse and condom use amongst adolescents in Uganda: A cross-sectional study. BMC public health, 12(1), 320.

Ritchie, J., Lewis, J.,McNaughton-nicholls, C., & Ormston, R. (2014). Qualitative research practice: A guide for social science students and researchers. London. SLondon:age Publications.

Rossetto, R.K. (2014). Qualitative research interviews: Assessing the therapeutic value and challenges. Journal of Social and Personal Relationships, 31(4), 482-489.

Sabatiuk, L., & Flores, R. (2009). Toward a common future: Latino teens and adults speak out about teen pregnancy.Retrieved from http://www.thenationalcampaign.org/resources/pdf/pubHYPERLINK "http://www.thenationalcampaign.org/resources/pdf/pubs/commonfuture.pdf"s/commonfuture.pdf

Sakar, N. (2012). Use of emergency contraception by the adolescent and young adult females. International Medical Journal of Obstetrics and gynecology, 19(3), 241-244.

Saldana, J. (2011). The coding manual for qualitative researchers. Thousand Oaks, CA:Sage.

Salmon, D. (2011). A qualitative study of how mothers and teenage daughters negotiate sex-related risk and independence. Journal of research in nursing, 17(3), 246-259.

Santelli, S., Lindberg, D., Finer, B., & Singh, S. (2007). Explaining recent declines in adolescent pregnancy in the US: the contribution of abstinence and improved contraceptive use. American Journal of Public Health, 97 (1), 150-156.

Savin-Baden, M., & Major, C. (2010). New approaches to qualitative research: wisdom and uncertainty. (1st Ed.). London: Routledge, pp19-27.

Schreier, M. (2012). Qualitative content analysis in practice. Scientific study of literature, 3(1), 165-168.

Seigart, D., Dietsch, E., & Parent, M. (2013). Barriers to providing school- based health care: International case comparisons Coltegion, 20 (1), 43 -50.

Shah, I., & Ahman, E. (2004). Age patterns of unsafe abortion in developing country regions. Reproductive Health Matters, 12(24), 9-11.

Shea, R., Bryant, L., & Wendt, S. (2016). Nappy bags instead of hand bags: Young motherhood and self-identity. Journal of Sociology, 52(4), 840-855.

Shefer, T., Bhana, D., & Morrell, R. (2015). Teenage pregnancy and parenting in schools in contemporary South African contexts: Deconstruction school narratives and understanding policy implementation. Perspectives in Education, 31(1), 1-10.

Shefer, T., Bhana, D., Morrell, R., Manzini, N and Masuku, N. (2012). 'It isn't easy': Young parents talk of their school experiences. In Morrell, R., Bhana, D and Shefer, T. (eds). (2012). Books and Babies: Pregnancy and Young Parents in Schools. Cape Town: HSRC Press, 127 – 148.

Smith, C. (2017). Family, academic and peer group predictors of adolescent pregnancy expectations and young adult childbearing. Journal of family issues, 39(4), 1008-1029.

Smith, K.A. & Harrison, A. (2013). Teachers attitudes towards adolescent sexuality and life skills education in rural South Africa. Sexual education 13(1), 68-81

South, S.J., & Cowder, K. (2010). Neighborhood poverty and nonmarital fertility: spatial and temporal dimensions. Journal of marriage and family, 72, 89-104.

Stokan,H., Davis, L., Sinhaei, B., LaMarca, L., Harris, A., Hellumk,K. & McCrea, K.T. (2017). "Love your love life": Disadvantaged African American adolescents cocreate psych-educational romantic and sexual health resources. National Association of Social Workers, 146-155.Strachan, J., Yellowlees, G. & Quigley, A. (2015). General practitioners' assessment of, and treatment decisions regarding, common mental disorders in older adults: thematic analysis of interview data. Ageing & Society, 35,150-168.

Summers, L., Lee, Y., and Lee.H. (2017).Contributing factors of teenage pregnancy amongst African-American females living in economically disadvantaged communities. Applied Nursing Research, 37, 44-49.

Swartzendrube, A., Sales, J.M., Brown.,J.L., DiClemente,R.J., and Rose, E.S.(2016). Alcohol use problems and sexual risk amongst young adult African-American mothers.Aids and behaviour, 20(1), 74-83.

Taylor, M., Jinabhai, C., Dlamini, S., Sathiparsad, R., Eggers, M.S., & De Vries, H. (2014). Effects of a teenage pregnancy prevention program in Kwazulu-Natal, South Africa. Health care for female international, 35,845-858.

Taylor, R. (2015). Beyond anonymity: temporality and the production of knowledge in a qualitative longitudinal study. International journal of Social Research Methodology, 18(3), 281-292.

Terre Blanche, M., Durrheim, K. & Painter, D. (2010). Research in practice: applied methods for the social sciences. (2nd Ed). Cape Town: Juta.

The (2011) National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa. Retrieved from http://www.hst.org.za/publications/2011-national-antenatal-sentinel-hiv-syphilis-prevalence-survey-south-africa.

Thoits, P.A. (2011). Mechanisms linking social ties and support to physical and mental health. Journal of Health and Social Behaviour, 52 (2), 145-161

Toomey, B. R., Umana,-Taylor, J.A., Jahromi, B.L., & Updegrafff, K. (2013). Measuring social support from mother figures in the transition from pregnancy to parenthood amongst Mexican-origin adolescent mothers. Hispanic journal of behavioural sciences, 35(2), 194-212.

UNAIDS. (2014). UNAIDS report on the global Aids epidemic: Retrieved from www.unaids.org/globalreport/Global_report.htm.

Viner, R.M., Ozer, E.M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. Lancet, 379, 1641-1652.

Watt, M.H.M., Aunon, F.M., Skinner, D., sikkema, K.J., Kalichman, S.C., & Pieterse, D. (2012). “Because he has bought for her, he wants to sleep with her”: Alcohol has a currency for sexual exchange in South Africa drinking venues. Social science and medicine Journal, 74, 1005-1012. http://dx.doi.org/10.1016/j.socscimed.2011012.022.

Wiles, R., Charles, V., Crow, G., & Heath, S. (2006). Researching researchers: Lessons for research ethics. Qualitative Research, 6, 283-299.

Willan, S. (2013). A review of teenage pregnancy in South Africa-experiences of schooling, and knowledge and access to sexual & reproductive health services. Partners in Sexual Health, 1-63.

Winters, L. & Winters, P. (2012). Black teenage pregnancy. A dynamic social problem. Sage publications.

Wood, L., & Hendricks, F. (2016). A participatory action research approach to developing youth friendly strategies for preventing teenage pregnancy. Educational action research, 25(1), 103-118.

World Health Organization. (2012). Early marriages, adolescent and young pregnancies. Report by the secretariat. Retrieved from http://apps.who.int/gb/ebwhal/pdf-files/wha65/A65_13_en.pdf.

Xu, H., Mberu, U. B., Goldberg, E. R., & Luke, N. (2013). Dimension of Rural-to-urban migration and premarital pregnancy in Kenya. The annals of the American academy of political and social science, 648, 104-119.

APPENDIX A: PERMISSION LETTER

Dear Sir/ Madam,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR SCHOOL / INSTITUTION/COMMUNITY

I……….4108325 (Student Number), studying at the University of South Africa, wish to make a request to conduct a research amongst learners in your institution. I am a Masters' degree student conducting research on teenage pregnancy.

I will take upon myself to respect the local customs and school image and also promise to provide copies of all reports on request by the school.

Your learners are teenage mothers, required to provide a detailed account of their unique experiences and also provide insight for their peers to delay parenthood.

There will be no financial incentives for participating in the research, but findings will be made known to the school. Participants may withdraw at any time if they feel like and data collected before withdrawal will not be used any further. The data collection instruments and consent forms to participate are herein attached for your attention.

Yours faithfully

Tebogo Mokoena

Return consent slip

I………………………………….Principal of school / Manager/ Community leader……………… does consent to the above in my institution.

Principal's signature Date

………………………….. ………………………..

APPENDIX B: PARTICIPANT INFORMATION SHEET

Dear learner

REQUEST FOR CONSENT TO PARTICIPATE IN RESEARCH STUDY

I, Tebogo Mokoena………, a student at the University of South Africa hereby invite you to participate in a research to be conducted with teenage mothers. Teenage pregnancy exists throughout South Africa and in other African countries. I would invite you to answer a few questions on your experience as a young parent.

These questions that I want to ask will assist educators, the government and other organisations to understand your situation ensuring they can be well informed. Please understand that you are not forced to participate in this research and the choice is yours on whether you want to take part or not. I would really appreciate if you do share with me your experiences. You will not be affected in any way if you agree to take part, you can also decide to stop at any time and if you do, you will be affected in any way.

This interview will be confidential and will last approximately 45 to 60 minutes. Whatever you are disclosing to me, will remain between us. I also ask for permission to record the interview. The choice of whether to record or not is yours. If you allow me to record the interview, I will not mention your name on the recording. You are free to mention if you want the recorder to be switched off at any opinion during the interview. The interview will take about one hour. I humbly request that you be honest and open as possible in answering the questions.

If you have any questions or concerns, please contact the researcher.

Name: Tebogo Mokoena………………………………………

Email address: tebogomkn@gmail.com

Contact: 0769064891

APPENDIX C: CONSENT FORM FOR THE INTERVIEW AND RECORDING

I ……………………………………………… (Full names of participants) hereby confirm that I understand the aforementioned information and the nature of the research project. By signing below, I acknowledge that I have read and understand the above information. I am aware that I can discontinue my participation in the study at any time.

Participant's understanding

- I agree to participate in this study.
- I understand the purpose and procedures of the study.
- I understand that I will not be identified by name in the final product.
- I acknowledge that the contact information of the researcher was made available to me along with the duplicate copy of this consent form.
- I am aware that all records will be kept confidential in the secure possession of the researcher.
- I understand that I may withdraw from the study at any time.
- If I have any further questions\concerns or queries related to the study, I understand that I may contact the researcher.
- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

Participant's Full Name: …………………………………….

……………………………………. ……………………………………….

Participant's Guardian Date

APPENDIX D: BIOGRAPHICAL QUESTIONNAIRE

Kindly mark the applicable answer below with a tick ☑

Personal Information

1. Age 13 - 14 15-16 17- 18

2. Gender: Male F Female

3. School grade ………………………

4. Location/ area………………………

5. How long have you been in that area?

……………………………………………………………

6. How many children do you have?

APPENDIX E: INTERVIEW SCHEDULE

Study title: EXPLORING THE IMPACT OF TEENAGE PREGNANCY ON DISADVANTAGED ADOLESCENTS IN MPUMALANGA

Interview code number …..........

Did falling pregnant at an early age change your life and affect your future?

……
………………………………………………………………………………………………………
……

What are the reasons for teenagers to participate in unprotected sex?
……
……
……………………………………………………………………………………………………..

Are there any contraceptive methods available to teenagers?
……
……
……………………………………………………………………………………………………..

What are the coping strategies used to cope with the challenges?
……
……
……………………………………………………………………………………………………..

Are there support programmes to assist adolescents in the community? ……
……
………………………………………………………………………………………………..