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Title: Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

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LIST OF ABBREVIATIONS:

SRH - Sexual and Reproductive Health

HCW- Health Care Worker

LO- Life Orientation

GBV- Gender-Based Violence

CSE- Comprehensive Sexuality Education

WHO- World Health Organisation

DECLARATION

I, Natheerah Holtman, declare that **Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape** is my work, it has never been submitted before at any other institution and all the sources used or quoted have been indicated and acknowledged by using complete references.

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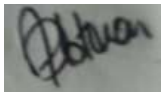
Signature: 

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DEDICATION

This study is dedicated to:

- To the Almighty God, with whom all things are possible;
- To my mother for the sacrifices she made for my basic education, which has enabled me to be successful in my career life;
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ABSTRACT

Background: The sexual reproductive health information needs of teenage girls are unmet in developing countries. This coupled with poor information-seeking behaviour to acquire appropriate SRH information and understanding of how the body works as well as misconceptions about contraceptive use expose teenage girls to unintended pregnancies and school dropout.

Aim: The study aimed to explore the sexual reproductive health information needs, and barriers of teenage girls at a high school in the Western Cape.

Methodology: A qualitative research method with exploratory, descriptive, and contextual research design was used for this study. The targeted population was teenage girls aged 16–17, across Grade 11. Purposive sampling was used to select participants. In-depth semi-structured interviews were conducted with 17 participants, which were audio recorded and transcribed verbatim. Data were analyzed using thematic analysis.

Findings: Themes that emerged from the study are inadequate knowledge about sexual and reproductive health, poor attitudes towards seeking sexual and reproductive health information, and certain behavioural patterns of teenagers negatively impacted meeting their sexual and reproductive health information needs. Social factors such as family norms, community and religious norms, financial constraints, and associated stigma also negatively influenced teenage girls' information needs and information-seeking behaviour in terms of using sexual and reproductive health services. The most frequently reported barriers were poor parent-teenager communication, nurses' negative attitudes, and the inconvenient operating hours of the clinics.

Conclusion: The information needs and information-seeking behaviour of teenage girls are influenced by many factors, which include the personal perceptions of the teenagers as well as environmental factors such as family, friends, the school, unfriendly health services, and the community.

Recommendations: There is a need to improve teenage girls' sexual and reproductive health knowledge and their decision-making power, parental/guardian, and school support systems in the use of sexual and reproductive health services at the school level are crucial. Improve access to relevant sexual and reproductive health information at schools. Address the negative attitudes of health personnel at clinics and create a safe and friendly environment for teenage girls to access and utilize sexual and reproductive health services without compromising their school class time.

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CHAPTER ONE

OVERVIEW OF THE STUDY

1 Introduction

This chapter presents an overview of the background to the research, both from a global and a local perspective, background information on the study, the rationale, and the problem statement. The chapter also presents the study's aim, objectives, and significance. Lastly, an outline is given of the subsequent chapters of the thesis.

1.1 Overview of the study

The health and social consequences of teenage pregnancy are serious and wide-ranging, with pregnancy and childbirth complications being the second leading cause of death among teenage girls globally (World Health Organisation, 2018). Family Planning 2020 is a global initiative founded in London in 2012 to make modern contraceptives accessible to an additional 120 million women by 2020 (Lince-Deroche et al., 2020). South Africa has retained and expanded its sexual and reproductive health rights (SRHR) policies in the areas of abortion, contraception, youth, and human immunodeficiency virus (HIV) treatment. However, persistent socio-economic inequities and gender inequality continue to affect South African women's SRHR (Erasmus et al., 2020). The Sustainable Development Goals (SDGs) of 2015 include universal access to sexual and reproductive health (SRH) information and services. Both strategies were adopted by South Africa, but the country has struggled to make progress on health-related SDGs for various reasons (Lince-Deroche et al., 2020). The National Contraceptive Policy Guidelines released in 2001 and updated in 2012 focused on the right of

all women to choose a contraceptive method and stressed the quality of care (Lince-Deroche et al., 2020).

This research study was conducted to understand the SRH information needs of teenage girls to prevent pregnancy, specifically at high schools in the Western Cape. Teenage girls' SRH needs include improving their knowledge about contraception and improving their information-seeking behaviour. Teenage girls require to be educated about their menstrual cycle as well as to understand the mechanism of action of contraception and conception.

1.2 Background

Globally, about 16 million teenage girls younger than 19 years give birth each year, accounting for about 11% of all births, with 2 million of these girls being under the age of 15 years; these pregnancies occur across all brackets of socio-economic status and countries (Balanda-Baldyga et al., 2020). However, it was reported that about 95% of teenage pregnancies were in developing countries, especially in Africa (Odimegwu & Ugwul, 2022). Sub-Saharan Africa had the highest prevalence of fertility among young women, and more than 82% of these pregnancies were accidental (Mjwara & Maharaj, 2018). Contributing factors that increased the risk of pregnancy for these teenagers were a lack of SRH information, including information about contraception, receiving incorrect and misleading information from their friends, and unwillingness to seek information from nurses because of their negative attitudes (Odimegwu & Ugwul, 2022).

Another source of misleading information came from teenagers watching pornography with no restrictions, which was common among those teenagers without parental supervision (Brody, 2018). SRH challenges such as teenage pregnancy could be coupled with low socio-economic status, poverty, and a lack of parent-child communication about SRH information (Odimegwu

& Ugwul, 2022). The poor information-seeking behaviour of teenage girls to acquire appropriate SRH information and an understanding of how their body functions, as well as the misconceptions about contraception, expose teenage girls to unintended pregnancies (Indongo, 2020). Many teenagers did not know that females can fall pregnant without having sexual intercourse, and teenagers who were not aware of how to prevent pregnancy or those who were told to abstain from sex were more likely to become pregnant than those who had adequate SRH information (Brody, 2018).

As a primary socializing agent of teenagers, parents are acknowledged as the primary source of information about sexuality for teenagers, and they are trusted (Indongo, 2020). However, teenagers found it embarrassing to talk to their parents about sex and it was also challenging for parents, who therefore left this responsibility to teachers and healthcare professionals (Mjwara & Maharaj, 2018). Parents found it difficult to approach the subject of sex with their children and, as a result, the teenagers were left with little option but to obtain the information elsewhere (Mjwara & Maharaj, 2018). Religiously conservative parents wanted the threat of unintended pregnancy to act as a deterrent from engaging in sexual activity, resulting in poor parent-child communication and guidance (Spadafino, 2017).

The high rate of teenage pregnancy may be attributed to the poor sex education at schools because it is not mandatory and some faith-based schools are not providing it as part of their curriculum (Indongo, 2020). Schools face the dilemma that even though they may recognize the importance of preventing teenage pregnancy, they believed that informing teenagers about contraception would encourage them to be promiscuous (Brody, 2018).

A teenage girl is in the process of physical development and gaining social maturity, and early pregnancy jeopardizes her successful transition into adulthood (Mare et al., 2022).

In South Africa the fertility rate among young people is still high, with almost 23% of young women having a child during their teenage years; the majority of pregnancies among teenagers were unplanned (Mjwara & Maharaj, 2018). More than 30% of teenage girls became pregnant every year, while 65% to 71% of these pregnancies among the youth were unplanned (Amoo et al., 2018). Despite the teenage pregnancy rate declining from 30% in 1984 to 23% in 2008, it still contributed to 13.6% of the births registered in the country in 2016, a rate far higher than in any other high-income country (Amoo et al., 2018). In South Africa, a range of health policies and programs exist to address teenage pregnancy, including school-based sex education, peer education programmes, teenager-friendly clinic initiatives, and mass media interventions, but despite these, the number of teenagers becoming pregnant remains high (Qolesa, 2017).

The Western Cape Province had the lowest number of teen pregnancies in the country, but there was still a need for SRH education and awareness to prevent teenage pregnancies at schools (Schafer, 2018). In 2017 it was reported by the Western Cape Provincial Education Department that 79% of teenage girls in the province were sexually active, of whom only 35% were using contraceptives (Schafer, 2018). The Department of Basic Education observed that about 68 000 school-going learners had given birth to at least one child in 2013 (Amoo et al., 2018). Even though SRH education was provided in some schools, the programme was reportedly not having the desired outcomes, as reported by the Department of Health, as a result of the lack of relevant information available to teenage girls, (Indongo, 2020). Stigmas regarding teen sexuality were formed and believed, due to the lack of information about contraception, and these restrict teenagers from visiting their local clinics for SRH information and services (Willan et al., 2020). Teenage girls at school are not being empowered effectively regarding their SRH, because teachers limit their teaching around the subject of Life Orientation, and often feel the need to be sensitive when addressing SRH issues to avoid

overstepping their boundaries and offending anyone (Mpondo et al., 2018). Based on a study done in a South African school, it is evident that teenagers need much more information about the prevention of pregnancy and should be assisted to develop an awareness of potential threats to their sexual safety and to learn skills for preventing or coping with such situations (Ramalepa et al., 2020).

Despite the increasing availability of contraception and other SRH services at public clinics, the negative and demoralising attitude of healthcare workers (HCWs) limits accessibility. It has been reported that the nurses' disrespectful behaviour often hinders teenage girls from gaining access to and utilisation of SRH services (Jonas et al., 2019). The nature and quality of relationships shared between a teenager and their parent/s can have a major influence on the decisions that they make about sexual activities. Teenage girls are reluctant to discuss issues of SRH with their parents and often experience anxiety because their parents are very strict and SRH is considered a taboo topic at home; therefore, it is usually avoided (Smith, 2020). Teenage girls seem to have poor decision-making skills, as they trust their peers, boyfriends and nurses to make decisions for them about their SRH. Teenage girls know how important the use of a condom is but still allow their boyfriends to make the final decision whether to use one or not, indicating their disempowerment with a lack of decision-making skills and trust in themselves (Mpondo, et al., 2018). The main obstacles hindering teenage girls from accessing and utilising SRH services are the misconceptions and myths that exist around contraception (Jonas, et al., 2019).

1.3 Rationale for the study

The motivation for doing this study was to gain a better understanding of the perspectives of teenagers and their experiences regarding teenage pregnancy by exploring their SRH information needs and barriers to such information, as well as by investigating their information-seeking behaviour in the Western Cape. Information about how to prevent teenage

pregnancy and the methods of doing this are available in the Western Cape, yet teenage pregnancy seems to be the norm. In the research area, there are alarmingly high rates of teenage pregnancy, and this study therefore aimed to ascertain the views of teenage girls on the information they needed to prevent teenage pregnancy. Once the findings of the study have been evaluated and understood, they could be used to bridge the gap between teenage girls and the prevention of teenage pregnancy, empowering their future by creating new opportunities.

1.4 Problem statement

In South Africa, more than 50% of female teenagers became pregnant due to a lack of knowledge about contraception, and 55% did so because they did not understand the risk of becoming pregnant (Mjwara & Maharaj, 2018). Contraceptives were misunderstood and therefore few young people chose to use them; many of those who do use them do so incorrectly and inconsistently (Schafer, 2018). The main factor contributing to teenage pregnancy was the lack of SRH information about contraception (Jonas et al., 2018). Many parents enforced religious beliefs to try and prevent sexual behaviour among their teenagers; this limited them significantly to only receiving information from their friends (Spadafino, 2017). Teenagers are at a tender age where they wish to explore their sexuality; however, intergenerational discussion of sex was still taboo, and as a result, young women were not informed about the protective measures that could be taken to prevent unplanned pregnancy (Mjwara & Maharaj, 2018). A large gap concerning the lack of information provided to teenagers around their SRH has been identified. This indicated a need to conduct a study to explore teenagers' information needs on SRH, their understanding of contraception and the consequences of using contraception incorrectly, which would assist in planning the prevention of teenage pregnancies.

1.5 Research questions

The following research questions guided the study:

- What are the SRH information needs of teenage girls at a high school in the Western Cape?
- What is the SRH information-seeking behaviour of teenage girls at a high school in the Western Cape?
- What are the barriers to meeting the SRH information needs of teenage girls at a high school in the Western Cape?

Interviews were planned and implemented to gain in-depth data which guided the understanding of the SRH information needs of teenage girls at a high school to prevent teenage pregnancy in the Western Cape.

1.6 Aim of the study

The study aims to explore the SRH information needs and barriers of teenage girls at a high school in the Western Cape.

1.7 Objectives of the study

The objectives of the study are as follows:

- To explore and describe the SRH information needs of teenage girls at a high school.
- To explore and describe the information-seeking behaviour of teenage girls at a high school regarding their SRH.
- To explore and describe barriers to teenage girls' access to SRH information.

1.8 Significance of the study

The findings of this study will serve as an indication to healthcare professionals, the school, communities as well as parents on the SRH information needs among teenage girls in the Western Cape to prevent teenage pregnancy. This informs healthcare providers as to what health education to promote to teenagers when having consultations about their SRH, and how to bridge any information gaps that exist. It is predicted that parents and communities should be made aware of their influence on teenagers' choices in lifestyle, and the need for better communication about their SRH development. The information collected could assist the South African Government with future research when developing new policies and strategies that address the lack of information that teenage girls have regarding their SRH, to prevent teenage pregnancy.

1.9 Operational definitions

Teenager: Also called a 'teen', a person who falls between the ages of 13 and 19 years (Collins English Dictionary, 2018). This study refers to girls between the ages of 16 and 17 years.

Teenage pregnancy: Refers to conceiving when between the ages of 13 and 19 years (Balanda-Baldyga et al., 2020). In this study, it refers to girls aged 16–17 years having unprotected sex without using methods to prevent pregnancy due to their lack of knowledge thereof.

Information needs: An information need is a recognition that your knowledge is inadequate to satisfy a goal (Maungwa, 2017). In this study, it refers to the SRH information needed by teenage girls to prevent pregnancy.

Information-seeking behaviour: This arises as a consequence of a need perceived by the information user, who searches for information to satisfy it, and finally transfers the information obtained (Maungwa, 2017). In this study, it refers to the behaviour of teenage girls in seeking and searching for information, and sources they refer to for guidance about their sexuality.

Sexual and reproductive health (SRH): This is a state of physical, emotional, mental and social well-being concerning sexuality, and not merely the absence of disease, dysfunction or infirmity (World Health Organisation, 2019). In this study, it refers to the well-being of young women regarding their sexuality and the information they require to prevent teenage pregnancy.

1.10 Conceptual framework: Information-seeking behaviour model

Since 1961, Wilson focused on information management and information-seeking behaviour and developed a series of information behaviour models (Kundu, 2017). Models of information-seeking behaviour describe an information-seeking activity, the causes and consequences of that activity, or the relationships among stages in information-seeking behaviour (Kundu, 2017). Information-seeking behaviour models were developed to study information-seeking behaviour in various social settings and to assist researchers in understanding different situations that predict actions by individuals who are seeking information (Thindwa et al., 2019). Some methods of information seeking are better termed acquisition instead of seeking, because it may take the form of unintentional seeking, for instance when an information user listens to the radio and receives information that they need (Savolainen, 2019). Information seeking is referred to as active searching and it differs from information acquisition, which is passive searching; the former signifies intentional pursuit, while the latter places more emphasis on the reception of information (Savolainen, 2019).

Information-seeking behaviour includes active searching through face-to-face communication and passive reception of information when the information that is needed is received without the information user searching for it, unintentionally (Makinde & VelileJiyane, 2020).

Wilson suggested that information-seeking behaviour occurs as a result of a need for information as perceived by an information user, who satisfies their need by using information sources or services, which results in either success or failure to find relevant information (Savolainen, 2019). Wilson's 1981 model aimed to outline the various areas covered by what he proposed as 'information-seeking behaviour' as an alternative to 'information needs' (Kundu, 2017). Wilson's second model of 1981 was described as a macro-model of information-seeking behaviour, stating that firstly, an information need originated out of physiological, cognitive and affective needs, and secondly, that the enquirer was likely to be challenged with barriers of different kinds which prevented the actual search for information (Maungwa, 2017). There is an integration between personal needs (psychological needs, cognitive needs and affective needs), the individual's social role (work-related responsibilities, expectations to perform) and external environmental factors (work environment, socio-cultural environment and physical environment) which makes a person realise that there is a need for information, and as a result, they try to look for information by overcoming potential barriers (Makinde & Velilejiyane, 2020). Wilson's (1996) model of information behaviour shows how information-seeking barriers develop during attempting to meet information needs, and these are psychological, demographic, role-related or interpersonal, environmental and source characteristics (Kundu, 2017).

Wilson's second model of information behaviour was suitable to address the research aim of this study, to explore the information needs of teenage girls to prevent teenage pregnancies. Identifying the SRH information needs of teenage girls is essential, as most teenagers are vulnerable. The figure below describes the application of the conceptual framework to this study. Wilson's second model of 1981 consists of 3 stages, namely, information needs, barriers and information-seeking behaviour (Maungwa, 2017).

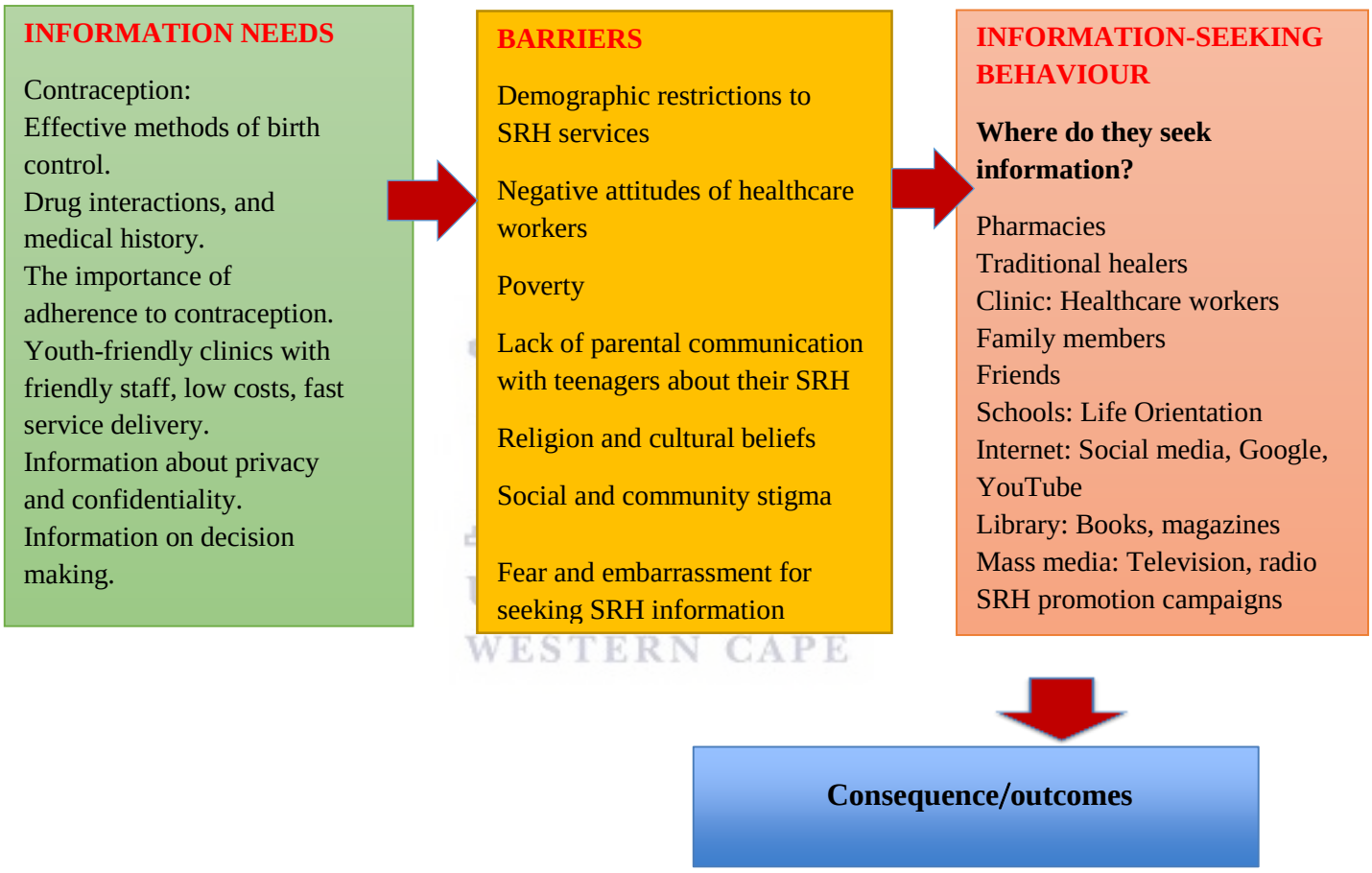

Figure 1: Application of Wilson's information-seeking behaviour model (1981) to the study (Maungwa, 2017)

Information needs comprise the information that teenage girls require to influence their process of thought when making decisions about their SRH, such as contraception. Limited discussion of all hormonal contraceptive methods, condoms and the absence of condom demonstrations to young women is a cause for concern (Chersich et al., 2017). They were

unaware of all the side effects of contraceptives, and lack an understanding of their human anatomy, specifically their SRH (Indongo, 2020). Information regarding youth-friendly clinics and HCWs as well as cost-effective and fast service delivery are also needed. There is a need for information about their human rights and patients' rights regarding privacy and confidentiality. These girls were not aware that they have a right to make their own decisions, especially concerning their SRH (Mpondo et al., 2018).

Barriers that have been identified are poverty, demographic restrictions to SRH services, unfriendly HCWs, lack of parental guidance, interpersonal religion and cultural beliefs, social stigma and fear of embarrassment (Kusheta et al., 2019). Poverty led teenage girls to vulnerability, exposing them to men who could offer them money or drugs in return for sex – often unprotected sex (Kusheta et al., 2019). Health facilities are not easily accessible to teenage girls due to their location as well as their fear of being recognised by the community. The teenage girls reported negative attitudes on the part of HCWs at the clinics; most of them are judgemental and their appointments were always rushed, leaving no time for an in-depth discussion about contraception (Kusheta et al., 2019).

Information-seeking behaviour is where teenage girls may seek information at pharmacies, traditional healers, HCWs at clinics, family members, friends and schools (Esmaeilzadeh et al., 2018). Information about preventing pregnancy and using contraception is available to teenage girls. Those girls who had access used resources such as the internet, social media, Google or YouTube, books and magazines. The information is also accessible through mass media portals such as television, radio and SRH promotion campaigns.

1.11 Outline of the study

Chapter One: The first chapter of this study is an introductory chapter which sets the stage for the entire research study.

Chapter Two: Chapter Two presents a review of the relevant literature related to SRH information needs, information-seeking behaviour and the barriers faced by teenage girls.

Chapter Three: This chapter presents the qualitative research methodology that was used in this study.

Chapter Four: Chapter Four presents the findings of the study

Chapter Five: Chapter Five presents a discussion of the findings

Chapter Six: Chapter Six provides a summary of the findings, the limitation of the study, recommendations based on the findings, and a conclusion.

1.12 Summary

Chapter One presented an introduction and background to this study. It provided a problem statement, the aim and objectives of the study and key research questions. Operational definitions and the significance of this study were also described, as well as the theoretical framework applied to the study.

The following chapter presents the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review conducted on the information needs related to SRH services, including contraceptive use, the decision-making of teenage girls, and access to and confidentiality of information. The literature review discusses the barriers to teenage access to SRH services, focusing on HCWs' attitudes, poor decision-making skills, lack of parental guidance, stigmatization and socio-demographic factors. The chapter also discusses the information-seeking behaviour of teenage girls and sources of SRH that are mostly used by teenage girls to prevent pregnancies. Lastly, a summary of the chapter is provided, highlighting the main review findings and gaps that were identified.

2.2 Search strategy

Among the numerous databases and websites available to search literature, the researcher used databases such as CINHAL, Medline, PubMed, WHO SRH databases, EBSCOhost, EMBASE and the Cochrane Library. A combination of journals, scholarly articles and grey literature, such as theses, was used. The researcher searched for literature from open-access journals such as *BMC Women's Health*, research articles and other sources including *SAHARA-J* and the Academia website, international journals such as *Global Health Action* and the *Pan African Medical Journal*, and Elsevier. Google Scholar, PubMed Health and Research Gate were used to find articles that were relevant to the study.

The keywords used to navigate through the literature were: teenage information need, teenage pregnancy, SRH information and teenage girls' lack of SRH information, teenage pregnancy and contraception use including side effects, schools, healthcare workers' attitudes and teenage

pregnancy, youth-friendly services, teenage girls' information-seeking behaviour, parent-child communication and teenage pregnancy, school sex education and curriculum, culture, religion and barriers to prevention of teenage pregnancy.

2.3 SRH information needs of teenage girls

South African teenage girls lack information about contraception, and it was evident that this caused the incorrect use of contraceptives (Qolesa, 2017). There is a need for information regarding SRH, such as the consequences of teenage pregnancy, to empower teenage girls to steer away from unprotected sex (Amoo et al., 2018). To enhance the prevention of teenage pregnancy and the development of health literacy in South Africa, there is a need for SRH knowledge to facilitate the development of health literacy on SRH services for teenagers. However, the problem of providing teenage SRH persists, such as low self-esteem and expectations among teenage girls, with many living in poverty and areas with high unemployment rates (Kitching et al., 2019). Peer groups are seen as important structures where girls can teach each other about sexuality; however, the information received is usually misguided and often leads to risky sexual encounters (Mpondo et al., 2018). Many teenagers have poor knowledge about their SRH and receive incorrect information or misinformation about SRH from school, friends and family (Skosana et al., 2020).

2.3.1 Reasons for use and non-use of contraception

The majority of sexually active teenage girls in a study by Kalamar et al. (2018) indicated that they never used contraception while, others reported using it incorrectly, which greatly increased the potential for unwanted pregnancies. Teenagers who use contraception frequently are unaware of all the techniques available and are negatively influenced by their peers and the media, which may lead them to select an improper method (Obiako, 2021). Teenage girls in South Africa have limited knowledge of contemporary contraceptive methods, including oral

contraceptives, injectable contraceptives, patches, spermicidal agents, and sterilisation, to name a few (Hlongwa et al., 2020). They also lack knowledge of the intrauterine device (IUD) and emergency contraceptive pill (ECP), including the best times to take them and any potential side effects (Hlongwa et al., 2020).

Teenage girls' restricted options for contraception are problematic, and they also lack knowledge of female condoms and information on how they differ from male condoms (Chikovore, 2020). Due to the poor sex education in South Africa, teens have little awareness of SRH and lack the skills necessary to put that knowledge into practice. As a result, very few teenagers use a condom during coitus (Qolesa, 2017). Condoms are free for teenagers, but there is no information about their proper use or that they are the least effective method of contraception, after the withdrawal method. This misleads teenagers to believe that condoms are 99.9% safe when they are being used (Brody, 2018). Limited discussion of all hormonal contraceptive methods and condoms, and the lack of demonstrations of condoms for young women, were cause for concern (Chersich et al., 2017). Female condoms are free, but rarely advertised, and the gap in knowledge about all contraceptives available to teenage girls has widened, statistically declining from 67% to 50% between 2008 and 2010, except for among women living with HIV (Erasmus et al., 2020). Despite the ill effects of unwanted pregnancies, teenagers have poor knowledge of SRH contraception and the physiology of conception, and limited access to sex education at home and at school (Skosana et al., 2020).

2.3.2 Decision-making skills of teenage girls regarding their SRH

Teenagers should have the necessary information, skills, and health education to make safe and informed decisions about SRH regarding pregnancy prevention (Singh et al., 2019). The process of knowing when to start, stop, or switch contraceptive methods, including condom use, is complex for teenagers, thereby influencing their decision-making process (Davids,

2019). Teenage girls' bargaining power for contraception is weakened by gaps in SRH information, which affects how to negotiate safe sex, make beneficial decisions, and avoid consequences (Hlongwa et al., 2020). Teenagers' decision-making is often at greater risk than that of adults because it is based on arousal and emotional reactions. They don't use condoms, because to their mind you trust and love your partner. Therefore, a key factor in improving a teenage girl's SRH knowledge is improving her decision-making ability (Davids, 2019). Decisions are made based on the information collected and how the teen perceives that information (Davids, 2019). SRH information that is not shared with teenage girls directly influences their sexual health decision-making (Skosana et al., 2020).

2.3.3 SRH service delivery to teenage girls

Teenagers indicated that using contraception is "boring and dangerous", this statement was directed towards the myths heard about the use of contraception and the misunderstood information about side effects attached to each contraceptive method (Schafer, 2018). Teenage girls are uncomfortable about visiting the local clinic for SRH services; this indicates the need for sexual education and access to the services (Schafer, 2018). Friendly SRH service delivery for teenage girls is an important factor in deciding to seek services again. It is unlikely that a teenager who received poor services would be interested in seeking the same services in the future (Jonas et al., 2018).

Effective contraceptive counselling and the provision of resources to expand access are crucial elements of the teenage SRH vehicle programme, because modern contraceptives like the Implanon implant, IUDs, oral and injectables, are quite effective when used properly (Gerancher, 2017). When a clinician consults with a teen, they tend to focus on cautions about the risks associated with their SRH difficulties, rather than addressing their concerns about contraception; this results in a lack of thorough SRH education for the teen and false beliefs

about contraception (Yakubu & Salisu, 2018). The HCW should address the teenage girls' needs, expectations, and concerns about contraceptive information, despite the patient's age or history of sexual behaviour.

2.3.4 Access to SRH information needs

In South Africa, it was discovered that the Black and Coloured communities had higher rates of teenage pregnancies (Obiako, 2021). This was significantly impacted by unfavourable preconceptions, such as false beliefs about condoms and the absence of accurate knowledge regarding contraception and condoms on the part of these vulnerable teenage girls (Obiako, 2021). Due to sex education in schools frequently being focused on teaching abstinence and protection, rather than SRH holistically, this method of instruction was ineffective (Pieterse, 2019).

Comprehensive Sexuality Education (CSE) was adopted in schools, but many of these initiatives lacked sufficient material on female condoms and other forms of contraception, such as the emergency pill (Venketsamy & Kinear, 2020). The curriculum content was inadequate, since important SRH topics like knowledge of sexually transmitted diseases, abortion, and where to find condoms and SRH services, were lacking (Venketsamy & Kinear, 2020). The use of contraceptives in schools and the promotion of better attitudes and beliefs around teen sexuality called for more education and awareness (Khoza et al., 2019). Although South Africa's 2012 Integrated School Health Policy (ISHP) outlines SRH care for youth, it has been challenged that SRH services are delivered in schools, despite the ISHP, pregnancy rates did not decline and services were underutilized (Bolarinwa & Boikhutso, 2021). Due to issues including unqualified teachers and the lack of absorption of the subject into the educational system, the Life Orientation subject could not be taught properly (Bolarinwa & Boikhutso, 2021). According to estimates, 13% of teenage girls dropped out of school because they

became pregnant, and some of them experienced bullying or exclusion at school (Erasmus et al., 2020). This shows how Life Orientation courses in schools do not educate teenagers adequately about sexuality (Erasmus et al., 2020).

The Life Orientation course is offered in schools, but the SRH curriculum fell short of equipping teenage girls with the knowledge they needed to make educated decisions about their sexual health, leaving them vulnerable to misinformed peer advice (Mpondo et al., 2018). Life Orientation instructors were not always adhering to the curriculum, which decreased the standard of SRH instruction in classrooms (Jonas et al., 2019). Instructors were frequently uncomfortable when tutoring SRH and generally, they did not want to deal with sensitive motifs; also some instructors lack the skills to give appropriate advice, and both of these reasons negatively affected the delivery of SRH information to teenage girls (Venketsamy & Kinear, 2020). Instructors may take an authoritative position when discussing SRH with teenagers, and this may have hindered their capacity to effectively engage and teach the Life Orientation course, which rebounded in poor delivery of SRH information to teenage girls (Pieterse, 2019). Instructors who taught Life Orientation depended on exemplary dispatches to deliver SRH information to teenagers, and this increased the responsibility for SRH laid upon teenage girls, and being authoritative instructors left no room for these girls to discuss their particular questions around SRH (Pieterse, 2019). Peer pressure at school contributed to teenage pregnancy, as many of these girls had little to no knowledge about their SRH, and weren't informed about this by their parents or community, as this is generally a taboo subject (Mtuta, 2019).

Professor Kadar Asmal (former South African Minister of Education) suggested an earlier start to educate teenagers about SRH, otherwise, they can be easily misled by their peers if proper guidance regarding their sexuality isn't given (Ramalepa et al., 2020). At most schools, sexual

health education is given in the form of a subject called Life Science, but most of the time they discussed sexually transmitted infections (STIs) rather than the prevention of early pregnancy (Brody, 2018). The effectiveness of this subject has been questioned, as there were allegations that schools and instructors were not doing enough and were avoiding their responsibilities (Ramalepa et al., 2020).

A previous study has shown that one in three teenagers at secondary schools in a district in North West Province were pregnant before reaching the age of 20 years, and an estimated 11 pregnancy terminations were done in girls younger than 18 years of age (Ramalepa et al., 2020). Teenage pregnancy was more likely caused by a lack of knowledge and information about sexual actions, which was encouraged by a lack of access to sex education at school; this was apparent in a study carried out in a South African school (Ramalepa et al., 2020). There was evidence that teenage girls did have lack of SRH information, as they received limited information both at home and school (Venketsamy & Kinear, 2020). Interventions that have been proven to be effective in promoting SRH were frequently delivered ineffectively, therefore having little influence on SRH knowledge, and teenage girls' attitudes, beliefs and behaviours, yet these interventions were still being enforced (Venketsamy & Kinear, 2020).

2.3.5 Privacy and confidentiality

Lack of confidentiality was an obstacle to meeting the girls' SRH information needs through SRH care services. Teenagers particularly valued confidentiality when associated with SRH services, as they are associated with sexual behaviour. We also considered clinics which are situated near schools to be less sensitive to this need, due to the risk of peer intrusion when visiting services (Pampati et al., 2019). Many teenagers did not fully understand the implications of confidentiality; about 90% of them understood that some information was kept confidential between doctors and themselves, and 76% thought that physicians may inform their parents if a laboratory test was done on them (Pampati et al., 2019). These teenage girls

were emotionally fragile and often scared to seek SRH services, especially contraception because their rights to privacy and confidentiality of information were often ignored and disrespected by the HCWs (Jonas et al., 2019; Pampati, et al., 2019). The lack of privacy experienced by teenage girls at the clinics discouraged them from enquiring and exploring more information about SRH from services rendered (Yakubu & Salisu, 2018).

The American College of Obstetricians and Gynaecologists (ACOG) recommends that HCWs work together to develop procedures to protect teenage girls' privacy and confidentiality, discuss SRH with parents or guardians during the first visit, build relationships and outline expectations (Gerancher, 2017). The lack of confidentiality at clinics is one of the reasons why teenage girls do not seek information from HCWs – they are worried that others might notice them and become aware of the reason for their visit, and inform their parents (Khoza et al., 2019). Therefore, teenage girls are reported to be less likely to turn to SRH services because of this concern. SRH services were more likely to be used by teenage girls who had private consultations with clinicians without parental supervision or consent than those who had not (Fuentes et al., 2018). Teenagers find it difficult to disclose their SRH information to clinicians because they fear being judged and their sense of privacy is often questioned, especially during genital examinations, which make them feel uncomfortable and embarrassed (Schantz, 2018). Teenagers do not trust medical facility record-keeping systems to protect confidentiality, since electronic records and digital reminders are not fully protected (Schantz, 2018). Teenage girls risk a denial of privacy and confidentiality when they use their parents' medical assistance systems as beneficiaries, since the billing process may inform parents of what the medical assistance was used for (Fuentes et al., 2018).

2.4 Barriers to information-seeking to prevent teenage pregnancy

Six barriers have been identified as the main contributors to teenage pregnancies: HCWs' attitudes, poor decision-making skills and influences, lack of parental guidance, demographic limitations, stigmatisation, and poverty. Each of these barriers is discussed below in detail.

2.4.1 Healthcare workers' attitudes

Teenagers were usually advised to go to their nearest clinic for information or services to prevent pregnancy, but they were afraid of being judged by the nurses and the community, making them feel embarrassed or angry, resulting in them not going to the clinics (Mjwara & Maharaj, 2018). The quality of SRH services that teenagers received was an important factor in whether or not they would ever seek services again (Jonas et al., 2018). The barriers teenagers faced to accessing and utilising SRH services resulted in delayed care-seeking, under-utilisation of services, unintended or unwanted pregnancies, and unsafe abortions (Jonas et al., 2018). Teenage girls described how fear of criticism and stigmatization by healthcare providers discouraged them from accessing SRH services (Essop, Tolla, Lynch and Makoae, 2018).

In South Africa, many HCWs expressed unprofessional, judgmental behaviour towards teenage girls seeking SRH information and services, which leads to discrimination (Mokomane et al., 2017). The HCW does not allow teenage girls to come to the clinic for contraception, exposes the negative attitudes of nurses towards them, and creates an unfriendly environment for accessing SRH services and information, creating barriers for these teenage girls (Smith, 2020). As a result, of the fear of HCWs' negative attitudes, teenage girls found it difficult to access SRH information and services (Mokomane et al., 2017). Teenage girls found it difficult to receive quality SRH services because of the general social stigma directed towards them for seeking these services (Jonas et al., 2017). Negative behaviour towards them by healthcare

professionals (such as ignoring their privacy and confidentiality rights) limited access to information about SRH and left these teenagers discouraged (Jonas et al., 2017). Nurses do not respect teenage girls who seek SRH services and information and become rude and short-tempered towards them before turning them away without any SRH services (Smith, 2020). It has been reported that the nurses' disrespectful behaviour often hinders teenage girls from accessing and utilization of SRH services (Jonas et al., 2019).

In a youth clinic, a teenage girl was embarrassed to ask for SRH information or services after being asked by an HCW to show her a used sanitary towel before receiving contraceptives (Chersich et al., 2017). HCWs had judgmental attitudes towards teenage girls who sought SRH information and therefore failed to provide the requested information and privacy and confidentiality to these girls (Chersich et al., 2017). HCWs often did not respect the privacy and confidentiality of teenage girls, which caused a sense of unease for the girls, who felt that they may be seen by community and family members, who may disclose their intentions to their parents; this hinders the teenager from returning to the clinic for SRH services (Smith, 2020).

2.4.2 Barriers to decision-making skills among teenage girls

Teenage pregnancies are often unplanned. This is caused by many factors that influence a teen's birth control decision; for example, peer pressure, and parents who don't allow their children to use condoms (Khoza et al., 2019). Socio-ecological factors such as gender, power, and cultural and religious views influence teenagers' decisions, and this controls their use of condoms (Webster, 2019).

Teenage girls' moral judgement of themselves caused them to not use contraception because they felt ashamed and religious beliefs strongly influenced their decisions (Khoza et al., 2019). Religious beliefs influence teenagers' decision-making processes regarding the use of

contraception because it implies that they have or are planning to have premarital sex, which is frowned upon in most religions, such as Catholicism (Khoza et al., 2019). South African teenage girls were particularly vulnerable as socio-cultural and religious beliefs encouraged submission to their male partners and impeded their decision-making process (Mbatha, 2021). Limited information on female condoms in South Africa results in inconsistent condom use among teenage girls. As such, exposure to risky sexual practices impairs a teenage girl's decision-making power (Davids, 2019). The nurse influenced the teenage girl's choice of method and/or continuation of the method through her biased advice influenced by her personal experience and opinions (Lince-Deroche et al., 2020). Teenage girls lack the autonomy to ensure the correct and consistent use of a contraceptive method, and their first sexual debut is usually coerced by gender-based violence (GBV) (World Health Organisation, 2020).

Reproductive coercion is created through various forms of abuse to maintain power and control in a relationship and is often aggressive, such as piercing a condom or removing it during sex without consent. It often takes the form of contraceptive interference and forms of reproductive compulsion (Webster, 2019). This interference influences women's decision-making regarding all aspects of SRH and may be associated with increased rates of physical, sexual, or psychological abuse in relationships, so teenage girls may be more susceptible than their adult peers to such abuse (Gerancher, 2017). Male partners are usually reported as perpetrators of physical abuse of female partners that causes emotional distress, and disapproval by male partners contributes to contraceptive misuse among teenage girls (Hlongwa et al., 2020). A teenage girl acknowledges that her male partner has made the contraceptive decision and refuses and advises against condom use to maintain ownership of her body and his claim to having sex with her (Masilo & Makhubele, 2017). Gender inequalities in a relationship undermine teenage girls' decision-making skills either to reject sex or bargain for the use of contraceptives (Yakubu & Salisu, 2018).

Fear has often been cited as influencing information processing as part of the decision-making process, resulting in a loss of attention to risk-related information (Davids, 2019). Denial of consensual sex provokes physical violence against girls, makes them reluctant to leave their families, and leaves them vulnerable and incapable of making decisions due to their low or limited self-esteem (Duby et al., 2021). Disempowered by gender inequality, South African women agree with their male partners not to use condoms just for the sake of gratification and the fear of being abandoned (Govender et al., 2018).

GBV among teenage girls is prevalent in urban areas of Cape Town, where they are reportedly physically and emotionally abused by their partners and forced to have sex without a condom (Onukwugha et al., 2019). In Cape Town, teenage pregnancy is largely the result of intergenerational relationships, where GBV and forced sex exacerbate power inequalities and prevent teenage girls from having safe sex with male partners, which decreases their ability to negotiate (Mkwananzi, 2017).

2.4.3 Teenage girls' lack of parental guidance and influences

Parents perceive that early exposure to contraceptives leads teens to engage in sexual activity and this may be a barrier to early contraceptive use by teenage girls (Makola et al., 2019). Parents were quick to dismiss or scold their teenage daughters when they initiated topics about boys or SRH (Mpondo et al., 2018). Parents were reluctant to address emotional issues related to their teenage daughter's developmental level, and discussion of SRH was avoided (Mpondo et al., 2018). Most parents believe that their children are too young to discuss SRH issues and that initiating this discussion may encourage premarital sex (Kusheta et al., 2019). Parents are often strict, and teenage daughters fear being scolded or misunderstood if they try to initiate discussions about SRH; they also fear that they will be prevented from having access to relevant SRH information (Kusheta et al., 2019). Teenagers felt comfortable disclosing to their peers

rather than their parents or community members because many parents enforced religious beliefs to try and prevent sexual behaviour among their teenagers (Spadafino, 2017).

Traditional African and Christian beliefs influenced parents' decision not to discuss SRH with their teens (Chikovore, 2020). Parents felt that it was shameful to discuss the issue of SRH with their teens, in part because of their cultural and religious beliefs that did not allow such discussions or the use of condoms; also, they believed that this issue should be discussed at school and not with them as parents (Kusheta et al., 2019). In South Africa, adults are embedded in a culture that silences teenage sexuality through strong values and beliefs in avoiding discussing sex issues and focusing on the negative consequences of sex (Essop et al., 2018).

Cultural beliefs prevented young women from obtaining information about SRH from their parents or adults, as discussions of sexuality were considered offensive and culturally inappropriate, especially for teenage girls (Mbatha, 2021). Teenagers from child-headed households perceived little hope for their future and often had less incentive to avoid pregnancy (Odimegwu & Ugwul, 2022). Preventing pregnancy was not their primary concern; therefore, they practised reckless sexual behaviour as they did not have the luxury of parental guidance (Odimegwu & Ugwu1, 2022). The impact of family structure provides both protection and risk for teenage pregnancies. This is because a teenage girl is strongly influenced by the circumstances in which she lives, especially during her teenage years. This is what shapes self-control, risk assessment, and resistance to peer pressure (Odimegwu & Mkwananzi, 2018). Teenage girls who share strong relationships with their parents and with whom they have open discussions about their SRH are known to have a later sexual debut, have fewer sexual partners, and are more likely to use contraception (Skosana et al., 2020). Pregnant teens blame the lack of parental guidance, as many South African mothers are not encouraged to talk to their teens

about sexual issues, and as a result, teens are shunned from gaining information and deprived of a primary source of guidance (Skosana et al., 2020).

Many parents threaten their teens and state that they must avoid sex rather than discuss issues because of embarrassment or upbringing, resulting in teenagers' poor information-seeking behaviour due to the fear that is instilled in them (Schantz, 2018). Teenage girls whose parents were reluctant to use SRH services and who did not participate in SRH conversations were less likely to use these services to find accurate SRH information (Khoza et al., 2019). Living away from family support structures leaves teenage girls vulnerable to risky sexual behaviour with no parental guidance, which may increase their sexual activity (Hlongwa et al., 2020). Teenage girls who seek SRH information and services fear that their parents will punish them for finding out about them having premarital sex, and as a result, they will not use these services, even if they do have access to them (Makiwane et al., 2018). Teenage girls are disadvantaged when they receive no or limited parental guidance on SRH, and are unable to make informed sexual choices, with inaccurate or incomplete SRH information shared between parents and teens, leading to teenage pregnancies (Masilo & Makhubele, 2017).

2.4.4 Socio-demographic factors

Teenage girls were faced with different costs connected with searching for SRH information, such as travel costs, costs for managing possible side effects associated with using contraception, and the cost of psychological strain caused by possibly being discriminated against or forced to use contraception that they have not chosen (Lince-Deroche et al., 2020). The decrease in the use of contraception among teenage girls has been related to socio-demographic factors such as coming from a rural area, having a low educational background, having low socio-economic status, limited knowledge on accessibility to SRH services, and lack of awareness about contraceptives (Makola et al., 2019). Long-distance travelling time to

the healthcare facilities hindered accessibility to SRH services, which increased the risk of teenage pregnancy (Jonas et al., 2017). The use of contraception and the method of choice are associated with the race and socio-economic status of the female and geographical level, with a noticeable difference between poor and wealthy districts (Chersich et al., 2017).

The injectable contraceptive method remains the dominant one in the Western Cape, particularly in low and middle socio-economic status communities, where choices of contraception are limited and stock is insufficient for the growing population (Chersich et al., 2017). There is an identifiable link between a teenage girl's race, level of education, socio-economic status and method of contraception. For instance, it was reported that educated girls living in richer areas were more likely to seek and use SRH services than those who had no education and lived in underprivileged areas (Chersich et al., 2017). Teenage girls are rendered vulnerable to teenage pregnancy if their parents have low socio-economic status because they find it difficult to afford basic needs and contraception (Yakubu & Salisu, 2018). Higher levels of teenage pregnancy have been identified among Black and Coloured South Africans, and this is the result of differences in socio-economic status, as it is evident that lower levels of education increase the likelihood of teenage pregnancy (Mkwananzi, 2017). Teenagers who had a higher level of education were more knowledgeable about SRH information and services than those who never attended school and those who attended school but did not complete their schooling (Munakampe et al., 2018).

2.4.5 Stigmatization

Teenage girls' resistance to seeking SRH information and services branched from their fear of being labeled as promiscuous (Makola et al., 2019). Stigma and discrimination by HCWs are common, with HIV-positive, unmarried, and teenage girls particularly at risk (Lince-Deroche et al., 2020). The stigma surrounding contraception prevented the use of it by teenagers, who

proposed that the use of a condom or carrying one led to a teenager being considered as being "loose" (Munakampe et al., 2018). Teenagers are afraid of being stigmatized, which results in their reluctance to access and make use of SRH services (Nyblade, et al., 2019). Healthcare providers shamed, interrogated and scolded teenage girls and at times refused to render services to them, which caused these girls to become victims of stigmatization (Nyblade, et al., 2019). Stigma and discrimination are obstacles preventing teenage girls from seeking SRH information and the delivery of this service to them, which raises concerns in the public health sector (Hussein & Ferguson, 2019). Gender, marital status, poverty and age, to name a few, are factors that contribute to how stigma and discrimination are perceived, anticipated or experienced by teenage girls specifically when they seek SRH information (Hussein & Ferguson, 2019).

Teenage girls who need to obtain SRH services such as contraception or abortion are reluctant to do so due to the societal stigma attached to teenage pregnancy; they fear being judged, teased and discussed among others (Duby et al., 2021). The fear of discrimination that teenage girls were challenged with from community members and HCWs reduced their access to SRH services (Munakampe et al., 2018). Stigma and discrimination forced many teenage girls to seek unsafe abortions due to their fear of disclosure of their pregnancy, shame and embarrassment in their community and family, as they faced stricter social norms around sexuality than boys did (Nyblade, et al., 2019).

2.4.6 Poverty

Poverty could lead to desperation for money, resulting in teenage girls participating in unprotected sexual activities with men 5–8 years older than themselves (NACOSA, 2018). Impoverished teenagers were vulnerable to abusive relationships and risky sexual behaviour, as they depended on their sexual partner/s to take care of them financially, rendering these girls

unable to negotiate safer sex, such as using a condom (Mbatha, 2021). Poverty was described as leading to young women having to depend on men or putting men before themselves; this resulted in issues including physical and emotional abuse by partners, pressure from partners to have sex or have a baby, and partners not wanting to use protection (Onukwugha et al., 2019).

Teenage girls located in impoverished areas have poor access to information about their SRH and related services (NACOSA, 2018). Children born to teenage mothers are more likely to become teenage mothers themselves, due to the cycle of health and social risks, such as living in low socio-economic areas and not completing school, resulting in poor living circumstances (Khoza et al., 2019). Many teenage girls with a poor educational background are financially dependent on men because they cannot get a job or they lack familial support, causing them to fall prey to risky sexual behaviour such as putting men before themselves regarding the decision whether to use a condom or not (Onukwugha et al., 2019). In South Africa, poverty and unemployment among the Black and Coloured communities are higher than in other racial groups, which leads to much higher statistics of teenage pregnancy in these population groups (Mkwananzi, 2017). Single parents may also be more prone to poverty and financial constraints that increase their levels of parental frustration and may be too busy to discuss issues of SRH with their teenagers, therefore disregarding and ignoring the topic (Amoo et al., 2018).

Teenage girls living in poverty were not motivated to finish school, rendering themselves as potential victims of 'sugar daddies' and being dependent on these men for money (Masilo & Makhubele, 2017). Once a teenage girl has finished school, she finds receiving a tertiary education impossible due to financial constraints and/or finds getting employment difficult; therefore, many decide to have babies so they can receive a social grant (Makiwane et al., 2018). Some teenagers look at the government grant as financial support and continue to have

unprotected sex, using their fertility as their way of making money; hence the Child Support Grant is contributing to this reckless behaviour (Malatji & Malatji, 2021).

2.5 Information-seeking behaviour

Teenagers who are equipped with the skills to search and access SRH information are effective information seekers, compared to their counterparts who lack these skills (Rugambwa et al., 2020). Teenage girls were more in need of SRH information than boys, and the quality of SRH information, from teenagers' perspective, had to be truthful, correct, valid and reliable (Esmaeilzadeh et al., 2018). Personal needs are the foundation of the motivation to seek information and the users' behaviour in searching for information was affected by this (Jayasundara, 2021). The view was that in order to find ways and means to satisfy these SRH information needs, the individual would seek such information (Maungwa, 2017).

2.5.1 Seeking information from family, teachers, peers and healthcare providers

Some teenage girls turned to their friends or close family member – not necessarily their parents – for SRH information or encouragement to attend the nearest clinic for assistance (Onukwugha et al., 2019). Teenage girls were exposed to SRH information at school through the Life Orientation subject taught by teachers or by reading relevant school textbooks (Onukwugha, et al., 2019). They struggled to seek information from public clinics due to the challenges they faced, such as the judgmental attitudes of many healthcare providers (Erasmus et al., 2020). Teenage girls searched for SRH information from multiple sources, including health institutions, doctors, and/or nurses (73.5%), school (38.2%), the media (23.5%), family (20.6%), and friends (16.2%) (Onukwugha et al., 2019). Parents, teachers and peers were recognized as sources for teenagers to seek SRH information from, as were Youth Unions that visited schools, community leaders, and traditional healers, who were easily accessible; however, parents are the preferred source (Munakampe et al., 2018).

Parents are the preferred source of information compared to teachers, healthcare providers and other family members, but teenagers wished that their parents were more open to discussing the topic of SRH with them, because the information received from the other sources was not adequate (Munakampe et al., 2018). Teenagers discuss their SRH matters with their peers, who most often provide misleading information and encourage sexual behaviour, which consequently puts them at risk of an unintended pregnancy (Jayasundara, 2021). Teenagers not only obtain SRH information from their peers, but they are commonly relied upon for counselling when they encounter sexual problems (Masilo & Makhubele, 2017). A teenage girl's desire to seek SRH information is influenced by her peers; for instance, if her friends were teenage moms, then she most likely would become one as well (Govender et al., 2018).

2.5.2 Seeking information from the internet and social media

The media was recognized as one of the sources for teenagers to seek SRH information from, including television broadcasts and the internet (Munakampe et al., 2018). The internet and social media were the most important information sources used by teenagers to obtain health information related to high-risk behaviours such as teenage pregnancy (Esmaeilzadeh et al., 2018). Social media, multimedia and cell phones are popular among teenagers when seeking information about contraception, sex and pregnancy (Govender et al., 2018). The most important sources to obtain health information related to high-risk behaviours performed by the teenagers were "the Internet" followed by "virtual social media", and the least important source to obtain such information was "radio" (Esmaeilzadeh et al., 2018). Parents have indicated that their teenagers prefer searching for SRH information from the media, such as watching television and browsing the internet than by asking them questions; however, they believed that the media puts their teenagers at high risk of experimenting with risky sexual behaviours (Kucheta et al., 2019).

In South Africa, most teenagers have access to social media and websites such as Facebook, which has become a new avenue for sharing information, providing direct communication with faster results, enabling teenagers to share their knowledge and information about SRH at alarming rates (Shava & Chinyamurindi, 2018). Facebook remained the most popular social networking site in South Africa, followed by YouTube and Twitter, with at least 22% of the 12 million Facebook users being between 13 and 18 years of age (Shava & Chinyamurindi, 2018). Teenage girls experienced freedom of expression on social media, which facilitated them being able to chat about all issues that affect them, such as SRH, and empowered them (Shava & Chinyamurindi, 2018). Teenagers used social networking sites as information sources for personal as well as educational needs (Philippe, 2018). YouTube is a place where teenagers go to satisfy their information needs through video information seeking, and such behaviour could play a part in the development of information practices and literacy (Philippe, 2018). Teenagers search for SRH information via the internet and commonly use their cell phones for access, which also promotes easier communication between peers and partners, motivating early sexual debut (Yakubu & Salisu, 2018).

The internet was found to be the most common way for teenagers to search for SRH information, and this included social media, government websites, live chats, instant messaging like WhatsApp, and online communities, because they could easily express their feelings without being stigmatized or judged (Pretorius et al., 2019). Online resources are not affected by socio-economic status or level of education, and this was beneficial to teenagers because it ensured privacy, anonymity, easy accessibility, immediacy, inclusivity, and the ability to connect with others to share experiences, and gave them a sense of control over how they search and receive the information that is needed (Pretorius et al., 2019). Teenagers tend to search the internet because it promotes anonymity, so they acquire information about sex and sexuality

from media including magazines, television and advertising, leaflets, books and websites; however, the reliability and validity of these sources may not be sound (Jayasundara, 2021).

The internet may be beneficial in many circumstances, but it can also be dangerous, where teenagers may have poor understanding of the information received online as no guidance is available to them; also, privacy and confidentiality are not promised, and this source of information is often unreliable and not trustworthy (Pretorius et al., 2019). Teenagers have grown up being influenced by technology, especially the internet, and as a result there has been an increase in their exposure to pornography by exploring images and videos to satisfy their curiosity about what sex is all about, without knowing if the information received is reliable or not, which seriously affects their sexual development (Jayasundara, 2021). Explicit sexual content affects the development of a teenager's brain, causing psychological problems; this could lead to promiscuity or early sexual debut, and issues such as depression and prevention of long-term relationships, even with their parents, because they are taught to bond with an illusion and not a person (Huerta, 2018). Teenagers are usually inadvertently exposed to pornography when browsing the internet, and often this leads to them wanting to see more to tame their curiosity, developing an internal battle between rational thinking and reward seeking (Huerta, 2018).

2.6 Summary

The literature review assisted to conceptualise the key terms and objectives related to this study. Various trends regarding teenage girls' information needs, the barriers they are challenged with and their methods for seeking information were identified. Lack of SRH information and interpreting it incorrectly, causing risky sexual behaviour, and early sexual debut were discussed as individual level factors influencing teenage pregnancy. Nurses' negative attitudes, limitations set by cultural and religious beliefs, parental values and communication with

teenage girls, and the SRH information gap at schools were discussed as social level factors influencing teenage pregnancy. Lastly, structural factors that were reviewed included poverty, stigmatization and health system factors.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the ways in which the researcher approached the study and aspects relating to the research methods used. The research approach and design, research setting, target population, sampling and methods used for data collection and data analysis, as well as the measures taken to ensure ethical compliance and the trustworthiness of the study, are addressed.

3.2 Research approach

A qualitative research approach was employed to conduct the study. The study focused on words rather than numbers, exploring the thoughts, opinions and feelings of participants, based on their personal experiences. Qualitative research is more appropriate for studying human perception, as it allows the researcher to gather the data in the form of words instead of numbers; its focus on the qualities and meanings of the phenomenon as expressed by the participants (Busetto et al., 2020). This allow the discussion between the researcher and the participants, which enhance investigating in-depth meanings as experienced by the participants (Cropley, 2019). Open-ended questions were used to allow participants the freedom to discuss matters around the topic, generating a two-way conversation between the researcher and participant. In this study the researcher has explored and gained a deeper understanding of the participants' SRH information needs and barriers that prevented access to the information, which enabled the generation of new ideas and knowledge. Qualitative research is a method of enquiry which focuses on in-depth aspects of the meaning, experiences and opinions of the selected participants, with the aim of understanding a phenomenon from their perspective (Busetto et al., 2020). The qualitative research approach allowed the researcher to investigate

this phenomenon as expressed through the views of teenage girls and to record the data as it was expressed in their own words, providing descriptive data.

3.3 Research paradigm

Constructivism is an approach that states that human beings construct their own understanding and knowledge of things through experiences and reflecting on those personal experiences (Ahmad et al., 2020). Knowledge is constructed based on personal experiences of the environment. Constructivism also uses observation to gather information; knowledge is a human product and is socially and culturally constructed (Ahmad et al., 2020).

The constructivism paradigm is associated with the qualitative research approach. An exploratory qualitative study within the constructivist paradigm was undertaken, which allowed reflection on individuals' personal experiences connecting new knowledge to the knowledge that they already had. It focused on a single concept or phenomenon and brought personal values into the study. The paradigm aimed to understand the phenomenon being studied, extracted from the experiences of the participants by using in-depth interviews (Ahmad et al., 2020).

Constructivism promote diverse viewpoints, it encourage participants to reflects their experiences, and they construct their own knowledge and that reality is determined by their experiences. Therefore, a constructivist paradigm was chosen to explore teenage girls' SRH information needs, barriers to this information and their information-seeking behaviour, and to describe their personal experiences in their own words. Participants were able to freely disclose their experiences, thoughts and feelings in their own words without limitations.

3.4 Research design

The core property of qualitative research is that it examines the way people make sense out of their own concrete real-life experiences in their own minds and in their own words; this information is usually expressed in everyday language using everyday concepts (Cropley, 2019). Qualitative methods are no longer regarded as mainly useful because they make it possible to deal with data that (regrettably) is unsuitable for statistical analysis, but are regarded by many researchers nowadays as offering a legitimate means for gaining information about and understanding of how human beings function (Cropley, 2019). A qualitative exploratory, descriptive and contextual research design was chosen to conduct this study, to both explore and describe the verbal reports on the SRH information needs of teenage girls at a high school in the Western Cape. The design was chosen to allow female teenagers who experienced early pregnancy (either directly or indirectly) to narrate their SRH information needs, information-seeking behaviour and barriers they were challenged with as they have experienced it. Semi-structured interviews were used to collect data. Descriptive research was used to accurately describe the data based on the experiences of participants, expressed in their own words.

3.4.1 Exploratory research

An exploratory study design was used for this study. The aim of this study was to explore the SRH information needs, information-seeking behaviour and barriers to access to information among teenage girls at a high school in the Western Cape. A study begins by exploring the full nature of a phenomenon, the manner in which it is manifested, and other factors to which it is related, including potential factors that might be causing it (Hunter et al., 2019). The researcher used the study's conceptual framework to explore and describe the SRH information needs of teenage girls at a high school, the information-seeking behaviour of these teenage girls regarding their SRH, and barriers to teenage girls' access to SRH information.

3.4.2 Descriptive research

Descriptive research was used to accurately describe the perceptions of participants with regard to the objectives of this study. A descriptive design is used to determine current problems in a practice and is used where more information is required (Busetto et al., 2020). A descriptive research design is intended to answer questions about the current state of variables for a specific group of individuals (McCombes, 2019). The design was not concerned with relationships between variables, but rather with the description of individual variables.

3.5 Research setting

The research setting is described as an environment in which the research study takes place, and can be a natural or controlled environment (Qolesa, 2017). The study was conducted at a high school in Mitchells Plain located in the Western Cape, populated by low- and middle-income families. This school was purposively chosen because it is a diverse school catering to all ethnic groups, it is one of the drug infestated area, and the high school is in an area with low-and middle-income families, where the prevalence of teenage pregnancy could be higher. The school served a total population of 61 757 out of Mitchells Plain's total population of 310 485 (Frith, 2011). The percentage of the total population according to race was as follows: Black 6.10%, Coloured 92.63%, Indian 0.40%, White 0.10% and other 0.76% (Frith, 2011). The language spoken in the area was predominantly Afrikaans (68.36%), followed by English (26.20%) and isiXhosa (2.99%) (Frith, 2011). There are a number of different religious groups in the area: 55.09% Christian, 25.85% Islamic, and 0.46% other (Frith, 2011). Female teenagers between the ages of 16–17 years were the target group identified for this study.

3.6 Research population

Bhandari (2022) defines a population as all elements, individuals, objects or substances that meet the criteria for a study. A population may be either broadly defined, when thousands of individuals are involved, or narrowly specified when the population includes a small number

of people (Heradien, 2019). The population targeted were female teenagers aged 16–17 years, who had directly or indirectly experienced teenage pregnancy, identified at a high school in Mitchells Plain in the Western Cape, across Grade 11. The target age group was more likely be identified at this grade. Some learners may have begun high school earlier than others, hence the young age of 16 years when in Grade 11; others may have failed a grade, and therefore the researcher extended the age range to 17 years. The study population was estimated at 112 girls across Grade 11 at this school.

3.7 Sampling technique and sample size

Purposive sampling is a non-probability sampling method, where participants are selected because they are likely to generate useful data for the study (Nikolopoulou, 2022). Purposive sampling was useful to select participants who were more knowledgeable about the phenomena of the study and to have more of the information needed for the study. A sample represents a part of a whole or a subset of a larger set (Busetto et al., 2020). Purposive sampling was chosen to select the participants. Seventeen (N=17) participants were selected for the initial sample size; however, the final sample size would be determined by data saturation. According to Hunter et al. (2019) data saturation is the collection of data in a qualitative study to the point where a sense of closure is attained, because any new data yields redundant or repeated information. Grade 11 girls were addressed in a short meeting where the aim and objectives of the research study and its significance were discussed, to explain the importance of voluntary participation. All participants were able to speak English or Afrikaans; this was ensured to avoid any language barriers which may result in inaccurate findings.

3.8 Inclusion and exclusion criteria

The inclusion and exclusion criteria for selecting participants for the study were as indicated below:

Inclusion criteria	Exclusion criteria
• Teenagers aged 16–17 years • Experiences of teenage pregnancy, either personal or have knowledge thereof through a close contact	• Teenage girls who appeared afraid and unsure • All none grade 11 teenage girls are excluded

3.9 Development of interview guide questions

The purpose of this research was to explore the SRH information needs of teenagers who have directly or indirectly been affected by early pregnancy due to their lack of information about prevention. The interview questions were designed around the study's conceptual framework and developed based on the literature review to address the objectives of the study. A semi-structured interview allowed the participants to express their opinions and feelings on the phenomenon without the restrictions of closed-ended questions or the interviewer's opinions. The questions in the semi-structured interview were self-developed for the purpose of the study based on the conceptual framework used. The purpose of the interviews was to obtain data from the participants as they are useful for addressing the aim and objectives of this research study. Questions were formatted to identify barriers of whatever nature, whether religious, poverty, poor healthcare services, or the like. The researcher also focused on identifying the different ways in which the young girls sought information regarding their SRH, which determined the truthfulness and reliability of the information received. The questions consisted of a limited number of open-ended key questions. The predetermined, open-ended, probing questions were used as a guide to engage the participant in a discussion based on the objectives of the study. The researcher asked questions such as 'Please explain your understanding about SRH' and 'Please explain what challenges you are faced with when searching for SRH information' (see Appendix 1).

3.10 Probing

Probing was achieved by asking the participants neutral questions such as 'Tell me more', and 'Please elaborate'. McPheat (2022) describes probing as a verbal or non-verbal prompt that is made by the researcher when participants need to provide a more detailed answer. Probing can also be useful to bring participants back on track, if they begin to wander off topic from the question posed by the researcher (Heradien, 2019). An examples of a probing question is 'Please tell me more about your experiences when searching SRH information from clinics, the school or your family' (see Appendix 1).

3.11 Pre-testing of interview guide questions

According to Busetto et al. (2020) the purpose of a pilot interview is to test the accuracy of the instrument, to establish whether the participant would understand the open-ended questions posed to them, and to identify possible vagueness of any questions. A pilot test was conducted on two teenage girls from the study population. Assent forms were handed out to the willing participants as well as a consent form which the participants gave to their parents/guardians; they returned this signed, to confirm their participation. The aim of pre-testing of the study was to test the appropriateness of the interview guide questions and to provide the researcher with some early suggestions on the viability of the research. It also facilitated the researcher's gaining experience in conducting interviews and building rapport with participants, and assisted the researcher to learn the skills for interviewing and maintaining the flow of conversation. The results of the participants used in the pilot study were used.

3.12 Data collection procedure

Data collection was conducted after ethics clearance was obtained from the University's Ethics Committee. A permission request letter was sent to the school and the Department of Education to seek access onto school grounds in order to conduct the study and initiate the interviews, to make sure that the study was ethical. Permission to access the high school and learners was

gained from the Department of Education. A meeting was held on a date agreed with the school to debrief the teenage girls in Grade 11 about the purpose of the study, and they received information regarding the aim and significance of the study and the schedule of interviews. The researcher explained the purpose of the study, and during the information session the assent forms were handed out to willing participants, as well as consent forms which they gave to their parents/guardians. The participants were requested to read and sign the assent forms to express their willingness to participate in the study; these were returned signed to confirm their participation. Printed copies of information sheets pertaining to the research study were distributed to the participants for their use as well as copies for their parents/legal guardians.

Semi-structured interviews were conducted by the researcher herself with each participant. The aim was to get an in-depth understanding of the matter under investigation; therefore, the questions that were posed to the participants allowed for discussion between researcher and participants. The questions asked were in line with the objectives of the study, and two to three probing questions were used per objective. Before the interviews took place participants were informed that their confidentiality and anonymity would be respected and upheld. Participants were asked for permission to use a voice recorder to record the interview, so that information would not be lost, and permission was granted. Each participant had their own time slot for interviews to avoid recognition by others. The interview was conducted during school time with the permission of the school's principal and the Department of Education. Learners' attendance was not as usual due to a rotational schooling system in order to abide by social distancing and COVID-19 restrictions. The duration of the interview was estimated at 30 minutes. Participants were assured that they could seek clarification if they did not understand the questions. The researcher listened and encouraged discussions, and provided an opportunity for participants to talk more. The researcher used an audio recorder and field notes were taken

while the researcher observed the participant's facial expressions and body language. Data collection continued until data saturation was reached.

On the date of the data collection, the researcher organised the list of participants with the assistance of the assigned teacher, to arrange which participant would be going first and when the next participant could be called. The teacher assisted the researcher with getting participants ready for the interview and keeping order throughout the process. Due to the rotational classes occurring at the school, no lessons were disrupted.

The interviews were done face to face and field notes were taken by the researcher, based on observations made of each participant. Probing questions such as 'Can you tell me a little bit more about X', 'Please tell me more about X', and 'Please elaborate more on X' were used by the interviewer to clarify interesting statements and relevant issues raised by the participant. Teenage pregnancy and SRH is a sensitive topic to discuss, so when participants were asked about their use of contraception, their knowledge about side-effects of contraception, SRH being taught at school and who they talk to regarding their SRH information needs, most participants became shy and giggled as they answered. Some participants would laugh at each question asked because they were nervous and shy. All participants maintained good eye contact, irrespective of their reluctance to answer a question. Some participants were more verbal than others and shared a lot more of their experiences. The participants seemed to be comfortable in sharing their experiences, maintaining a relaxed posture and co-operative discussion.

As the researcher was conducting the last interview there was repetition of existing findings, with very little new data emerging, indicating data saturation. Data collection was discontinued, when data saturation was reached on 17 Interviews. The researcher checked and confirmed that

all the necessary documents, reports and audio were collected before leaving the school on the last day.

3.13 Data analysis

The data gathered were analysed using deductive thematic analysis and the six steps of data analysis according to Braun and Clarke (2022). Thematic analysis was used as it allowed the researcher to search and identify themes from the transcribed data (Ward et al., 2018). The data analysis began with the transcription of the individual participants' audio recordings. The data collected were all completed in English, transcribed verbatim by an independent transcriber and checked by the researcher. Field notes were read while listening to the recordings to ensure consistency of the data. The researcher made additional summaries of ideas which arose during the interviews. The interviews were transcribed by reading, rereading and listening to the transcripts of the participants. This was done to comprehend their communication about SRH matters and to identify any errors or missed information in order to increase credibility (Nowell et al., 2017).

After the data were transcribed, the researcher began generating codes as per the second step of analysis. The transcribed interviews were coded manually. Codes were assigned to phrases, expressions or behaviours that emerged from the participants' answers to the interview questions. The participants' views were analysed, compared and contrasted with the objectives of this study and the literature. The study's objectives and conceptual framework guided the researcher during this process. Reflexive journaling was used to contribute to the establishment of an audit trail, becoming auditable evidence to support the trustworthiness of the study.

The development of themes would take place in the third step of analysis. Themes were created from the codes produced in step two, by grouping similar codes from the data based on the participants' own language and interpretations. Themes emerged based on the SRH information

needs of participants that were recognised, the barriers to accessing the SRH information, such as the lack of parental guidance, and the information-seeking behaviour of the participants. The researcher developed a set of categories and then assigned information to its specific category.

In the fourth step themes were reviewed and refined. The researcher read the entire data set again to ascertain whether or not the themes worked in relation to the study's conceptual framework, research questions and objectives. At the end of this step the aim was for the researcher to have a good idea of what the different themes were, and the overall story they tell about the data collected. The codes and themes that emerged from the analysis by the researcher and supervisors were compared, discussed and refined accordingly.

Defining and naming themes took place in the fifth step of analysis. For each theme, a detailed analysis was conducted and written. Potential sub-themes were identified to display the meaning within the data. Names should be concise, punchy, and immediately give the reader a sense of what the theme is about (Braun & Clarke, 2022).

The sixth step of analysis was the writing up of a report. The write-up of a thematic analysis should provide a concise, coherent, logical, non-repetitive and interesting account of data within and across all themes (Braun & Clarke, 2022). The report was written to tell the story of the data in a way that convinces the reader of the merit of the analysis. Direct and short quotes from participants were used to aid in the readers' understanding of specific points in the interpretations.

3.14 Reflexivity

Reflexivity refers to the researcher being actively involved in the research process and continuously reflecting on their values, recognising, examining, and understanding how their social background, location and assumptions affect their research practice (Palaganas et al.,

2017). The researcher, as a health professional maintained an awareness of reflexivity throughout the entire research process, by clarifying questions when the participants mentioned information which they assumed the researcher would know. The participants were made to feel safe to disclose any information pertaining to the interviews. This was done to reduce the risk of bias and being misled by the researchers' own experiences, knowledge and interpretations. The researcher kept a book during the research process to document and reflect her personal opinions and feelings regarding teenage pregnancy, to be aware of how these may influence data collection or data analysis.

3.15 Trustworthiness

Trustworthiness is one way in which researchers can persuade themselves and readers that their research findings are worthy of attention (Nowell et al., 2017). Trustworthiness is all about establishing credibility, dependability, confirmability and transferability. The objectivity of the researcher is important; therefore, the feelings and perceptions of the researcher did not play a role in the research. The data collected for this descriptive qualitative study was evaluated for trustworthiness.

Credibility is how confident the qualitative researcher is as to the truth of the research study's findings. In this study, the researcher used triangulation to show that the research study's findings were credible (Statistics Solutions, 2019). Triangulation asks the same research questions of different research participants, and collects data from different sources through different methods to answer the same questions (Devault, 2019). Triangulation aims to enhance the process of qualitative research by using multiple approaches, namely, methodological and data triangulation (Korstjens & Moser, 2018). Methodological triangulation was used by gathering data by means of different data collection methods, such as in-depth interviews and field notes (Korstjens & Moser, 2018). Numbers were allocated to participants to protect their identity and to link with direct quotations to enhance the credibility of the discussion and

findings. Information about the barriers to accessing SRH information, which contributes to teenage pregnancy, was obtained from teenage participants either directly or indirectly affected by pregnancy. Field notes were written during the interviews to ensure credibility of the data. Data triangulation was secured by using the various data sets that emerged throughout the analysis process, that is, raw material, codes, concepts and theoretical saturation (Korstjens & Moser, 2018). The researcher studied the data from the raw interview material until a theory emerged to provide the scope of the phenomenon under study. Information was probed during interviews until data saturated was reached. A detailed summary of the interview was written immediately after each interview to clarify the data obtained from participants and for confirmation of the data. To establish confidence in the truth of the findings, voice recordings were played repeatedly during report writing to ensure that all information was transcribed correctly. Suggested techniques to address credibility include activities such as prolonged engagement, persistent observation, data collection triangulation, and researcher triangulation (Nowell et al., 2017). The researcher also used a method called persistent observation. Developing the codes, concepts and core categories helped to examine the characteristics of the data (Korstjens & Moser, 2018). The researcher consistently read and reread the data, analysed the data and revised the concepts accordingly. The researcher recoded and relabelled codes, concepts and the core categories. The researcher studied the data until the final theory provided the intended depth of insight.

Transferability is how the qualitative researcher demonstrates that the research study's findings are applicable to similar situations, similar populations, and similar phenomena (Statistics Solutions, 2019). In this study, the researcher used thick description to show that the research study's findings were applicable to other contexts, circumstances, and situations.

Confirmability means that the findings, conclusion and recommendations are based on participants' responses (the transcripts and field notes) and not any potential bias or personal motivations of the researcher (Statistics Solutions, 2019). In this study the researcher provided an audit trail, which highlighted every step of data analysis in order to justify decisions made to accurately interpret participants' responses. Biased opinions of the researcher were eliminated by using direct quotes from the raw data, thus ensuring objectivity. The interpretation should not be based on the researcher's preferences and viewpoints, but needs to be grounded in the data (Korstjens & Moser, 2018). The researcher used a voice recorder during the interviews to ensure correct tracking of information during data transcription. The researcher also kept a notebook in which all activities that were carried out during the interviews were documented. The researcher's supervisors confirmed the interpretation of the data themes and responses identified by the researcher, thus ensuring that there were no discrepancies in the data analysis. In addition, all transcripts and soft copies of the study have been secured in storage on a hard drive and Google Drive, and are only accessible to the researcher. The researcher was responsible for providing a complete set of notes on decisions made during the research process, and the field notes and transcripts are available upon request. This allows the reader to follow the process of the research study and enabled the auditor to study the transparency of the research path.

Dependability is the extent to which the study could be repeated by other researchers and that the findings would be consistent (Statistics Solutions, 2019). In this study the researcher's supervisors reviewed and examined the research process and the data analysis to ensure that the results were consistent and could be repeated. The process of the study as well as the researcher's findings and interpretation of data were checked and discussed with the researcher's supervisors for debriefing in order to minimise bias.

3.16 Ethics consideration

The human rights and human dignity of all participants were treated with respect. An ethics clearance letter was obtained from the Humanity Social Science Research Ethics Committee at the University of the Western Cape and permission to conduct the proposed research study was granted by the Department of Education for the period from 23 March 2020 to 20 September 2021. Completed assent forms and consent forms were requested from all participants who met the research criteria.

Information was provided to the participants regarding the process of the study. The researcher explained to them that their confidentiality and anonymity of the information would be maintained during the study period, dissemination and publication of the results. Anonymity was ensured by keeping the recordings and the transcriptions of the recordings nameless. The names of the participants were protected as the researcher used numbers to identify each participant. In addition, the researcher ensured privacy in all personal identification of the participants during the interviews. Data collection was conducted in a private venue at the school which was safe and located away from the other classrooms. A 'Do not disturb' sign was placed on the outside of the venue's door to pose an instruction to those passing by. Recorded data are kept safe in a cabinet under lock and key and the soft data is protected on a desktop with a password to maintain and uphold confidentiality. Only the researcher and the supervisors have access to these. The data will be destroyed after five years from the completion of the study, by shredding the hard copy and deleting the soft copy from the computer (Liquori, 2022).

Participants were reassured that the information would only be used for the purpose of the study. Anonymity and confidentiality were enforced consistently throughout the study and beyond. Teenage pregnancy is evidently a sensitive topic to discuss and the possibility of

emotional instability among the participants were recognised. The researcher liaised with the Life Orientation teacher for guidance in referring participants who required psychological assistance to the school's social worker. Participants were informed about this information before data collection commenced.

3.17 Summary

This chapter introduced the qualitative research methodology that was used in this study and explains the process that was adopted in collecting the data. Data collection methods and tools that were used in the study ensured trustworthiness, and this was explained. The chapter also described the method that was used in analysing the data and the steps that were followed, according to Braun and Clarke (2022). Ethical matters that were relevant to the study were summarised and presented.

In the following chapter the findings of the study are analysed and interpreted.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 Introduction

This chapter comprises the analysis and interpretation of the findings that emerged from this study. The coded data was grouped into categories and sub-categories in accordance with their similarities and shared meanings. Themes were developed from these categories, which shared the central idea or underlying meaning. Three themes and ten categories emerged from the analysis. Verbatim quotations received from the participants were cited to enhance the credibility of the findings.

The characteristics of participants are presented, followed by a table presenting the main themes that emerged from the data, which are subdivided into categories and further divided into sub-categories.

4.2 Characteristics of the participants

The participants comprised 17 teenage girls between the ages of 16–17 years. This research setting is a predominantly Coloured area (16 Coloured participants and 1 Black African participant in the study), and all of them could write and speak the English language. This group of participants belonged to different religious groups and cultures: 13 girls belonged to the Christian religion and 4 to the Islamic religion. One participant indicated that she is a teen mom.

Not all of the participants' households were headed by both parents. Most participants lived with their mothers or grandmothers, and they were identified as the financial heads in the household. One participant indicated that she resides with her legal guardian. Most of the participants have siblings living with them. All participants are residents of the same community. The participants were complaisant during the interview process and maintained good eye contact with the researcher. These teenage girls displayed positive body language, which created a productive and satisfying

atmosphere. The interviews together with the field notes that were taken during them added richness to the findings.

Table 4.1 shows the themes, categories, and subcategories that emerged, with the application of the conceptual framework to the findings.

CONCEPTUAL FRAMEWORK	THEMES	CATEGORIES	SUB-CATEGORIES
Information needs (what is the information needed for effective understanding of SRH)	**1.** Information on reproductive health needs of teenage girls	**1.1** Teenage girls' understanding of SRH	1.1.1 SRH knowledge of teenage girls
		1.2 Knowledge about the different contraceptive methods	1.2.1 Lack of information about the different contraceptive methods 1.2.2 Information about the side effects of contraception 1.2.3 Misinformation/misinterpretation about the usage of contraception
Information-seeking behaviour (where do they seek information)	**2.** Teenage girls' reproductive health information-seeking, sharing and source of information	2.1 Teenage girls' SRH information-seeking behaviour for decision making	2.1.1 Teenage girls' information-seeking behaviour about the different types of contraception and their contraceptive choices 2.1.2 Teenage girls' information-seeking behaviour on sexual experiences
Barriers to information needs and information-seeking behaviour	**3.** Barriers to teenage girls' access to reproductive health information and risk factors	3.1 Barriers related to traditional and cultural/religious beliefs	3.1.1 Traditional beliefs 3.1.2 Cultural/religious beliefs
		3.2 Unavailability of user-friendly clinics	3.2.1 Nurses' attitudes and the availability of contraception. 3.2.2 Clinic times and accessibility
		3.3 Inadequate Life Orientation course	3.3.1 Life Orientation course related to SRH is not sufficient to prevent teenage pregnancy 3.3.2 Inadequate SRH counselling services at the high school

		3.4 Lack of access to the internet or compatible devices	3.4.1 Schools' restrictions to internet access 3.4.2 Availability of compatible devices
		3.5 Engaging in risky behaviour	3.5.1 Engaging in commercial sex 3.5.2 Drug/alcohol addictions

Table 4.1 Summary of themes and their respective categories and subcategories

4.3 Theme one: Information on reproductive health needs of teenage girls

SRH is a broad topic in the medical field, and learning about this aspect of the body may or may not be of importance to a teenage girl. In this study, it refers to the well-being of young women regarding their sexuality and the information they require to prevent teenage pregnancy. SRH is not only about sex, the human anatomy and physiology, specifically the reproductive organs are also included. This information should be taught and learnt at school; however, participants were not knowledgeable regarding this. Teenage girls with low education levels are at a higher risk of becoming pregnant than those with a higher level of education. This theme describes the insufficient knowledge that teenage girls have about their SRH. Many teenagers become sexually active while very young, and this poses a risk to them because they become vulnerable to falling pregnant. Early sexual contact is commonly associated with unsafe sex, lack of SRH knowledge, lack of access to contraception, and lack of skills to negotiate contraception.

When the researcher asked the participants about their understanding of SRH, not many girls could respond with a definition, indicating their lack in knowledge thereof:

> **P1:** I do not understand what sexual and reproductive health is.
>
> **P2:** I think it is about how you act sexually towards another person and how your sexual health is.

When a teenage girl is not equipped with knowledge about their SRH, it renders them vulnerable to many consequences, and teenage pregnancy is one of them. Certain participants were unsure as to the risk of conception during foreplay with their partners:

> **P9:** I am not sure what to do before and after having sex to prevent pregnancy. Like maybe there's something you have to do after that to prevent pregnancy. Also, I have questions like if

you're having sex with a partner and then he ejaculates inside you, can you fall pregnant? And even if he ejaculates on the outside on your private part, can you still get pregnant?

There are three categories discussed within this theme. The categories are further classified into subcategories, and these are all be presented below.

4.3.1 Category one: Teenage girls' understanding of SRH

The lack of knowledge about SRH is a key factor that contributes to teenage pregnancy. Participants could not define or describe the meaning of SRH but most of them were sexually active. Early sexual debut is often associated with negative psychosocial and health outcomes. In many circumstances pregnancy is accidental and this is often the result of risky sexual behaviour, which mostly arises due to the lack of knowledge about SRH. This is illustrated by the extract below:

> **P14:** Not much. It's almost like they're giving you advice not to have sex and if you have sex like what you must use to prevent pregnancy and stuff like that. But if you're at a young age obviously you can't have sex because you're not a big girl. You know what's right and what's wrong. You mustn't have sex before the time.

> **P1:** Just like sexual information and how many young girls fall pregnant. It is interesting to learn about how to take care of my body because I have a child already and I am not ready for another child.

> **P4:** I'm nervous [giggling]. All I know about SRH is that it is about having sex [giggling], but I'm still too young to have a baby. I know a person can use condoms to prevent falling pregnant, but further than that, I don't know.

These participants expressed that they have very limited SRH knowledge. They are poorly equipped with the necessary information needed to prevent an unwanted pregnancy. These answers provide evidence that these participants do have a lack of SRH information, increasing

their vulnerability to teenage pregnancy. Knowledge is power and these participants have limited SRH knowledge, rendering them powerless to protect themselves.

4.3.1.1 Subcategory one: SRH knowledge of teenage girls

Knowledge of SRH includes fertility and sexuality, explains the functionality of male and female sex organs, and so much more than just pregnancy. Many participants felt that having knowledge about their SRH is important, but they were not sure which avenues to follow in order to obtain the information desired. There is certain information about SRH that these participants are aware of, like that the use of contraception prevents pregnancy; however, they struggle to put into words what SRH entails. They are aware that SRH includes the reproductive organs but they are unsure regarding the mechanism of action when it comes to contraception, menstruation, hormonal changes in the body, and so on. When asked what SRH means to them, this is what participants had to say:

> **P12:** Like it's about sex and a person's SRH system, including the sex organs and how a female falls pregnant.

> **P3:** SRH is about having babies. Talking about sex and obviously reproduction. So that's about birth or whatever related to having babies.

Some participants had no idea what SRH entails or means to them. They found it difficult to explain and asked the researcher to explain it to them:

> **P5:** No, I do not understand what SRH is. Is it about having babies? I know about family planning, the injection, but that's all. Please tell me.

> **P6:** I don't know what SRH means. I don't understand it, please explain it to me. I know about some contraception to use to prevent getting pregnant but I don't know if that is part of SRH.

It is evident that there is a poor understanding of what SRH entails among these teenage girls, and this needs to be corrected.

One participant expressed her understanding of SRH as follows:

> **P10:** I have my grandma who had a few Pap smears, my mommy doesn't have a womb anymore and basically that's what I know. I never went for anything. I only had my fallopian tube or ovaries removed, I can't remember what it is called, but I know it's my inside female organs. My ovaries/fallopian tubes were low and the doctors removed some of it and then said I was fine afterwards. That's all as far as I know.

Another participant had questions that revealed a lack of knowledge of SRH:

> **P17:** I want to know if I go on injection or the tablets, in the future like in long-term, will it prevent me from having babies or stuff like that? Is there a possibility that it can cause something like that? I am not clear about that and what if your partner uses Viagra, will it have a side effect on you as the girl? Like if that person uses it every time they have sex, will it like have a side effect on me and not him?

Certain participants were unsure as to the risk of conception during foreplay with their partners and had questions about that. The lack of SRH knowledge among teenage girls is a huge causative agent of teenage pregnancy. Many participants verbalised what they have read up on certain SRH topics, but they showed no accurate understanding thereof:

> **P17:** SRH is about your ovaries and stuff like that, as well as STIs [sexually transmitted disease] and I think that's all, I don't know enough information about it.

> **P7:** I don't know what happens but they say when you have oral sex and use a vibrator and you put it in the vagina then you can get a yeast infection, but I don't know if that is true because I read about it on the internet and I experience something that looks like a yeast infection. I experience that but I don't know if that is the truth about the oral sex and that stuff.

Misunderstanding SRH information is a disadvantage to women in general, young or old, married or unmarried. Unplanned pregnancy may be an undesirable outcome for some women,

caused by their misunderstanding of methods to prevent pregnancy or how the human body functions through menstruation, fertility and conception.

4.3.2 Category two: Knowledge about the different contraceptive methods

Despite the variety of contraception that is available to females in the Western Cape, a considerable number of teenage girls are still faced with challenges with using them. Low contraceptive use has been associated with the lack of knowledge on accessibility and awareness of contraception. Using contraceptives correctly and consistently will contribute to a decrease in teenage pregnancy. Information gaps exist about the contraception knowledge and skills of using contraception correctly among teenage girls. Teenage girls might not be aware of the consequences and risks of engaging in unprotected sex and may misinterpret the use of contraception as they were not well informed regarding it. The following extracts illustrate this.

> **P7:** I only know that like it's there to help you to avoid having babies and stuff like that. But I don't think that's like 100 per cent also, because like my cousin she had a loop in but she got pregnant even though she had the loop in.

Teenagers in this study concentrated more on what they heard about the side effects of contraception rather than prevention characteristics. As a result, the use of contraceptives was low. On the question of whether the participants knew how to use the pill or the injection and how it works in the body to prevent pregnancy, this is what they stated:

> **P9:** No. I don't have a clue [laughs]. I've heard about female condoms but I haven't seen one and I don't know how to use it.

> **P8:** I know that with contraception females take it and they can have unprotected sex but they won't be able to fall pregnant.

P12: I actually don't know how the injection works or how the condom works. I am in a relationship and my boyfriend uses a condom. I heard about the injection but I don't know anything about the side effects and how it works in my body.

Participants expressed that they were not well informed about contraception. It was found that even though some young people are aware of the risks when practising unprotected sex, they nonetheless continue with the act. Participants explained about the importance of preventing pregnancy and that contraception is a way to do so. However, there were a few participants who comfortably declared that they had no intention of using contraception now or in the future because they felt that it was not safe.

4.3.2.1 Subcategory one: Lack of information about the different contraceptive methods

The low use of contraceptives is associated with limited knowledge and awareness about contraception. The lack of information about contraception prevents teenage girls from accessing it. The participants expressed their desire to increase their SRH knowledge to equip themselves with the correct tools for the ultimate protection against pregnancy. None of the participants wishes to be pregnant at this point in their lives. Participants expressed their concerns about not knowing how to use condoms correctly and not understanding the mechanism of action of contraception within the human body.

The most common contraception mentioned among participants was the injection, particularly the three-month injection, also known as Depo-Provera. Most of the participants heard that there was more than one contraceptive method available, but they did not know all the different methods that exist. The methods that were mentioned included the three-month injection (Depo-Provera), the oral contraceptive, and condoms; only a few participants mentioned Implanon and the IUD. Knowledge of these methods was obtained through family members or friends that use these types of contraception.

P11: I know like you can use condoms that will prevent but it is not always 100 per cent. So you can go on the injection also and birth control (the pill). All I know is that there are tablets available as an option and you must drink it daily.

P12: A person can use a condom or the injection, I only know these two options, but I don't know how it works.

P7: I've only heard about the tablets but I don't know all the different names of tablets available. I only know that contraception is used to like avoid you having babies.

Although some participants identified one or two methods of contraception, a minimal amount of them used contraception. This was due to their perceptions about contraception, based on what they have heard:

P8: I don't really know. I have only heard about the pill and injection from family and friends but I don't know a lot about it.

P6: I know about the needle and the tablets but I don't know much about the tablets. I just know what my friend says. She first went on the tablets and then it is better than a needle. I don't know really. Tablets or the injection, that's the only choices.

P17: Family planning, condoms and not having sex at all is how to prevent pregnancy [laughing]. I only know about the injection and the tablet that a female can use and I don't know if the loop is also part of that. I don't know how the family planning works.

It was clear that these participants were aware of some common methods of contraception, but it was also evident that they did not have adequate information about contraception.

4.3.2.2 Subcategory two: Information about the side effects of contraception

Even though these different methods were known, they were only known by name. The side effects of contraception as well as the mechanism of action to prevent pregnancy remain a blur and misunderstood. Sharing the correct information regarding the side effects of contraception

was greatly neglected. The duration of a consultation with a health professional regarding the use of contraception is too short to allow explanations and questions, resulting in the misuse of or the discontinuation of contraception. Nurses' negative attitudes, their lack of SRH skills about contraceptive use, and their lack of knowledge about the side effects of contraception contribute to the high prevalence of teenage pregnancy. As a result of this barrier, teenage girls frequently obtain information from family and friends, who may or may not provide correct information about contraception, thereby increasing the risk of teenage pregnancy.

The side effects of contraception should not only be known on paper but also understood to ensure the desired outcomes are achieved and maintained. In this study, participants were more concerned about the side effects of contraceptives than the benefits of using them. Participants were asked about their knowledge regarding the side effects of contraception and many of them did not know or interpret the side effects correctly:

> **P8:** I want to know about contraception and the side effects and I just think that they should make this type of information easier to access.
>
> **P7:** Yes, Miss, because I do have a cousin that's now on the loop and I have a cousin that was on the tablet but her hair started falling out and she also started losing weight and bled a lot. But that's all I know about the tablet. It makes your hair fall out and lose weight and you bleed a lot.
>
> **P1:** I would ask like maybe about the contraception, how will it work? How is it going to affect you? Or like for pregnancy, what are the steps to take and how will it make my health better?
>
> **P11:** I don't know the side effects of contraception. I just know like with the injection, if you are using it then you can't have babies in future.
>
> **P4:** Can I ask a question quickly? The people I know who use the injection couldn't fall pregnant after using it, is that also now part of that? She tried to fall pregnant but she couldn't because she went on an injection.

P10: Like you get dizzy, your hair falls out, some get thin and some get fatter, and if you're at a younger age on contraceptive all the blood, especially with the injection, stays inside of you, it doesn't come out. This can also cause you to get cancer like inside cancer, known as '*baarkanker'* in Afrikaans. And you can die of it as well.

Participants were not aware that the side effects were not generalised across all methods of contraception. Participants classified the term 'birth control' as a method of contraception. This is a clear interpretation of her lack of SRH knowledge, specifically about contraception:

P7: I feel like the injections was like too much for me, but I want to know like why because they say the injection is different for everybody. But I was on the 3-month injection and then they told me like it was too much. And then they put me on the 2-month injection, but then it was still the same. Now, why is it doing that? They just told me like it is too much – that's all. When I asked them after the injection if I could go on the tablets, they told me no I couldn't because it is not going to work for me as the injection does. So I couldn't understand why and I was scared to choose the loop because I thought the loop was going to do much worse than the injection. So that's why I stopped using the injection, it was too much for me.

Other participants spoke about side effects as follows:

P9: No, I haven't heard about the side effects, because the last time I went to the hospital, but my mommy did not know about this, I was just going with my friend so she got an injection, but then afterwards she was like having continuous periods and like the blood was dirty. So I just thought to myself that no, I wouldn't want that. And she felt pain sometimes, like when she has her periods her private part pains and when she pees she says it burns.

P14: Sometimes you get fat or thin, your facial expression changes, like some people's ways change and so. You're not the same person, but you can see also when like someone is on something, contraception or so, you get fat, you get thin, sometimes you stay the same. You're not the same with your partner as you were before, because there's something else happening now, with your hormones.

The changes in weight were the most common side effects heard from the participants. It is of concern that their knowledge of side effects is limited, increasing their resistance to using contraception. The fear of the unknown is a barrier for teenage girls in accessing contraceptive services.

4.3.2.3 Subcategory three: Misinformation/misinterpretation about the usage of contraception

Women in general are not given all the information about contraception; this affects the way the information is perceived and shared among other women. Information that is misinterpreted will be shared incorrectly, and this creates a communication chain with irrelevant and incorrect information about contraception. This negative perception of contraceptives was influenced by misinformation received from their various sources, highlighting the influence that others can have on decision-making around contraceptive use.

One participant was totally against the use of contraception due to her personal beliefs:

> **P14:** I don't think that's good for a girl to go on family planning before having sex, because you know what's right and what's wrong. Don't have sex before the time and use contraception to prevent babies. You preventing a blessing because the baby is a blessing. You can't go on contraception before the time unless you're older and you have a baby, then after years you go off then you get another baby. But don't prevent a blessing because a baby is a big blessing. No matter your age, the time – you will never know what's going to happen, but don't go on family planning before having sex. I don't believe in that.

Despite the knowledge displayed by the participants about the methods of contraception, certain misconceptions and myths existed that influenced their decisions around their use of contraception. Many females believe that Depo-Provera causes infertility and that oral contraception is risky because a female falls pregnant easily while using it. Often teenage girls

are not consulted correctly and are usually rushed to choose a contraceptive method. This leads to teenage girls being poorly educated regarding contraception. The way a teenage girl would interpret SRH information about contraception also depends on her level of education. Poor understanding and incorrect reading negatively influence their interpretation of contraceptive usage. It is therefore important that teenage girls receive correct and the most relevant information regarding the contraception of their choice. Some of the misinterpretations are quoted below.

> **P10:** My mommy also says if you use the pill, it's nothing, but it also makes me high risk for falling pregnant, because once I skip or I don't drink it on time, I can fall pregnant. My mommy always asks: why don't you go on something? I'm like no, my hair is going to fall out, or I tell her I am going to become fat. I tell her no, look at how I am now and if I go on contraception I become "*maer*" [thin]. No, people will think that I am *tikking* [doing drugs]. No, no. I think of a lot of stuff. When I see people who were fat and are now very thin, I ask myself like what happened to them. No, I don't want to be thin or fat. I cannot.

Implanon is a contraceptive method that is inserted into the female upper arm and removed after three years. This method is often not offered at clinics, and when females ask for it they do not receive a proper explanation, causing incorrect usage. Most women do not call this contraception by its correct name, but instead call it "the chip":

> **P10:** You can use a condom. You should use contraception like the chip or the loop. The chip is a sim card that they put in the people. An older lady who lives opposite us, she had a chip in but then I saw it move once and I was like what is that? She said it is called the chip. I asked her if it was like a tracking device and she began laughing. So, I asked my mommy what it was and she said it is to prevent pregnancy and it can move but you can die if it moves in the wrong place, but that lady took it out.

Some participants misinterpreted what they have heard about the ECP and believe it to be a way of terminating a pregnancy:

> **P7:** I know that the morning-after pill you can take if you're pregnant and you don't want to be pregnant then you take that. It is almost like to terminate the pregnancy then you take a morning-after pill.

The misinterpretations of SRH information are being incorrectly conveyed from generation to generation in these lower-socio-economic areas, succeeding in perpetuating a dangerous cycle. This is a huge contributing factor to the high statistics of teenage pregnancy in the Western Cape.

Some participants believe that using contraception stops their menstruation cycle and that through this mechanism the body 'stores' blood, and this blood becomes known as 'dirty blood'. Other participants see contraception as a means of cleansing the female body and getting rid of 'dirty blood'. Some teenage girls misinterpreted which females can use contraception and thought that contraception may only be used by adult women who are married. It is commonly misinterpreted that a female cannot conceive after using contraception due to the damage to the reproductive health system caused by the contraceptive's side effects:

> **P1:** My mommy takes the pill to prevent pregnancy and like cleanse your body. She believes the menstruation blood stays behind in the body when the injection is used and calls it "dirty-blood". The dirty blood needs to be removed.

Participant 1 explained to the researcher that her mother uses the oral contraceptive because she believes it cleanses her womb from any bloody deposits or 'dirty blood' left behind, which may have been caused by her experiencing amenorrhoea.

P9: My friend had the injection, but then afterwards she was like having continuous periods and like the blood was dirty. So I just thought to myself that no I wouldn't want that to happen to me.

P11: I just know like with the injection if you are using it then you can't have babies in future. If you want to get pregnant in the future, you can't get pregnant because of the injection.

4.4 Theme two: Teenage girls' reproductive health information-seeking, sharing and sources of information

An information need is identified when a person does not have enough information about a particular topic and there is a requirement to fill the information gap. In the previous theme it was evident that teenage girls have a lack of knowledge regarding SRH. Theme two focuses on the information-seeking behaviour of teenage girls to support their decisions around their SRH and equip them with the tools required to render adequate protection against unwanted pregnancies.

Teenage girls have an interest in searching for information about the risks of the withdrawal technique, contraception use and side effects, different sexual experiences, STIs, and so on. Teenage girls are automatically disadvantaged when looking for information about their SRH because many believe that they are too young to be thinking about sex or using contraception. The easiest way to obtain information without being judged is in their private space. When their parents have an open-door policy, it allows teenage girls to freely express what they are thinking and feeling. Some of them searched for this information from their families, friends, libraries, schools, places of worship, and clinics as well as the internet. In contrast, other participants were faced with barriers when trying to access SRH information from these sources. This increased their resistance to seeking SRH information, rendering them vulnerable to risky sexual behaviour. Some participants indicated that they feel embarrassed to seek information and fear being judged by others:

P16: I stay with my eldest sister. I'll ask her mostly questions about situations I have already experienced. If I've experienced something like having sex without a condom and there's a chance I could fall pregnant, I would ask her what can I do? I still didn't fall pregnant but I still asked her what can it do to my body? And how will it affect me and such stuff?

P15: I don't live with my parents; I live with my grandparents, but I don't talk with them. I'm scared to talk to them.

The participants faced many challenges when seeking SRH information, like the judgmental and unprofessional behaviour of HCWs. Nurses are seen as unfriendly and participants tend to steer away from this source of information, because they do not want to be embarrassed and scolded:

P6: The way I would say, they're very impatient with a person. They just want to do stuff really fast. Like if you ask a question, they'll be like look here Miss, we must get this over and done with. So we don't have time for questions. Some of them are friendly. Not most of them. They're rude. Their attitudes are not nice.

The researcher explored participants' information-seeking behaviour to protect themselves from falling pregnant, but many teenage girls did not seek information despite their lack of knowledge about their SRH problems. The following extracts illustrate this:

P7: No, Miss. I still need to know; I don't know, Miss [giggling], things like when I got my period I bled, but then when I put in a pad I stopped bleeding. I thought like what is happening, and by the Monday I got my period again. I couldn't understand why this happened. I thought that I started my period the Friday and then I put in a pad but there was no blood, only to get my period on the Monday.

P8: One day I will go online or ask my mother. I didn't start thinking about having sex yet.

P9: I am not sure what to do before and after having sex to prevent pregnancy. Like maybe there's something you have to do after that to prevent pregnancy. Also, I have questions like if

you're having sex with a partner and then he ejaculates inside you, can you fall pregnant? And even if he ejaculates on the outside on your private part, can you still get pregnant? All the questions I have about my SRH I will just keep it in my head [laughs] because I feel safe in my head. People judge you by your every move.

P17: That's also a topic that I actually want to know, the discharge topic, because when I was younger I went to Red Cross for my discharge but then they told me that I must stop eating peanuts, peanut butter and stuff like that because that is the cause of me getting a discharge. But I still get it even though I'm not eating that stuff anymore and it doesn't have a nice smell and it leaves like ugly marks on your underwear and stuff.

Even though participants mentioned that they wanted to learn more about their SRH, some were too shy and embarrassed to do so. Some participants were shy, making minimal eye contact in the interviews with the researcher; however, it was evident to the researcher that some participants were not interested in searching for SRH information. The main reason was that they were not sexually active yet. They seem to think SRH information is focused on being sexually active. Furthermore, it was reported that some participants were in relationships for as long as 18 months but had not been sexually intimate with their partners, they only kissed instead. These participants mentioned that the time was not right and that their partners understand.

4.4.1 Category one: Teenage girls' SRH information-seeking behaviour for decision making

Females who are educated expose themselves to SRH information which empowers them to make informed decisions about their SRH and contraceptive methods. Not only is lack of knowledge a cause of risky sexual behaviour, poor decision-making is also a cause thereof. Due to the lack of information-seeking behaviour about SRH, teenage girls are disadvantaged and cannot protect themselves against teenage pregnancy. They are not making informed

decisions or making the right choices. Some of the participants felt limited in their rights to make decisions, especially when they attended clinics for contraception. They are stripped of their rights to make decisions regarding their SRH. The common contraceptive methods offered are Depo-Provera (3-month injection) and Nur-Isterate (2-month injection) and one type of oral contraception. The following extract from the participants illustrates this:

> **P1:** When I went to the clinic for 3-month injection they had the tablets and the two months' injection. I told the nurse I want the two months' injection, but she told me the tablets are better because it teaches me responsibility. So I told her that previously I've been using the tablets but I fell pregnant. So she told me I didn't have a choice. I just had to go on the tablets because that's how she feels it is going to teach me responsibility. Nurses there they want to put you on what they feel is better for you. You can't have your own say. I didn't have a choice. You are forced to take whatever the nurses give you. They just tell you when to take it [the pill] and you must set an alarm to remember, that's all. Even if you want to know information from them, they don't tell you if there's any other options of contraception.

Many teenage girls don't have information-seeking behaviour; as a result, they become victims of GBV, such as being belittled and bullied by their partners or peers in making SRH choices that they do not agree with. Sometimes teenage girls are in abusive relationships and experience GBV or reproductive coercion, which victimises and disempowers them. Girls may perceive agreeing to have sex as a way of holding on to their boyfriends/partners. In many local communities and cultures, it is believed that females should be submissive to their male partners, which negatively influences their decision-making power. Female partners are often the victims as a result of gender inequalities. The most common type of reproductive coercion is contraception sabotage, meaning the females' partners either hide the contraception or find other ways to prevent them from using it. Some teenage girls living in the area experience sexual violence when they refuse to engage in sex without protection. These girls lack

reproductive autonomy and are faced with high risks of becoming pregnant. Coercive sex and GBV have been associated with each other as well as with the increase in teenage pregnancy.

Teenage girls often find themselves in relationships with older men who can support them financially, which increases the risks of power and gender inequalities. In relationships where male partners have more power, the teenage girls are less able to voice their opinions or make decisions about their use of contraception. The level of power the male partner has determines a teenage girl's ability to negotiate safe sex and their exposure to the consequences that they are submitted to.

> **P17:** My boyfriend is older than me. We use condoms, but not all the time, when we don't then he pulls out before he ejaculates. He is in jail at the moment, he sometimes would force me to have sex with him and then he gets aggressive. Sometimes he chokes me and stuff like that and he beats me, and that is why I don't still want to be around him, I'm not completely myself. I am still a little bit scared of him because that's how he is. I told him many times that I don't want to be in the relationship anymore, but he doesn't understand that. He doesn't take advantage of me but he just doesn't understand when I say no. I spoke to my cousin already and then my cousin actually she confronted him about it, and then he was more *kwaad* [Afrikaans meaning angry], he asked me why I told her. So he said that he doesn't want to listen to me. So he told me I mustn't do that – tell everyone what he does. So I told him I didn't tell everyone, I only told my cousin and she confronted him about it. He was very *kwaad*.

Some teenagers view decision-making to be about hope and the expectation of showing true love within a relationship. Showing true love was the gateway to the sexual debut within the relationship. Teenagers decide to use condoms as a protective measure due to their anxiety and concern about their future. Participants vocalised their desire to have their decisions respected without being judged or reprimanded.

4.4.1.1 Subcategory one: Teenage girls' information-seeking behaviour about the different types of contraception and their contraceptive choices

A teenager's decision-making is often influenced by other people's opinions. It is evident that teenage pregnancy can be influenced by what teenagers seek to know, see and hear from their peers. The curiosity of wanting to experiment with what is said and done by peers about sexual engagement, and the pressure to fit in puts teenagers at risk of teenage pregnancy. The majority of participants mentioned that they spent quite a bit of time with their peers seeking information about sex. Decisions made by teenagers are often influenced by their peers' actions and opinions. In most circumstances, teenage girls are not given many choices of contraception to use at the clinic, irrespective of the vast range that is available. The following extracts illustrate this:

> **P1:** I used to go to the clinic every day for tablets and to seek more information, but the nurses want to put you on what they feel is better for you. You can't have your own choice.
>
> **P6:** At the clinic the nurses do give you a choice, but they don't give you all the information you seek to know and need to choose a contraceptive method from. They give you a choice of tablets or the injection, that's the only choices we get.

Teenage girls are commonly given the choice between injectable contraception methods and oral pills. According to the participants, the injectable contraception was the most used method. These methods are convenient and affordable for the providers and users; however, many women default on their contraception when using them. The common factor identified with the injectable contraception is that they are often out of stock in the public sector, and users are given little to no choice when an alternative is required. Switching between methods renders any female at risk of becoming pregnant, therefore thorough counselling is important. Some participants also expressed that counselling was not given when they were put on an alternative method:

P4: Yes, I know about that one [the injection, giggling]. I feel like the injections I was on it was like they say, it was like too much for me, but I want to know like why, Miss, because they say like the injection is like different for everybody. But I was on the 3-month injection and then they told me like it was too much. And then they put me on the 2-month injection, but then it was still the same. Now why is it like doing that?

P17: I know about family planning, condoms and not having sex at all [laughing]. I only know of the injection and the tablet that a female can use and I don't know if the loop is also part of that. But I don't know how the family planning works.

P8: Females use contraception and then they have sex because they don't want to fall pregnant. I have heard about the pill and injection but I do not know any information about it besides that it prevents pregnancy.

Participant eight is unsure regarding the contraceptives' mechanism of action in her body, and therefore struggles to make a decision on what method to choose. Most of the participants did not know how the injectable contraception works within the body.

Besides the two types of injectable methods, there are multiple choices for oral pills; however, not all of these were previously disclosed to the participants. There are two types of pills, but only one containing two hormones, an oestrogen and a progestin, is usually prescribed for teenage girls. Teenage girls often prefer to use oral contraceptives, but this may not be the most effective method if not taken correctly. Teenage girls should be knowledgeable about all the contraception methods available to them as well as their mechanism of action within the body, so that they can make the most appropriate choice. Almost all of the participants were not aware of what the emergency contraceptive pill (ECP) was. They have not heard about it or they have heard incorrect information about a certain pill but did not know its name:

P1: No, when my friend started being sexually active, they told her if she fell pregnant she had to, you know, she had to take it the morning and after.

P9: I have no knowledge of the morning-after pill. I think maybe you can have an abortion or you can abort the baby. What is the emergency pill?

The ECP should only be used in case of emergencies, for example, if a condom breaks. The ECP is available over the counter for teenagers to purchase. Knowledge around ECPs is limited as the feedback received from participants evidently showed their lack of knowledge regarding it, which is risky and renders them vulnerable to not preventing unwanted pregnancies. Condoms are known as barrier contraception and are the least effective method, only better than the withdrawal technique. A female should consider using another form of contraception in conjunction with the condom, because the condom is not 100% fail-safe, being a barrier method. Many females do not know this and therefore cannot make a safe choice. There are male and female condoms available, but most of the participants had not seen or touched a female condom before. Even though the participants have heard about and seen a male condom, they did not know how to use it correctly. Participants verbalised that they were fearful to try to use the condom. Some participants who did not know how to use condoms correctly therefore relied on the withdrawal technique, greatly increasing their risk of pregnancy. These participants were unaware of the high risks and consequences they were facing by doing so.

P17: We use condoms, but not all the time, when we don't use condoms, then he pulls out before he ejaculates. I know there's female condoms but I don't know how to use a female condom.

P10: I saw finger condoms and hand condoms. I will never use a condom because I'm too scared it gets stuck and can't come out. We were shown how to use these condoms by the Desmond Tutu Foundation when they came to our school. They brought dolls and all the girls were just laughing and they showed us this is the hand condom, etc.

Those who reported being sexually active had different opinions regarding contraception. Some participants only used condoms because they are unfamiliar with contraception or they

believe that the contraception is bad for their bodies. Other participants were using the hormonal contraceptive methods:

> **P4:** About condoms, say now, okay I do like a boy though – going nine months in now this Saturday, but now, Miss, I don't know anymore because I also want to explore the other stuff but with using a condom. I am scared of using a condom because the other people tell me that it breaks.
>
> **P9:** I've heard about female condoms but I haven't seen one and I don't know how to use it either.
>
> **P16**: Yes, Miss, but I don't know how to use a female condom. I know how the male condom is used. There is a lot of stuff I'm not comfortable asking, like how should I use a condom and when should I use a condom.
>
> **P15**: I was not shown how to use a condom, male or female condoms. I am not sexually active yet and I don't have a boyfriend.

Those participants who were not shown how to apply and remove a condom misunderstood this barrier method, thereby creating assumptions from which fears evolved. The emotion of fear normally limits an individual's decision-making process.

4.4.1.2 Subcategory two: Teenage girls' information-seeking behaviour about sexual experiences

Teenagers are at the stage in their life where their bodies are physically developing and they become attracted to each other and want to explore their sexuality. They may or may not be in relationships and they may or may not use contraception. A teenage girl's outlook on her SRH depends on the information she has learnt regarding that topic and her means for searching for SRH information. She may be interested to seek SRH information to assist in protecting herself against pregnancy, or she may not be interested because she is not sexually active yet. Most of

the participants had mentioned that they are in relationships, some short-term and others long-term relationships. Not all of the participants felt comfortable to disclose information about the level of sexual intimacy in their relationships. Some participants reported that there was no intimacy because they were not ready and others said that they just kissed their partners:

> **P13:** No, my boyfriend and I didn't talk about sex [laughing], we just kiss. Parents tell me like if I have sex with a person without a condom I can get an STI or HIV. I don't talk to them about contraception and stuff like that because the time is not right. [Laughing]

The participants felt the need to search for information about sex and preventing pregnancy, and also searched for information about their menstrual cycle and abnormal vaginal discharges:

> **P7:** No, Miss, it is like I don't know what happens but they say like when you do like oral sex, and you put it in the vagina then you get a yeast infection but I don't know if that is true because I like read about it on the internet and I experience like almost like a yeast infection, looks like yeast. But I experience that but I don't know if that is the truth about the oral sex and that stuff.

Some participants indicated that they have no interest in searching for information about sexual experiences. Their reasons were based on not being sexually active yet and /or they are in long-distance relationships and do not see their partners often. At the same time, these participants acknowledged that they would seek SRH information when they are ready to have their first sexual encounter. Some participants mentioned feeling afraid to actively search for information about sex and therefore had no interest in doing so. One participant expressed that she does not spend much time searching for SRH information:

> **P16:** Not very often, because usually after I am at my boyfriend's, I come back to the clinic for appointments and I'll always ask more questions, but because we're in a long-distance relationship we only see each other one weekend a month. So, once a month, Miss.

> **P14:** Like now we're dating a year and eight months, but for me I can give him what I want to give him but he loves me and he understands me because we have a good understanding. I told

him that my parents don't want me to have sex now and I also don't feel comfortable having sex with him now, but he is willing to wait because he loves me. For me, I'm not ready yet. When I'm ready I will do it, because I am still a learner and I don't know what is going to happen with my body after having sex for the first time. Am I going to change? Is he going to change towards me? Because that's what I heard happens. Now I give him sex or whatever then not long after that then he's a changed person. Then I'm going to be alone and he moves on. And then what happens to me? I'm just lost. That's why I'm not ready to have sex yet, even though I love him with my whole heart. I told him that I'm not yet ready.

4.4.2 Category two: SRH information-sharing behaviour

The teenage girls' information-seeking behaviour is challenged by many barriers. These barriers created anxiety as their fears were increased due to their vulnerability. Participants had differences in their frequency of looking for SRH information. Most participants indicated that they looked for information often, but some participants had limited internet access and compatible devices at home like computers. Participants who were not shy to discuss their SRH were the same ones who indicated that they seek SRH information every month. The participants shared different opinions and experiences to express their ways of seeking SRH information. The data collected has shown that there is a gap in the participants' SRH knowledge. It was evident that nearly all of the participants showed an SRH information need and the interest to search for it. A participant mentioned that she will seek SRH information regularly because she wants to explore her sexuality and cannot wait for marriage:

P4: … my family are very strict with religion; they say no sex before marriage but I want to have sex before marriage. I can't speak to them because they're so judging, they judge you straight.

P17: … I do not search for SRH information every day, only sometimes when I see something is wrong with me, then I will ask my mommy or go look for information and stuff like that.

P15: … I look for information once a month. Information I look up is like what must you use to have safe sex? How to prevent getting pregnant? I was told by my elder cousin that I must go to the clinic and get the tablets or injection or use a condom to prevent getting pregnant.

Some participants made use of the internet to seek SRH information but battled with confirmation to ensure that the information could be trusted:

P3: … I don't talk about my SRH with anyone, I am a *bietjie* [little] nervous. I think I would rather use the internet, but I don't know if the information is truthful, it must probably be.

4.4.2.1 Subcategory one: Sharing SRH information with the family

Sex continued to be a taboo topic in their households. Some participants cringed or had a shy giggle when the word 'sex' was mentioned. These participants seemed to be introverts and only spoke when spoken to. The participants who indicated that they were shy in nature reported that they are reluctant to talk about their SRH, because they did not want to be judged or embarrassed. They were afraid that their families, friends and community would make many assumptions, for example that they are promiscuous. Participants expressed that they did not feel comfortable to share information about their SRH or sexual experiences with others. There were, however, a few participants who reported that they shared information with their close family members as well as close friends. The most common topic of discussion was contraception. Some participants were raised by their grandparents and were hesitant to discuss their SRH information with them because they did not want to seem disrespectful:

P11: … I don't like sharing my stuff [personal information]. I will share information with the teacher alone but not in front of the class because I'm a very shy person.

P5: … Boys and girls are all in one class and I am too shy to participate, to keep a conversation with the teacher. You can ask her questions but I'm too shy.

Participants who have close relationships with their mothers reported that they could discuss anything with them. Their mothers have spoken to them about sex, contraceptives, using condoms, and the like. The following participant trusted sharing her SRH information with her mother alone:

> **P1:** … I told my mommy… the first day when I broke my virginity, I told my mommy and she was a little bit angry, but she understands and not like I spite her. I'm happy because we're still together because you get many young girls that fall pregnant and then their boyfriends leave them as is. Like my mommy ... I'm very close to my mommy. I just trust my mommy. My mommy is the only one that I'm close to because she helps me with everything. I would first talk with my mommy about having a boyfriend. If my mommy says it is fine, then my mommy will like give you what is safe and that. And if my mommy agrees then I would go to the clinic and find out information about what contraception is or on the internet to prevent them from making a mistake or falling pregnant without them knowing.

Not all participants shared this view about their mothers. One participant mentioned that her mother was too strict; therefore, when speaking to her she would use an alias in order to get the SRH information that she needed:

> **P9:** With my mommy, not really. I can just talk to her about oh listen here, this happened, there was this girl. Or I can use a second person when I'm with family, not myself when I want to talk to her. But if I talk to her directly about myself then she gets so worried like oh, what has this child done now? So I don't want her to get worried, so I rather use a second person than myself.

Another participant expressed this as follows: "… in the house now, my mommy does not want to hear about that type of stuff."

A few participants were still reluctant to speak to their mothers because they did not share a close relationship. Some of the participants were raised by their grandmothers, without ever

knowing their parents. These participants did not feel comfortable discussing their SRH with the elderly, because it seemed disrespectful:

> **P11:** Like we live with my grandma but she will only tell you that you will get pregnant if you have sex – that's all. Otherwise she won't talk about topics like that with me, we don't communicate a lot.

> **P7:** … we live with my granny but I feel shy and embarrassed to talk to her about sexual topics.

The most common source of information in a family, beside the mother, was reported to be the cousins and sisters. Some participants felt that they can speak to their cousins and older sisters about anything; however, others felt that their families may judge them and accuse them of being promiscuous:

> **P16:** No peer pressure, I don't have friends outside the house because I'm never outside. We're four girls, two cousins, me and my two sisters. So I usually talk to them.

Some participants reported that they do not want to burden their family members with their personal issues because they did not want to cause them stress. Those participants that indicated that they could talk to their families also expressed their trust towards them. They mentioned that their family members share information with them based on the own SRH experiences. Participants also reported that they find it difficult to disclose any personal information to the elders in the family, because they fear their reactions. One participant mentioned that her boyfriend spoke to his aunty on her behalf about contraception:

> **P9:** … I have a cousin who is like a sister, but I feel like if I ask her a lot of questions she would feel maybe that I'm stressing her so much, so I rather just keep quiet.

> **P17:** … I can only talk to my aunty and my godmother. Like she understands and when you tell her something, she won't tell anyone. She would always refer to her life. Everything she

tells me, she will refer to her life. She will keep it to herself and then she will give us advice on what we ask, that's why I always go to her, but I don't tell her everything.

One participant expressed that she could share information with her dad, but that he was very over-protective and overreacted when she did so:

> **P10:** … my daddy will now and then speak but we will not talk about sex because it is not his favourite topic when it comes to me. He would be looking at me with that face that makes you think he is threatening you. I am the eldest and I have a baby sister, but he still thinks I'm the baby. He will still say you're my baby I don't care who says what. He will scold at me and cover up for me when my mommy is scolding me. I can't even talk to a friend that's a boy.

Fear of being judged and stigmatized by family, friends and the community also resulted in these participants not being interested in sharing their SRH information.

4.4.2.2 Subcategory two: Sharing SRH information with friends

Most participants expressed that they could share information with their friends. They mentioned that they treat their friends like family. Sometimes the participants preferred to discuss issues with their friends instead of their family. These participants mentioned that they are comfortable with sharing information with their friends and they trust their opinions and advice:

> **P9:** … I don't really worry about it because I'm not sexually active yet. Sometimes I research it or ask my friends. I don't really ask my mother because she's over-protective. She would say 'Look at this child, she wants to have sex, oh my God'. I just rather keep quiet or I go on the internet or I talk to my boyfriend about it.

> **P10:** … I will tell someone so that I can receive their opinion and guidance. My besties will support me with whatever I decide to do. I have understanding besties.

P4: … I will talk to my friends but not my family. No, they are judgmental, they're *saaliegh* [religious].

Other participants mentioned that they only had male friends, or did not have any friends at all to share their information with:

P17: … I don't actually have a lot of girlfriends. I have mostly boys as friends. I only have one girlfriend, but we don't hang out a lot together.

P14: …Yes, I have close friends to talk to and stuff [find out SRH information].

P1: … my friends also now of last year, they all judge me, but not like I'm badmouthing them, but today both of them are pregnant because they all looked down on me of how I was pregnant and they don't have sex, but they want to talk high and mighty. But they have their own children of not like judging … or looking down on someone.

Participant 1 had expressed her disappointment with her friends at the time they came to know of her pregnancy. They were judgmental and isolated her from their group of friends.

4.4.3 Category three: Source of SRH information

Teenagers are developmentally normally interested in information about sexuality issues. They want and need to explore their sexuality and often desire to experiment with this part of their development instead of ignoring it. Even though participants knew about some of the SRH services available at the clinics, it was interpreted as only meant for adults or married individuals and not for teenagers. They are limited as to who they can speak to regarding their SRH, because they fear judgement and being embarrassed. There are five sub-categories which indicate the different information sources used by the participants, namely: the internet and library, Life Orientation class, family members, friends/peers, and the local clinic. Some

sources were commented on as being used more than others. Participants verbalised that they were aware that the information they are receiving may or may not be factual and true:

> **P1:** I will ask my mommy about any information I need. Sometimes I will go on the internet just to search the consequences of using contraception. But basically, my mommy. I am the closest to her.

> **P5:** I will search for information like, after you skip on your 3-months injection, what happens to you? Do you get your periods instantly or do you still skip or etc.? All that and how would your hormones be. So, basically questions about the contraception side effects.

4.4.3.1 Subcategory one: Internet and library

The internet was seen to be a means to access SRH information. Participants complained about the internet access not always being available to them. They indicated that the school has Wi-Fi and they are allowed to access the connectivity, but most of them have no access at home. Most participants expressed that they feel safe using the internet because they can remain anonymous, relieving them of their fears of being judged. They felt that they could browse the internet for anything and receive the quickest response. They felt that they could ask all the questions they wanted to and Google would not question them or disrespect them in return:

> **P11:** I would go on the internet and google whatever comes to mind about my SRH.

> **P14:** I'm going to Google, which is the first thing I would do. I would ask my mommy because she's now past that stage [experienced] and so on. That's my only options. I trust Google.

> **P17:** Sometimes I'll be at home and if I have data I will go on the internet to Google things about SRH and stuff like that.

The participants mentioned that the public library was located behind the local clinic. The library was easily accessible to most participants. In general, a library is a seen to be good source of any type of information; unfortunately, these participants struggled to make use of it.

They could access books and computers at the library, but needed a library card. None of the participants that were interviewed possessed a library card. They could not browse the internet to search for information or borrow library books for reading material at home. They never made time to apply for a card, nor did they know anyone that they could borrow a card from. Irrespective, some participants complimented the librarians for their assistance when seeking specific information:

> **P7:** We can't also use by the library because you must have a library card that you must use at the library.

> **P17:** Most of the time I would go to the library, which is just next to the clinic, to look for information. I don't have a library card at the moment, you can only use the computers if you have a library card. I want to open one again so that I can use the computers. I do find the library books useful. The librarians are helpful; they can tell you exactly where everything is.

4.4.3.2 Subcategory Two: Life Orientation (LO) class

Most participants preferred to speak to a female teacher, but a few were more comfortable with a male teacher. They felt that by speaking to a female they could expect her to understand where they are coming from and to provide realistic advice. The other participants had no problem with having a male teacher. They felt comfortable enough to disclose their SRH questions or concerns with a male teacher. Most participants felt that they could not speak to their Life Orientation teacher because the only time they could communicate was during a lesson. Participants mentioned using a Life Orientation textbook to guide them through topics which they did not understand, but it was not as helpful as they thought it would be:

> **P4:** I prefer a female teacher because I feel safer to talk with a Ma'am than a Sir.

> **P10:** In Life Orientation the teacher teaches you whatever you should know, but they don't do it in detail so that everybody can understand, because we all do not understand things in the

same way. Some people want more detail and some are like okay we know that. We do get it but some teachers just don't explain it in a way like on our level of understanding. They will explain the information generally and assume everybody understands, but everybody doesn't. We are not going to say we don't understand because we will look and feel like we are idiots, that's why we won't still say something. Now in Grade 11, we have a female teacher. In Grade 8 and 9 I had a Sir. In Grade 10 I had a Sir but he never gave class. I prefer a male teacher. One particular teacher printed your Life Orientation in your brain. About health and sexual activities and contraception and stuff like that. He covered general things and what happened here by us at school, he spoke about it. Like, the girls fall pregnant here in the area. Children in Grade 8 fall pregnant. Twelve-year olds fall pregnant.

P7: When we talk to our LO Miss, she asks us what do we think about this and what do you think about that? And if whoever experienced something like that you can talk to her and tell her in front of the class what your experience is and stuff like that.

P14: I can't trust a man with my feelings over sex, but with a woman she can understand me because we're more or less the same.

Life Orientation is a subject taught to the whole class with mixed genders. The majority of participants felt that they could not disclose any personal information to the teacher or in the classroom, because there was no privacy. The participants reported that they usually just listen to what the teacher says, but do not feel comfortable discussing their SRH in front of their male peers. Most of the participants prefer to speak to their teacher privately and not in the classroom. Participants did mention that they could speak up when the NGO, The Desmond Tutu Foundation, came to the school to talk about condoms and such topics:

P8: I prefer one-on-one talks with the LO teacher.

P9: There is no privacy or confidentiality in the LO classroom.

P10: It is actually normal, like at this school the learners don't interact with each other much, like certain groups, certain friends. That's our school. That's the way it is. But everybody knows everybody. When it came to that programme, the Desmond Tutu programme, girls who didn't like each other spoke together and laughed. Like we didn't hear arguing or talking bad about each other like 'You slept with a Bongu'. Everything said in the room just stayed in the room. A person felt comfortable. At first, it was weird, because now you're shy, but the lady who came she was like proactive. She is from a coloured area. She said she also lives in area and then we started to open up to her. We also start answering questions.

4.4.3.3 Subcategory three: Family members

Many participants expressed their difficulties when trying to connect with their family members to discuss SRH. Some mentioned that they will never talk to their parents, siblings or even grandparents. There are boundaries that exist in their families, that are not crossed. Grandmothers are strict and do not tolerate conversation regarding SRH. Participants were fearful of being judged and shunned from the family. Other participants felt close to their parents, especially their mothers. They have an open relationship with them and feel comfortable speaking to them and seeking information from them. They find the information received to be trustworthy.

P16: My sister is very over-protective and we're a lot of girls. She keeps on telling us don't have sex, don't fall pregnant. If you have sex, use a condom. So there are some questions we would like to ask her, but then we don't want her to feel disappointed because she keeps on talking to us about it, concerning sex and stuff, Miss. I don't have friends outside the house because I'm never outside. We're four girls, two cousins and me and my sister, my eldest sister. So I usually talk to them.

P10: Yes, I get information from my family, my granny, and from my two best friends. The one granny is still alive. My granny will talk to me about SRH. I have a cousin who is on contraceptives and she uses the morning-after pill. I have another cousin who I am very close

with, we can talk freely to each other. Then I have two aunts who live in Mitchells Plain who I feel comfortable speaking to. I am close with my parents as well and will talk to them about my SRH.

4.4.3.4 Subcategory Four: Friends/peers

The implication of the lack of open communication between teenagers and their parents about sex-related issues on account of socio-cultural norms creates an environment where teenagers value and respect their friends' opinions more than their parents'. This can put them at risk for teenage pregnancy because of the lack of correct information. Some participants prefer to search for SRH information from their friends instead of family because they are less judgmental. Participants indicated that their friends were experiencing the same scenarios, therefore they could speak to each other and source new information. Few participants mentioned that they did not feel comfortable speaking to anyone about their SRH.

Participants saw their friends as their family and trusted the information received from them:

> **P6:** I usually ask my friends. I don't really ask my family. Just small stuff like if I ask them about the needle, then they're like they inject it here by your bum and it lasts for three months or for two. You don't get your periods during that time and then after the three months then you must go again. So that's all I know.

> **P12:** I talk to my friends. They don't talk about ways to prevent pregnancy, they tell me things like how and when to have sex.

> **P13:** Here's a group at school. They tell you about sex and the negatives and the positives of it. The positives are [laughing], like if you use a condom, you won't get HIV or an STI and so. The negatives are about falling pregnant, getting HIV and STIs.

4.4.3.5 Subcategory Five: The local clinic

The majority of the participants did not favour seeking SRH information from the clinic, for numerous reasons. Even though the clinic was easily accessible to all the participants, it remained the least used source of information. The main reason for this was the HCWs' judgmental and negative attitude towards them. They felt afraid and unwelcomed when attempting to seek SRH information. The clinic was not seen to be youth-friendly, because the clinic operating hours was not in-line with their school times. The clinic has an appointment schedule, which they find difficult to adhere to as it clashes with the school's times. The long waiting times spent at the clinics was a disadvantage to a scholar. This demotivated them from returning to the clinic for SRH services. Participants also mentioned that nurses rushed their consultations and gave them little to no time to discuss any questions or concerns they may have had:

> **P11:** My grandma works. So when I get home from school I have to look after the children, so I don't get much time for myself. By the time I can go to the clinic, then it is closed.

> **P16:** I don't like going to the clinic because they are always busy. You have to come to them with something serious, and for them that's not going to be serious.

4.5 Theme three: Barriers to teenage girls' access to reproductive health information and risk factors

Many challenges were identified that the participants were facing when trying to access SRH services. Participants expressed their fear of being recognised and judged by the community, their parents and families, as well as by the HCWs. Some of them felt uncomfortable with accessing information or services regarding SRH. The participants experienced many limitations and barriers, resulting in their lack of interest in searching for the correct SRH

information and/or SRH services. When participants were asked if they find that churches or mosques are open for them to go to for SRH information, there was a difference in opinion.

Participant 14 did not find it challenging to access SRH information from her church, whereas participant 9 suggested a different experience:

> **P9:** In my religion you're only supposed to talk about sex when you are married, so there's no-one that I can really go to.

4.5.1 Category one: Barriers related to traditional and cultural/religious beliefs

Cultural/religious values and traditional beliefs play a large role with regard to teenage pregnancy. Traditional and cultural/religious beliefs affected many things in a teenage girl's lifestyle, and access to their SRH information/services was one of them. Talking about sex or anything else related to sex was seen as a taboo in many of the participants' households due to their culture and/or religion. Many cultures and religions are strict about not having sex before marriage; however, teenagers experience different hormones as they develop that influence their SRH choices. These restrictions cause huge barriers in family homes and communication is inhibited, leaving teenage girls vulnerable when choosing to explore their sexuality. Most participants said that it was difficult to talk about sex in their homes or religious groups, but there were a few participants who felt differently.

> **P4:** … I don't talk, that's not for me. I am afraid to talk about it because every time you talk to the family, they make eyes [eye rolling] as if to say I know what you do. No ways.

> **P7:** ... I can't ask anybody at home. Like you can't go to your priest and ask him about this and that. It is very wrong; you can't do it.

This challenge is seen to be common among the participants and their family members. The source of information, namely within the religious groups, depended on who provided the

teenagers with the SRH information and that individual's personal opinions and values regarding intimacy before marriage.

4.5.1.1 Subcategory one: Traditional beliefs

Most of the participants reported that they do not have open communication about SRH topics with their parents, because this topic was regarded as taboo. Issues related to sexuality were not ever discussed in most of their households. Participants felt uncomfortable discussing such topics with their parents. The participants associated initiating sex talks with their parents or grandparents as being disrespectful according to their tradition. Furthermore, parents did not create a platform for their teenagers to talk freely about sex or any other topic about their SRH. It is evident that some parents were not comfortable discussing sex and contraception with their children. Traditions are inherited from generation to generation, and the participants' parents were not made to feel comfortable talking about SRH, namely sex, in their homes as teenagers, so the cycle continues. Parents did not know how to initiate discussions around intimacy or comfortably answer questions pertaining to their daughters' SRH.

Participants revealed that their parents admitted that they were afraid to talk about sex because it would have seemed as if they were promoting promiscuity. Parents believed that it was traditionally unacceptable to have discussions about contraceptive use with their children, as they believed that this would be an encouragement for teenagers to have sex:

> **P12:** … yes, in the house my mommy does not want to hear about that type of stuff. She usually accuses me of such stuff. I'm like that if you accuse me of something then I'm going to do it. There's no communication between us, we don't talk about such things, nothing like that.

> **P10:** … they [parents] would throw me out. They'll disown me from the family. I'm dead also at the same time and my funeral will be on the weekend [laughing]. They're very strict.

P3: … no, they'll kill me. It is just tradition; it says you can't talk about sex. Like my parents, they wouldn't sit down with me and talk about the consequences of having sex. They would just say okay no boyfriend, nothing. So that comes with that saying no sex, no nothing.

4.5.1.2 Subcategory two: Cultural/religious beliefs

This challenge is related to the stigma surrounding teenage pregnancy and teenagers being sexually active. This stigma is influenced by social, religious and cultural norms. It seems that there was stigma attached to the use of contraception by teenagers. It is clear that teenage girls knew about contraception, but they were resistant to accessing and using these methods because of the negative attitude of the community and family. Teenage girls had some knowledge about the different methods of contraception, but were more concerned about how people would react towards them should it be known that they were using contraception. The opinions that other people had about contraception influenced the participants' low uptake of contraceptives. Although teenagers had the basic knowledge about contraceptives, there was still a gap between the knowledge they had and the use of contraceptives, which they attributed to fear of the community knowing that they were using contraceptives.

The following was expressed by the participants:

P10: … yes, they will always say 'Why does 'X' do that [go on contraception], isn't she Muslim? Why didn't she wait for marriage before having sex?'. For me, she's just a person like any other person who has sexual feelings. You can't like kill yourself just because you want to have sex and you want to try something new, but you can't because your religious community judges you or your family's reputation is degraded, so to uphold your family's reputation you are not going to do anything bad, but you're going to suffer at the end of the day. They are always judgmental.

P17: … I feel they talk openly about it, especially in our Christian religion. Not still the Muslim religion but in the Christian religion they'll talk openly.

Most of the participants said that they were reluctant to access SRH services from the clinics. They felt that nurses violate their privacy and confidentiality by threatening to report condom or contraceptive use to their parents. Many teenage girls are afraid of being recognised at the local clinic by the community and neighbours, who pose a threat by increasing the risk of their parents being informed:

> **P3:** … somebody [from the community] might see me there and tell my mommy. So that prevents me from going to the clinic.

> **P1:** When I fell pregnant it didn't make me feel nice. It made me feel disappointed in myself. I didn't want the child anymore because everyone judged me and had something to say. In the beginning, when I went for this contraception and they [the community] see you, the whole community will gossip about you, this one about that one and the whole road knows [aware of private information] and then they say you're pregnant, but you're not.

Contraceptive use is associated with sexual intercourse, which is forbidden before marriage in many cultures/religions.

4.5.2 Category two: Unavailability of user-friendly clinics

The availability, accessibility and acceptability of healthcare services for teenage girls affects their decision to use contraception, which in turn puts them at risk of becoming pregnant. Despite the SRH services being available, participants felt that the request for their Identity Documents when visiting the clinic or otherwise wanting to see their parents created barriers towards accessing health services. These teenage girls felt discouraged from visiting the clinic due to the discrimination against them because of their age. HCWs' unfriendly behaviour, unfavourable appointment time slots and long waiting times are all contributing to factors that label clinics as not being user-friendly. The following excerpts relate to this:

P17: … the clinic is most of the time full of people because it is very slow there. They [nurses], like how can I say, their attitudes towards us is like almost as if they, how can I say, *amper soes ek wiet bietere as jou en jy kan nie vir my nog soe en soe vra nie want ek wiet, soe man* [Afrikaans: They have the attitude as if to say they know better than you do so you can't still ask them questions or tell them your opinions]."

P10: …When you go to the help desk and they want to go through a lot of things first, but you didn't come for that. You just want to know if you can get an appointment. It is your first time; you don't know what to do. They're not going to guide you like okay, do this before you can do that. No, they're going to be sarcastic and if you say something and then you [are regarded as] rude and they want to put you out.

The nurses' negative attitudes make the healthcare system unfriendly to teenage girls, who then rather seek information from their peers, which may sometimes be incorrect:

P1: … I don't feel comfortable going to this clinic by us. They don't make a person feel welcome and like it is fine, you can go there. My mommy always says that I should go to the clinic, but I don't want to because they're not *lekker* [nice] there.

4.5.2.1 Subcategory one: Nurses' attitudes and the availability of contraception

The participants also expressed dissatisfaction regarding the manner in which the HCWs addressed them. The attitudes and behaviour of the HCWs towards teenage girls were described as being unfriendly, hostile, rude and judgemental. The teenage participants expressed that the negative attitudes of staff were a barrier to accessing SRH services at the clinics. As a result, they stayed away from the clinics, fearing judgmental and negative attitudes and being reprimanded by the nurses. The implications of the nurses' judgmental attitude can deprive the teenagers of obtaining quality information which they can use to make informed decisions. The researcher asked the participants what is preventing them from going to the clinics for SRH services, and the majority of the participants had the following to say:

P8: … So the nurse and doctors at the clinic don't help you because I've noticed that they ask the girls my age what they are doing there and if they are pregnant then they ask questions like, 'Why do you open your legs early?' and stuff like that.

P11: … Nurses at clinic scolds a lot if the girls miss their appointments, that's what I heard.

P9: … what I heard when you go to a nurse, the nurse would go to another nurse and say, 'Look at this child she just got pregnant, why would she do that? She's so young. You know these children don't have manners'.

P10: … at our clinic everyone is unapproachable. You want to ask something, but the way their faces look, it is like they are thinking 'I don't have time, just leave me alone'. They are moody sometimes. Some nurses are okay, they listen to you, but the other nurses just want to get done. They don't care how they do it or what they say. My granny, she is another one who scolds the nurses saying '*Julle is 'n klomp vuilgoed*' [Afrikaans: You are a bunch of dirt], then they want to come help quickly because their *matrone* [Afrikaans: matron] will come see what the problem is. That's why I won't still go there.

P13: … Here at the clinics the nurses don't really help you. You just come and they don't really talk with you or so. They are sarcastic to a person.

Nurses' behaviour is what made the healthcare system unfriendly to teenage girls, forcing them to seek SRH information from their friends, which may be incorrect, increasing their risk of unwanted pregnancies.

4.5.2.2 Subcategory two: Clinic times and accessibility

The local clinic was in close proximity for most of the participants; however, the appointment system at the clinic was unfavourable for scholars. The participants were given appointments for early mornings or late afternoons to access their SRH services, but these times were not conducive as school starts early and ends late. The clinics are not open for SRH services on weekends:

P7: … at the clinics they said they have a time, maybe 7 o'clock till 8 o'clock in the morning, where they only take five people to make an appointment for the contraceptive injection. If you come after that time you can't make an appointment. That's also a problem because like two years ago they would always do family planning on a Friday at 12 o'clock, but we come out of school half past 12pm. And now it is on Wednesday and Thursday at 7 am to 8am, but that's the time when we must go to school.

P17: … they [the nurses] have attitude because they're going to ask us why you're coming this time because they help schoolchildren first thing in the morning. If you go in the morning, they will help us first, but if we come in the afternoon, we will have to wait long. They will tell us you can't come now or they will tell us come back tomorrow and stuff like that, they will *skell* [Afrikaans: scold] at you.

The researcher asked participants whether if they go to the clinic in the afternoons after school, the nurses would help them at that time; most of the participants said that they would be turned away and asked to come back the next day.

The following extracts from participants illustrate this:

P13: … when I went to the clinic after school, they turned me away and they said I must come back the next day. You must come early in the morning. So I told them I was at school and couldn't come earlier, but they still turned me away and they didn't help me.

P9: … no, if I come out of school then I get home maybe like half past 3, then if I want to go to the clinic they tell you 'No, no you kids are always in a hurry and you can never do your stuff in time'. Then they judge you and tell you no, you must come the next day because they have their own time and need to go home early.

Participants defaulted on their contraception appointments because the times were impossible for them to attend without being late for or missing school. The following extracts from the participants illustrate this:

P7: … I was on the 2-months contraceptive but I'm not taking it anymore because of the side effects, and when I went back to the clinic for something else they said I have to make an appointment, but I never made an appointment before. I always go and then I tell them I want to go on the injection and then they tell me to fetch my folder and stuff like that, but now I have to make an appointment and they only see 5 people. They said it is only on a Thursday and a Wednesday that they take 5 people at a time.

P8: … Sometimes, it depends on what time I come out of school. Sometimes the clinic closes 4 o'clock and I come at home half past 3 sometimes, and I won't be able to get there in time.

Most of the participants did not agree with the appointment-based system that their local clinic used, because it created challenges for them. The nursing staff did not show empathy towards them either. Another reason for teenage girls' reluctance to visit the clinic included the long waiting times, which contributed to low utilization of SRH services. Teenagers visiting the health facility after school felt that nurses were not being considerate towards them as they were made to join the long queues, even though their visit to the clinic was after a long day at school:

P10: … No, they are too busy, you cannot disturb them. You will have to wait until they decide that they're now done with lunch or done *skinnering* [gossiping] or whatever they do and then they will help you. By the time they come back, I'm gone. I don't have *lus* [desire] to hear them complaining, so I walk out.

It is for this reason that participants might feel that the health system is failing to meet their needs as teenagers, resulting in them becoming reluctant to visit the health facility.

4.5.3 Category three: Inadequate Life Orientation (LO) course

The key factor that contributes to teenage pregnancy is the lack of education. All participants confirmed that they were provided with sexuality education at school by the Life Orientation teacher; however, the topics discussed were not appropriate, nor were they consecutive and

sufficient. Participants mentioned different topics that were discussed in class, but it was predominantly mentioned that the teacher does not elaborate on SRH and contraception. A few participants mentioned using a Life Orientation textbook, with which they did self-study. Other participants said that they received Life Orientation in Grade 9, and others said they have attended the class but since COVID-19 and lockdown protocols with staggering of school days, they have not:

> **P9:** … In Life Science you will learn about it but you don't learn about the information that we need, and we last did Life Orientation in Grade 9. And in the beginning of the year we didn't write about it, we just do verbalised, but it is not related to sexual and reproductive things.

> **P7:** … They only have Life Orientation. They talk about like the wellbeing of the body like nutrition and about how you treat others, bullying and your future goals.

4.5.3.1 Subcategory one: Life Orientation (LO) course related to SRH is not sufficient to prevent teenage pregnancy

Life Orientation is a subject taught as per the curriculum in the Western Cape. This subject covers many topics and SRH is one of them. Most participants felt that Life Orientation was helpful; however, they received little SRH information. Few participants reported this subject to be helpful in their lives, their growth and their development. The following excerpts illustrate this:

> **P13:** … I find the subject helpful. Just like the main stuff [about SRH], like how to use a condom and how to prevent pregnancy. There is no privacy and confidentiality during LO, I'm not alone in the class.

> **P4:** … In our LO textbooks they also talk about things like how to protect yourself from falling pregnant, and you will get your sexual and reproductive health stuff also in there. We [learners] do our own reading.

P11: … The school has Life science but I don't do that subject. But we learn about our sexual and reproductive health in Life Orientation. Like I can't explain now. It is like they will tell us about the reproductive organs of the male and female body in general. Life Orientation is not helpful because the information given is not what I want to know about my SRH, but its things I know already, how the body functions, etc.

P7: …They talk about like the wellbeing of the body and all that stuff and about how to treat others and stuff like that and your goals and stuff.

Participants mentioned that an outsourced company visited the school once and spoke to the learners about condoms and the different types of contraception. The company was called the Desmond Tutu Foundation, which is a non-profit organisation. They also demonstrated how to use condoms on dolls, which most participants indicated was not discussed in the classroom during LO:

P10: … We were shown how to use these condoms by the Desmond Tutu Foundation. They brought dolls and all the girls were just laughing, and they showed us this is the hand condom, etc. I saw finger condoms and hand condoms. I will never use a condom. I'm too scared, it will get stuck and can't come out. … I just listened and I ask questions but I won't do it myself.

P12: …It is in my classroom, we just discuss about sex and they don't ask questions. But last year there was a thing like that at school where people from Desmond Tutu came and spoke about SRH with us, in a group and one on one like this, but they don't come here anymore.

The Life Orientation classes were reported to be boring and uninformative and left them with unanswered questions. SRH information was shared among all teenagers in the classroom and the participants did not feel comfortable discussing their personal issues in front of their male peers. It is evident from the responses that learners were provided with limited information about sexuality at school, and that the setting did not seem conducive to enable active learner participation.

4.5.3.2 Subcategory two: Inadequate SRH counselling services at the high school

The researches asked participants if there were any psychologists, counsellors, and/or social workers available to them at school. The participants' answers varied, as most of them acknowledged the NGO called PASCAP (Partners with After School Care Projects) which supported the students. Their availability was staggered, especially because of COVID-19 protocols. Most participants said that they did not use PASCAP services. A few participants mentioned that their visits with PASCAP were not conducive and they did not return. One participant mentioned that she is being treated by her family psychologist, and therefore does not make use of the school's services. The rest of the participants reported that they were either not aware of the services available at school or they denied being informed. Some participants mentioned that they did not trust the counsellors either because they did not feel that a male counsellor could give them the correct advice:

> **P10:** … I was once by our school's group called PASCAP but I go to my private doctor at Melomed. That's our psychologist, we use the medical aid. PASCAP is helpful but it is just like, I feel what a person tells them, they are going to tell your parents. I don't like that. I have two teachers in the school that I would talk to and they'll be okay with that, and after talking I'll feel much better.
>
> **P11:** There is a social worker around the school and there is PASCAP but due to COVID-19 they are not at school.
>
> **P1:** … Only social workers because I was once there. … they didn't really send me yet for this pregnancy.
>
> **P17:** Yes, one of the teachers was a social worker before he became a teacher, so he told us that if we have problems and stuff like that we can come to him, and he referred us to another teacher but I don't know what he was.

P6: … I don't know if there is a social worker or counselling at the school. I don't think so. No one at school informed me about this.

4.5.4 Category four: Lack of access to the internet or compatible devices

Participants expressed many challenges that prevented them from accessing SRH information. A lack of devices such as computers or access to the internet was one of them. These participants come from an underprivileged area, where parents are often unemployed and depend on government grants to survive. Most participants especially depend on accessing computers at school and at libraries. Other participants with personal cell phones or computers have limited or no data or Wi-Fi available to access the internet:

P8: … It is not always that I look for information [SRH], but sometimes when I'm really bored and if I open my phone and I get a notification about for e.g. a girl got pregnant, then I just say to myself let me check reasons for that on the internet.

P9: … The school doesn't allow us to use the computers for personal things and my access to the internet is limited, it is only available at night.

P12: I don't have access to the internet, I don't have a phone or computer at home.

4.5.4.1 Subcategory one: Schools' restrictions to internet access

Participants have indicated that although the school has Wi-Fi for students and staff, they do not always have internet access via the school internet, or at home due to financial restraints. These participants expressed that they do not always have money to buy data to browse the internet:

P1: … I don't have money to buy data for my phone so I can't access the internet to search for SRH information.

P14: … I am not always going to have data and it is a challenge because sometimes I need to Google for information but then I have no data. My mommy is not always going to be there for me.

Those participants who do not have personal devices or data are disadvantaged at school and at home. Participants expressed that data availability and internet access was a common problem which left them feeling vulnerable, especially when they had questions that needed to be answered:

P6: … I can't access the internet all the time, I would obviously need to buy data but I don't always have money.

P14: … It is a challenge; I don't always have access to data or Wi-Fi. There's going to be a time when I will need that information and it will be a problem, because then you don't have information needed to help you.

If the school allowed the learners to access the Wi-Fi and computers, then these participants would be able to search for any health-related information to learn. Particularly, at their age, this may increase their knowledge to enable them to take care of their health, physically and emotionally:

P1: … you have to buy your own data but the school does have a computer lab, but we have never been on the computers here, only teachers use it.

P10: … It is a challenge to access the internet sometimes, because I don't know what's up with the school's computers, but from next year on I think we will be use it when doing work for CAT (Computer Applications Technology). We never did computer lessons at school.

Others expressed personality problems when it comes to exploring information and not having time to search for it on Google because of too many responsibilities at home:

P11: … I can't you go on the internet to look for information, and I am a shy person to ask people questions about my SRH. I don't know what I would Google though [laughing]. My mam works, so when I get home I have to look after the children, and I don't get much time for myself to sit and Google information.

4.5.4.2 Subcategory two: Availability of compatible devices

All of the participants mentioned that they could not access the library computers without a library card. They also mentioned that the school has a computer lab, but they could not use those computers unless it was for school purposes. Not all participants had compatible devices to make use of during their private time away from school. One participant mentioned that she had no cell phone and others mentioned that they did not have computers at home or did not have access to an internet café:

P12: … I don't have a computer or phone, so I can't access the internet at home. The school has Wi-Fi but only allows us to use the computers sometimes for school work.

P8: … I don't always have access to the internet at home and I just don't have money to buy data to search.

P17: … I don't have a library card at the moment, but you can only use the computers if you have a library card.

As expressed by the participants, not having personal devices that are compatible for internet access was a challenge that they faced. This demotivates them and inhibits their process of searching for SRH information needs.

4.5.5 Category five: Engaging in risky behaviour

Poverty is one of the main contributing factors for teenage pregnancy, as it limits a teenage girl's right to make decisions and/or choices. Young girls living in poverty have a higher rate of teenage pregnancy than the average population in South Africa. Poverty causes a person to

do unthinkable and dangerous activities to survive. These are associated with commercial sex, alcohol or drug use.

4.5.5.1 Subcategory one: Engaging in commercial sex

Most of the time teenage girls engage in sexual activities for survival, and they are also allegedly partaking in risky sexual encounters for personal gain. This personal gain may include buying themselves luxuries and gifts or to fund a reckless lifestyle like an alcohol or drug addiction. The researcher asked participants if they have observed girls who desperately needed money and resorted to having unprotected sex so that they could satisfy their cravings, such as for drugs and food, or clothes and education. Participants commented as follows:

> **P1:** … many young girls sell themselves (interact in commercial sex) for money or for drugs. It's like they are addicted; they can't stay without it.

> **P14:** This problem is common in this area because there's a lot of 'druggies' [drug addicts]. It is like they sell their bodies [partake in commercial sex] in return for drugs.

The participants have shared that commercial sex is a big problem in the area where this study was conducted, and many of them knew girls who engaged in these types of unsafe activities.

Teenage girls who are brought up in poor families may have expensive desires, and engaging in transactional sex is an easy way to satisfy their needs. Many times teenage girls feel the need to fit in at school, but cannot afford to do so, consequently turning to 'sugar daddies' for monetary gifts in exchange for sex:

> **P7:** … I know about a girl that's living in one area. She likes to have sex with the gang members to get money for food for her family and so on.

> **P10:** The guys with money take advantage of girls, because they know for a fact they have no money, and they will do anything to survive. They get the money but they also get blackmailed,

e.g. threats about sex tapes that will be leaked if they don't follow orders. Yes, it is actually a big problem, especially here in this area.

P11: ... Sometimes the girls in this area have sex when they need money and if it's unprotected they can fall pregnant.

4.5.5.2 Subcategory two: Drug/alcohol addictions

Risky sexual behaviour increases a teenage girl's probability of becoming pregnant. Alcohol and drug use may encourage unintended pregnancies. Drug addiction is a huge problem in this area, and some participants have witnessed this scenario play out. In many circumstances teenage girls would engage in unprotected, random sexual encounters in order to access drugs easily. Sexual desires are increased when an individual uses drugs, and the drug interacts within the human body. The following are extracts from the participants:

P17: … after the girls intoxicated with drug or alcohol, they might be forced to have unprotected sex, but that is unsafe. They can pass on sexually transmitted infections to the girls. They don't know all the places and different women the men are sexually active with.

P15: … You do get some of the girls that go to a lower extent just to get money to buy drugs. They would have unprotected sex with different men without thinking of the consequences. **P10:** They get infections from having unprotected sex and or they get pregnant; if they can't cope, they kill the baby. They will not go to the clinic for help if they don't want a baby. They will do whatever they hear from other people that they think is right, and put their life in danger as well.

P9: … Girls are having sex for money, maybe to contribute to their drug addiction or they don't have food to eat, so their last resort is to have sex for money. They sleep with any random man who can transmit STIs or any kind of disease.

This study established that teenage girls who are under the influence of alcohol or drugs are vulnerable to engaging in risky sexual behaviours through a lack of self-control. It is evident that teenagers' risky behaviour, such as consuming alcoholic beverages and also the lack of recreational facilities, can lead to risky sexual behaviour and resultant teenage pregnancy.

4.6 Conclusion

The analysed data revealed that the decision of teenagers to use contraceptives is influenced by many internal and external factors. Although the participants have knowledge about contraception, the utilisation of services remains poor due to many interrelated barriers. In the next chapter, the researcher will discuss the findings in accordance with personal, social and environmental factors.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

In the previous chapter, the findings of this study were presented, highlighting what this study added to the existing body of knowledge regarding understanding the SRH information needs of teenage girls at a high school to prevent teenage pregnancy in the Western Cape. Three themes emerged from the study: the information needs of teenage girls, the information-seeking behaviour of teenage girls, and barriers to teenage girls' access to SRH information. In this chapter, the findings are discussed concerning the current evidence in the literature and the conceptual framework of Wilson's model of information-seeking behaviour.

5.2 Information on SRH needs of teenage girls

SRH is a health concern that is poorly addressed at facilities such as schools and clinics, resulting in limited access to the SRH information that is needed by teenagers. The low level of SRH awareness and knowledge increases teenage girls' vulnerability to the incorrect use of contraception, with them believing SRH myths, which increases their risk of STIs and unplanned pregnancies. A contributing factor to the lack of SRH knowledge stems from poor social support and community engagement. This finding is consistent with the existing evidence of Narker (2022), who reported that the governing bodies of high schools did not allow the topic of SRH to be addressed among teenagers, as they believed that it would be promoting promiscuity. Wilson's conceptual framework explains that environmental factors, such as political (school governing bodies) conditions, affect information needs (Wilson, 1999). Similarly, Kundu (2017), who used Wilson's theory, suggests that an information need is perceived by an information user in different stages or sequences. To satisfy that need, the

user makes demands upon formal or informal information sources or services. The study reveals that there is an information need about SRH among teenage girls, particularly the availability of counselling services at schools and local clinics regarding contraception and the importance of adherence to contraception. There is an information need about the locations of youth-friendly clinics with friendly staff, low costs, and quicker SRH service delivery. Teenage girls need assurance regarding their privacy and confidentiality of information. Information needs were identified in the study as an area of concern because all of the participants could not adequately understand SRH. Participants' main needs were information about contraception, how to use it correctly and the side effects involved. This finding is supported by Brody (2018), whose research showed that half of the high school seniors have already become sexually active and require the most recent information about contraception as well as easy access to SRH services. Most teenage girls are not exposed to the variety of contraceptive methods that is available or their advantages and disadvantages.

5.2.1 Teenage girls' understanding of SRH

Teenage girls often misunderstood SRH due to their lack of knowledge thereof. The participants voiced that they were not ready to have babies; however, they did not know how to protect themselves adequately. They have heard information about SRH from family members and friends but did not always understand the information received. They would develop their understanding thereof with little to no guidance when putting the information into perspective. This lack of appropriate guidance to empower young girls created a sense of anxiety and vulnerability among teenagers. Wilson (1999) proposes that the basic need can be defined as psychological, affective, and cognitive; in this aspect, information about SRH is the teenager's personal affective need. According to Qolesa (2017), the lack of understanding of SRH is considered one of the major factors involved in teenage pregnancy. Females are

designed to have the same reproductive developments and changes, but they differ hormonally. The participants indicated that they know about certain types of contraception, but not all. They were uncertain about the contraceptives' mechanism of action within the female body, which included the side effects of contraception and the menstrual cycle. When teenage girls are not well informed about how to protect themselves, it rendered them vulnerable to consequences such as GBV, coerced sexual relations, poor decision-making skills, and unwanted pregnancies. This finding was supported by Webster (2019), who found that the most common type of reproductive coercion is when male partners withhold or destroy contraception.

5.2.2 Knowledge about the different contraceptive methods

There are various contraceptive methods available in the Western Cape; however, not all were advertised as optional choices. The study reveals that poor SRH consultations and lack of SRH knowledge led teenagers to misinterpret the information about contraceptive use. The mode of delivering this vital information hindered how the information was perceived by the participants. Generally, there was a lack of contraceptive knowledge due to the information not being discussed in detail during consultation visits with health professionals. This finding was supported by Yakubu and Salisu (2018), who reported that during a consultation, the clinician does not explore the fears of teenage girls regarding contraception, causing inadequate SRH education and misconceptions. Wilson's (1999) model of information behaviour explains that the environment is the main barrier to satisfying personal information needs. The participants heard about the two types of contraception, injectable and oral contraception, but they did not know them by name, usage, or side effects. The injectable method was the one most spoken about in their environment and commonly used by the participants' friends and families. This finding is consistent with the findings of Chersich et al. (2017), who reported that in South Africa the injectable progestins depot-medroxyprogesterone acetate (DMPA/3 months) and

norethisterone enanthate (NET-EN/2 months) were the most popular contraceptive methods. A condom is a barrier method of contraception that was readily available in most public areas; however, the findings reveal that teenage girls were hesitant to use it because they did not know how to do so correctly. Brody (2018) reported that condoms were freely accessible to teenagers, but there is no information attached on how to use them correctly.

Some side-effects of contraceptives were mentioned, with the most common side-effects identified being weight gain and infertility. However, Villines (2020) reported that numerous studies have shown that contraception does not cause weight gain. This type of information about weight gain stems from the misguided information received from their environmental information sources. The uncertainties about side effects played a key role in a female's disapproval of the effectiveness of contraception. The use of contraception was low among teenagers since they feared the possibility of experiencing these side effects more than the risk of conception through unprotected sex.

The findings contributed to a clearer understanding of what Fakudze (2018) stated – that the reasons for teenage girls not using contraception include their fears of being stigmatized and exposure to unpleasant side effects. The participants felt that using contraception was unsafe and the perceived side effects of contraception discouraged teenagers from using or continuing to use contraceptives. According to Shelver (2022), many learners were sexually active but not all were using contraception; learners indicated that contraceptives were dangerous and boring. Not all contraceptive methods are suitable for all females; therefore, a thorough discussion with a professional is necessary to identify the most suitable method and to alleviate the occurrence of possible side effects. It was evident from this study that the SRH information received from friends and family was often misinterpreted, resulting in teenage girls avoiding contraception. Some participants believed from what they heard that the three-month injection caused infertility, but they had no evidence to substantiate this. This finding is supported by Mwaisaka

et al. (2020), who found that teenage girls perceived contraceptives as jeopardizing future fertility and that they could lead to serious health complications, such as prolonged menstrual bleeding, problems conceiving, and birth defects.

The study reveals that information about oral contraceptives and Implanon was misinterpreted. Participants perceived that oral contraceptives could cleanse the body from 'dirty blood' stored in the body during amenorrhea. This finding is similar to the findings of Polis et al. (2018), who found that some women perceived amenorrhea to cause a build-up of "dirty" or "blocked" blood, which in turn was perceived as causing blood clots, fibroids, emotional disturbances, weight gain, infertility, or death. Misinterpretations of the information about oral contraceptives were a big barrier for teenage girls, as it prevented their use of contraception. The withdrawal method was also mentioned in the findings as a way to prevent pregnancy. However, this method is not considered to be a form of contraception and is not safe to practice. This finding was supported by Jean Hailes for Women's Health (Anon., 2018), who reported that the withdrawal method is not effective and is not a form of contraception. Some teenage girls misinterpreted that oral contraceptives were effective as soon as they started using them, which is not true. A female's natural hormones in the body need to become familiarized with the artificial hormones of the pill before it is 100% effective. According to research by Cleveland Clinic (2022), women need at least one week for the hormones in a contraceptive pill to work with a woman's natural hormones to prevent ovulation.

Most teenage girls misinterpreted the purpose of an ECP and used it as a quick way to prevent pregnancy. The ECP is a high-dose contraceptive pill that should not be used inappropriately. The ECP is most effective within the first 24 hours of unprotected sex. This finding is supported by Wilson's (2020) study findings, which reported that the ECP is a high-dose birth control pill that is effective for up to five days and does not cause abortions. It does not have the same mechanism of action as the abortion pill, which was another misinterpretation made by teenage

girls. This finding can be explained by the study of Villines (2020), stating that the ECP delays the process of ovulation, preventing the egg from being released and fertilized, whereas abortion is a procedure done to interrupt an established pregnancy.

5.3 Teenage girls' SRH information-seeking, sharing, and source of information

The information-seeking behaviour of the teenage girls explored in this study was in progress; however, it was met with a few barriers. Personal information needs are the foundation of the motivation to seek information. Wilson's (1999) model of information behaviour highlights that part of the information-seeking behaviour may involve other people through information exchange, and that information that is perceived as useful may be passed on to other people as well as being used, instead of being used by the person himself or herself. Wilson describes information-seeking behaviour as the purposive seeking of information as a consequence of a need to satisfy some goal (Kundu, 2017). The findings of the study reveal that teenage girls do seek information from various sources as the need arises, such as from the internet and library, to access information quicker and more easily. Teenagers would Google SRH information by themselves or with friends when accessing the internet.

A local clinic is an option for obtaining SRH information; however, it is not the best option for teenage girls, due to the nurses' negative attitudes toward them. This finding is incongruent with the findings of Daniels (2021), who identified that when teenage girls are at the clinic they don't get the information they seek on how contraception works. Most teenage girls find it easier to speak to friends than family members, and they share new and pre-existing knowledge about SRH, contraception, and sex. Teenage girls feel comfortable confiding in girls their age who are experiencing the same information needs as they are. Teenage girls also seek SRH information from their family members, mostly from mothers or sisters, while others preferred to do their information-seeking privately using the internet. This finding was incongruent with

the study conducted by Nmadu (2017), which reported that teenage girls' preferred sources to obtain SRH information were friends and the internet.

5.3.1 Teenage girls' SRH information-seeking behaviour for decision making

A teenager's knowledge plays a vital role in their information-seeking behaviour for decision-making, which influences their health and development. Teenagers' decisions to seek SRH information and services may be influenced by external factors such as family, friends, teachers, and nurses. In this study, family and friends were the strongest influences that affect teenage girls' behaviour. Similarly, Narker (2022) reported that family and friends are the strongest influences that affect a teenager's information-seeking behaviour. When teenage girls approach their family members for advice or information about sex, they are often faced with resistance and reprimanded as it is regarded as a breach of societal norms. This causes teenagers to turn elsewhere to get their questions answered. Teenage girls perceive family, especially older family members, to be hesitant to discuss SRH matters. This finding is supported by Nmadu (2017), who stated that discussions about SRH were a 'no-go' area among families, specifically parents, because of societal norms which discouraged such discussions. The teenage girls in this study reported that in many circumstances their family would scare them with information about how bad sex is for them and that they should just stay away from it. Teenage girls were led to believe that even just enquiring about sex was considered bad, sinful, and inappropriate for their age. This discouraged the teenage girls from asking questions about SRH, which contributed to their lack of knowledge and poor information-seeking behaviour. This finding is supported by Duby et al. (2022), who stated that if teenagers admitted to their parents that they are in a romantic relationship or asked questions about sex, they would be met with anger or violence; as a result, they avoided seeking information from their parents. Findings in this study present some participants who felt that they could discuss any matter about their SRH with their mothers; however, this is not always the case, as many teenage girls

are scared to seek information about contraception from their mothers. This type of familial restriction on vital information will continue to impact how future generations are sexually educated. According to Duby et al. (2022), parent-teenager communication is particularly important in reducing the rate of teenage pregnancy. Parent-teenager communication about SRH and sex has a significant influence on teenagers' behaviour in making responsible decisions regarding their SRH and attending clinics for those services.

This study reveals that the majority of teenage girls attending school felt that SRH services should be provided on their school's premises, which would overcome some barriers to their information-seeking behaviour. However, there were concerns about their privacy and confidentiality when accessing these services at the school. This finding was supported by a study conducted by Nmadu (2017), which revealed that respect for privacy and confidentiality facilitated teenagers' access to and utilization of SRH services. The findings also showed that participants had poor insight into how to use female condoms and blamed the school's poor Life Orientation education system for this. It was evident in the study that teachers need to be educated on how to teach Life Orientation correctly. This finding was congruent with that of a study conducted by Venketsamy and Kinear (2020), who stated that teachers need to be adequately trained in the content and teaching methodologies of CSE in schools to deliver Life Orientation competently.

Teenage girls reported that they were nervous and feared going to their local clinic in search of SRH information and services because nurses displayed judgmental and strict behaviour towards them. Often the teenage girls felt bullied and unsupported by nurses at the clinic. This finding is congruent with those of Narker (2022), which states that nurses were unsupportive toward teenage girls' information-seeking behaviour in decision-making about their SRH.

5.3.2 Teenage girls' SRH information-sharing behaviour

The study identified that most of the participants felt awkward and uncomfortable speaking to their parents about sex. Besides feeling uncomfortable, they also had fear about their parent's reactions to their inquiries. A study by Kitching et al. (2019) supported this finding, as it reported that adults scare and shock girls by communicating with them and conveying how bad sex is. A few participants showed a desire to share and have frequent conversations with their parents about sex, despite how uncomfortable it may be. Other participants revealed that they lived with their grandmothers and felt that it would be disrespectful to share and discuss SRH issues with an elderly person. Their grandmothers were strict and did not entertain SRH topics, since these were seen as taboo. A similar study indicated that it is culturally immoral and disrespectful to talk about sex with their grandchildren (Narker, 2022).

Teenage girls' curiosity about sex stemmed from conversations and interactions with their friends. They felt comfortable sharing information with their friends who had experience. The findings presented that most participants had close friends whom they could trust to share their personal information. According to Qolesa (2017), adolescents spend more time with friends and peer groups than with their parents, which can affect their choices and decisions. Sharing SRH information with friends could have positive and negative effects. Participants indicated that some friends were judgmental and unsupportive, which caused them to exit the circle of friends as they no longer trusted them. In contrast, most friends were understanding and supportive of the decisions made as to whether to engage in sexual activity or not. This finding is supported by Narker's (2022) finding that some teenagers are hesitant to talk about sex with their friends, while others found it easier to do so and felt supported by them.

5.3.3 Source of SRH information

The findings indicated that the internet and the library were common sources of SRH information. These sources protect teenage girls from experiencing social stigma and allowed

them to remain anonymous. Many participants validated the relevance and trustworthiness of the information obtained from these sources. Those who used the library found the librarian helpful in locating relevant literature and information. These sources of information encouraged independence among the participants when seeking information. The internet and library were often used as information sources when teenagers had an inquiry about their SRH. Evidence to support this finding was found in a study by Yakubu and Salisu (2018), who stated that teenagers search for SRH information via the internet and commonly use their cell phones for access, which also promotes easier communication between peers and partners, motivating early sexual debut.

The findings reveal that Life Orientation classes as a source of information at the high school did not adequately equip teenage girls with SRH knowledge. This finding is consistent with the findings of a study conducted by Nmadu (2017), where it was reported that teenagers were exposed to reproductive health messages which were commonly about HIV and STIs, rather than contraception, through programs organized by the school or NGOs. Most participants preferred to have a female teacher because they could comfortably ask questions related to SRH topics, and the teacher may be able to relate to the queries they had. A few participants mentioned that they used a Life Orientation textbook for reference; however, other participants could not identify any prescribed textbooks related to SRH. Kitching et al. (2019) reported that parents felt that it was the teachers' responsibility to discuss SRH topics with their teenagers. However, in this study, it was identified that some teachers did not know what to teach the learners during Life Orientation, and at times they felt uncomfortable discussing the topic themselves. This finding is in agreement with the findings by Kitching et al. (2019), who asserted that when teenage girls tried to talk to their teachers, the teachers seemed to find excuses not to talk about sexuality. They were not receiving valuable information from either their parents or their teachers.

Participants in a peer group study by Duby et al. (2021) indicated that they felt positively affected by building social confidence, and the ability to talk, share and laugh with peers when discussing SRH topics. They would seek information from their friends before their family members. According to Qolesa (2017), teenagers would not ask family members because they were afraid of them questioning why they were interested in searching for SRH information. Parents feared promiscuity, teenage pregnancy, and all the challenges associated with it, so when speaking to their mothers the teens did so with caution. According to Jonas et al. (2020), when parents know about their teenage girls using contraception and support them, it becomes easier for the girls to use and access it correctly and consistently.

Participants blamed the nurses' inappropriate behaviour and the unpleasant clinical environment for their reluctance to access clinics for SRH information and services. Most of the teenage girls reported that nurses were rude, unfriendly, judgmental, and opinionated. Teenage girls were embarrassed and stigmatized when attending clinics for contraception. This source of SRH information was seen as the least favorable to access. A study by Jonas, et.al. (2020) provided evidence in support of this finding by stating that nurses shout at teenage girls and humiliate them by saying they are too young for contraception in front of everyone at the clinic. Information received from the clinic also depended on the level of education that the nurse had around SRH. Nurses did not provide teenage girls with sufficient SRH counselling, thereby limiting their SRH knowledge, specifically about contraception. This finding was supported by research by Jonas, et al. (2020), which stated that nurses do not explain to teenage girls how the injection works and what side effects to expect.

5.4 Barriers to teenage girls' access to reproductive health information and risk factors

The findings of this study revealed that traditional, cultural, and religious beliefs, negative attitudes of nurses, unavailability of user-friendly clinics, an inadequate Life Orientation course, and lack of access to the internet or compatible devices are the main barriers to SHR

information needs and information-seeking. Wilson's model of information-seeking behaviour shows how the information-seeking barriers develop during trying to meet the need for information and these are psychological, demographic, role-related or interpersonal, environmental, and source characteristics (Kundu, 2017). In addition, engaging in commercial sex due to poverty or addictions, the lack of parental advice and support, social stigmatization, and fear of embarrassment for seeking SRH information all posed barriers for teenage girls. Wilson's 1996 extended model of information-seeking behaviour describes how when seeking to discover information to satisfy a need, the enquirer is likely to encounter barriers of different kinds (Wilson, 1999). A person realizes that there is a need for information, and tries to look for information by overcoming potential barriers. These barriers have a negative influence on teenage girls' motivation to seek information. The teenage girls were faced with these barriers from the point of realizing there is a need for SRH information to their information-seeking behaviour. All the teenage girls in this study revealed that they need to obtain SRH information to understand their SRH in all its aspects, such as their menstrual cycle and conception, among others. At the same time, most of the teenage girls expressed that they experience difficulties when trying to satisfy their information needs. This finding is supported by those a study conducted by Jonas et al. (2020), which reported that the lack of SRH knowledge was perceived to be one of the barriers preventing teenage girls from accessing SRH services.

5.4.1 Barriers related to traditional and cultural/religious beliefs

Traditionally, it is expected that only married women will use contraception, and if young girls enquired about SRH then they were believed to be promiscuous. The findings contributed to a better understanding of a study by Loi et al. (2019) which identified that contraceptive use was associated with a promiscuous lifestyle. Many teenage girls did not know that it was considered acceptable by many people outside of their religion and/or culture to search for information about SRH. The community disapproved of teenage girls accessing SRH services, and while

participants wanted to seek SRH services at the clinics, they feared being recognized by members of the community, who may or may not know their families. This finding was supported by Nmadu (2017), who found that teenagers were afraid of being seen by family and neighbours when utilizing SRH services. Teenage girls are negatively labeled when they use contraception or if they are found with condoms; this creates a stigma around contraceptive use. This finding is congruent with a study by Daniels (2021), who reported that the contraceptive use stigma toward teenage girls resulted in many of them having to hide their contraception, if they were using the pill, or hide their clinic cards from parents and, in some cases, from their boyfriend.

This study revealed that teenage girls were influenced by religious norms, which impacted their accessibility to SRH services. These greatly restricted participants who belonged to staunchly religious or cultural families. In many religions and cultures, it is believed that sexual relations should only occur within a marriage, otherwise it is considered sinful. Unmarried teenage girls are particularly affected by contraceptive use stigma because of religious beliefs about premarital sex and social norms. This finding is in agreement with those of Loi et al. (2019), who noted that religious beliefs and socio-cultural norms continue to contribute to the condemnation of premarital pregnancy and contraceptive use. Religious and cultural taboos prevented parents from discussing SRH matters with their teenagers, which meant that limited guidance and support were provided to the teenage girls in this study.

5.4.2 Unavailability of user-friendly clinics

The findings of this study indicated that nurses refused to accommodate learners in the afternoon after school. The nurses' unprofessional attitudes and behaviour contributed to the unfriendly environment at the local clinic. These findings are consistent with those of a study conducted by Nmadu (2017), who identified that the judgmental and unfriendly attitudes of HCWs toward teenage girls seeking information related to SRH also violated the rights of these

teenage girls. Findings also revealed that the unavailability of contraception posed an interference with the girls' use of contraception. Nurses would give them a two-month injectable method instead of the three-month injection because of not having stock. Daniels' (2021) report verified this finding, stating that when teenage girls were using the injection there were stock-outs at many clinics because of COVID-19, causing them to be switched to an available method.

The study identified that teenage girls were expected to be at the clinic in the morning during school time for contraceptives. There would be no time for travel between the clinic and school, and the entire experience would be rushed with no time to exercise their information-seeking and consultation for more understanding and decision-making. This finding is similar to the findings of Nmadu (2017) that teenagers complained that the clinic's operational hours usually corresponded with the time they are meant to be at school. This study also suggested that long waiting times were another contributing factor to the low utilization of SRH services. Teenagers visiting the clinic after school felt that nurses were not being considerate towards them, as they were made to join the long queues even though their visit to the clinic was after a long day at school. The non-flexible operating hours of the clinic were not favorable and hindered teenage girls' use of SRH services. Mokomane et al. (2017) stated that some of the health facilities' barriers included the opening hours, which are not convenient for school-going adolescents.

5.4.3 Inadequate Life Orientation (LO) course

The Life Orientation class has been offered for both genders (boys and girls) in the same class, which limited the amount of interaction among the learners of different gender groups. The teenage girls could not speak openly about their SRH concerns or answer personally related questions honestly due to their fear of being judged by their male classmates. Most participants preferred to be silent during Life Orientation class because there was no privacy or

confidentiality in the classroom, which hindered their participation in discussions. The lack of privacy experienced by teenage girls discouraged them from enquiring about and exploring more information about SRH from services rendered (Yakubu & Salisu, 2018). In addition, some teachers did not feel comfortable discussing SRH topics with the teenagers and steered away from doing so. Loi et al. (2019) provided evidence for this finding, stating that teachers are poorly equipped to provide comprehensive sex education. The results showed that teenage girls did not know how to apply and use condoms and very few had seen a female condom. This was never demonstrated during the Life Orientation class. According to Venketsamy and Kinear (2020), many educators across South African schools lack uniformity in professional training and come from a diverse range of fields which do not always adequately equip them for delivering CSE confidently and effectively.

The findings of this study indicated that there were social workers and counselors available at the school; however, not all teenage girls knew what procedure to follow to access them for help and support. These personnel were off-site during the COVID-19 pandemic, which increased the difficulty of accessibility for teenage girls. This barrier often left the girls feeling despondent and they would eventually stop seeking the information they needed. This finding is supported by the findings of Daniels (2021), which assert that counselling is needed where young people can talk about relationships rather than only how to prevent pregnancy.

5.4.4 Lack of access to the internet or compatible devices

Financial constraints were seen to be a barrier to teenage girls' access to and utilization of SRH services. This finding implied that teenage girls struggled with data support or access to Wi-Fi when trying to access SRH information. They relied on personal data for network coverage. Teenagers were often not able to top-up with data because they relied on financial support from their caregivers. According to Duncan-Williams (2020), data prices were too high due to COVID-19, especially for mobile prepaid data. Wi-Fi access at the school was poor and mostly

unavailable for learners. The participants expressed that although they do have limited access to school Wi-Fi and the school's computers, these were not readily available to them. They could only use the computers and Wi-Fi for school tasks and could not search for personal information. This forced teenage girls to use their devices – if they had them and had data.

The findings revealed that most teenage girls did not have access to compatible devices at home. Devices are expensive and teenage girls in this study were not working and therefore could not support themselves. Some households only have one device to share; for example, a cell phone was shared between all members of the family. This did not protect their privacy and put them at risk of being embarrassed and judged. Those who had their own devices indicated that it was difficult to maintain having data available because of financial dependency. These findings are consistent with those of Mizunoya et al. (2020), who found that more than two-thirds of school-age girls and 63% of youths aged 15 to 24 years lack internet access at home. The study provides insight into the relationship between financial constraints and the restricted information-seeking behaviour of teenagers.

5.4.5 Engaging in risky behaviour

The lack of support and guidance provided to teenage girls by their parents or caregivers renders them vulnerable to many risky activities. It was evident from the study's findings that none of the participants engaged in commercial sex for financial gain; however, participants were familiar with girls who did engage in commercial sex for monetary gain. The results suggested that teenage girls take part in commercial sex for money to support their families or their lifestyle habits, such as wearing expensive shoes or clothes. Similarly, the findings of Ruiters (2022) indicated that young girls are lured to sex parties and paid R1500 or given clothing in exchange for sex with men, who are normally twice their age. This type of activity normally occurred among older men. The teenage girls interviewed were aware of the consequences faced by engaging in this risky sexual behaviour. The participants heard that

these girls would often not use condoms or contraception to protect them from STIs or pregnancy – and this would often be the demand of the paying customer. A study by Kitching et al. (2019) suggested that teenage girls with no parental guidance are more at risk of exploitation by sexual predators such as 'sugar daddies'.

Drug and alcohol addictions contributed to unsafe sexual activities like commercial sex. This was just a different incentive for engaging in commercial sex. The same risks were involved among the same age groups. The findings reveal that addicts did not care about the risks involved, but needed to satisfy their cravings which cost a lot of money. These findings are supported by those of Ruiters (2022), who reported that young girls are unwittingly becoming trapped in the sex trade when offered money, drugs, or alcohol. Those teenage girls who are addicted to drugs and/or alcohol have no clear way of thinking – all they wanted was what they craved. The participants revealed that this was occurring in their community as a result of high drug and alcohol addiction rates.

5.5 Conclusion

A teenage girl's information needs and information-seeking behaviour are influenced by both the personal perceptions of the teenager and environmental factors. The study reveals that factors like inadequate knowledge about SRH, poor attitudes towards seeking SRH information as well as certain behavioural patterns of teenagers impacted negatively on their SRH information needs. Social factors such as family, community, and religious norms, financial constraints, and associated stigma also negatively influenced the information needs and information-seeking behaviour of teenage girls to utilize SRH services. Health system factors such as the nurses' poor attitudes toward teenage girls and the inconvenient operating hours of the clinic were also found to prevent access to and use of SRH services. Teenage girls would make more use of SRH services if they were made to feel welcome and comfortable when attempting to seek information and SRH services.

CHAPTER SIX

Summary, limitations, recommendations, and conclusion

6.1 Introduction

The previous chapter discussed the findings of the study. This chapter outlines the overall summary of key findings, the limitations of the study, recommendations, and conclusion. The findings of the study demonstrated the interrelatedness of different factors influencing teenage girls' SRH information needs and information-seeking behaviour, making it a complex public health problem to address. This chapter provides recommendations for relevant stakeholders, focusing on what needs to be addressed and improved at high schools, health facilities, and at community level to allow easier access to SRH information for teenage girls.

6.2 Summary of key findings

The aim of this study was to explore the SRH information needs, information-seeking behaviour and barriers to SRH information among teenage girls at a high school to prevent teenage pregnancy in the Western Cape. Parents/guardians were seen to be the key barrier at the interpersonal level. This study has revealed that the level of parent-teenager communication is poor. The gap in SRH information identified in this study has existed from generation to generation and is influenced by familial religion and/or culture. Parents/guardians are reported to be strict and unapproachable. When teenage girls initiated discussions about their SRH, this was commonly met with judgement, and in a reprimanding tone of voice. Parents/guardians found it easier to avoid topics about sex and contraception and left the responsibility of SRH education to the school teachers.

Teachers, on the other hand, did not feel comfortable discussing SRH either. The teachers did not provide SRH information as per the curriculum due to their personal views and feelings

about the topic. Teenage girls have concerns about privacy and trust issues about teachers and other learners, and this created yet another barrier to seeking SRH information. Teenage girls in this study felt that there is no privacy in the Life Orientation class. The classroom includes both genders, and teenage girls do not feel comfortable talking about personal issues in front of everyone. They feared that their inquiries about SRH would be discussed outside of the classroom. As a result of these barriers, teenage girls usually turned to their friends for information about sex and contraception. Another key finding is that teenage girls feel happier discussing their SRH inquiries with their friends rather than with their family. They do not feel judged by their friends, because their friends can relate to their SRH concerns.

The nurses' negative attitudes toward teenage girls' SRH information needs and access to SRH services were the main barriers identified at the health service level. Nurses' negative behaviour toward teenage girls had a negative influence on their methods used for seeking SRH information and services, consequently placing the teenage girls at risk of an unplanned pregnancy. Clinics are a vital source of SRH information, especially regarding contraception; however, participants were not eager to seek information there due to their fears of embarrassment and stigmatisation. The participants felt that they had no right to go to the clinic, because they were made to feel that way by the nurses. In this study the teenage girls turned toward sources of information such as their friends or the internet, which may provide incorrect information and increase their misinterpretations of contraception. Some teenage girls would not seek SRH information at all for fear of receiving the same reaction from other people.

Apart from misinformation and negative perceptions influencing their decision to use contraception, cultural and religious norms are contributing factors that influenced teenage information needs and information-seeking behaviour. Teenage girls were challenged by many barriers, like stigmatisation from the community and their families, when inquiring about their

SRH because their cultural and/or religious norms acted as inhibitors to this type of information.

6.3 Limitations

One limitation of this study was that it focused on data collection from teenagers who were residents of the same community, excluding teenage girls from other communities in the Western Cape. Therefore, the findings of the study cannot be generalised, as the sample was not representative of the entire teenage population. Only 17 participants from that location were interviewed. However, the aim of this qualitative research was not to generalise but rather to have an in-depth understanding of the phenomenon, which a small sample could achieve.

Recruiting participants through the school was found to be challenging due to the COVID-19 national lockdown. Social distancing and personal protective equipment had to be adopted and adhered to. This prevented the researcher from speaking to the population group as a whole when presenting the research topic and what the study entailed. Each Grade 11 class had a different day of attendance at school in order to maintain social distancing, which made access to the study population challenging and prolonged the data collection process.

Teenage pregnancy is a very sensitive topic to discuss, and this presented another limitation to the study. Sensitive information may have been withheld from the researcher. As this is the researcher's first experience in qualitative research, there was a limitation on how to explore such sensitive information systematically. Participants could have shared information which they thought the researcher wanted to hear, which might not necessarily have been the truth.

6.4 Recommendations

Recommendations regarding Comprehensive Sexuality Education, availability of SRH information resources, addressing negative attitudes of nurses, improving parent-teenager

communication, and implication for further research are made based on the findings of this study.

6.4.1 Improve Comprehensive Sexuality Education (CSE) at schools

Interventions to improve parental/guardian support in the use of SRH services at the school level are crucial to empower teenage girls in decision-making around risky sexual behaviour. Improved accessibility to SRH information services will equip teenage girls to control their fertility, increase educational and economic opportunities and enhance their SRH and general wellbeing. The desired outcome is to have a significant decrease in the rate of teenage pregnancies. SRH information should be addressed through CSE both inside and outside of the classroom. Teacher-teenager communication within the class needs to be formulated as a general discussion, to allay the teenagers' fears of judgement and embarrassment. Personal discussions need to be addressed in private using an appointment system to encourage privacy and anonymity. Teachers need to be trained to be competent to teach CSE/Life Orientation before being delegated to do so.

6.4.2 Availability of SRH information resources

Access to relevant SRH information empowers teenage girls to make their own decisions about their bodies and their future by changing their sexual behaviour. It is recommended that new behaviour change strategies, such as digital health and educational games that lead to health practices and promote focus on school work to succeed with better future choices, be developed and created. Resources containing SRH information should be readily and freely available at all youth-friendly facilities, to allow teenagers to access SRH information as needed.

6.4.3 Address nurses' negative attitudes

The nurse-teenage girls' interactions appeared to prevent access to and utilisation of SRH services by teenage girls. The nurses' negative attitudes should be addressed through in-service

training to improve their attitudes so that they remain positive and professional, as well as to create a safe environment for teenage girls. Only competent, youth-friendly nurses should be assisting teenage girls. Teenage-friendly clinic hours together with teenage-friendly nurses is likely to encourage access to SRH services without judgement and bias, which will help reduce teenage pregnancy. Clinics should maintain reasonable hours to render SRH services to teenage girls without compromising the school learning hours.

6.4.4 Improve parent-child communication

There is a great need to improve parent-child communication. Parents and caregivers are the primary sexuality educators for their children. Improving their confidence and self-esteem and equipping them with appropriate information and resources to discuss sexuality can help the teenage girls to talk to their parents about such sensitive topics. A positive youth development programme, such as parent-child communication workshops, should be initiated; this could be arranged through schools and facilitated by the Department of Health and the Department of Education. This type of educational workshop can also be offered using the online platform to reach more parents. The purpose of the workshops is to motivate and strengthen communication between parents and their children in order to address the SRH inquiries. The positive effects of the parent-child communication on sexuality behaviour are found to be greater when parent and child feel connected to one another.

6.4.5 Further research

Further research using a quantitative research approach is recommended. There are many contributing factors influencing the information needs and information-seeking behaviour of teenage girls to prevent unplanned pregnancy. Quantitative research on a larger scale will be useful to involve the wider community in the study and identify contributing factors, so that a comprehensive plan of action can be drawn up to influence policy to establish teenage-friendly

SRH services and their implementation to address the high rates of teenage pregnancy in the Western Cape. It is evident from the findings that the problem of teenage pregnancy needs to be addressed by using a multi-faceted approach, including possible educational interventions to address community stigma and myths around contraceptive use.

6.5 Conclusion

It is evident that barriers to teenagers' access to SRH information needs and information-seeking behaviour contribute to the high rate of teenage pregnancy. The study discovered that parental/family support is poor when it comes to discussions about SRH. Teenage girls felt judged and disrespected when trying to access SRH information. Poor parental support on SRH information needs led the teenage girls to outsource the gaining of information to their friends, and such sources may not be accurate or trustworthy.

This chapter provided a summary of the key study findings, the limitations of the study, and recommendations for improving teenage girls' access to SRH information and services.

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APPENDIX 1

INTERVIEW GUIDE QUESTIONS:

Title: Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

1. Can you please explain how can teenage pregnancy be prevented?

Probing questions:

 Can you tell me more about the different methods of preventing teenage pregnancy?

 What information do you know related to contraceptives method?

 Please explain what do you do when you do not have enough information about teenage pregnancy?

2. Can you please explain how often do you seek information to know about teenage pregnancy?

Probing question:

 Please elaborate on the areas that you usually seek SRH information to prevent teenage pregnancy?

3. Tell me what are the key barriers of health information needs you have experienced when trying to prevent teenage pregnancy?

Probing question:

 Please tell me a little more about what and/or who prevents you to access relevant information about teenage pregnancy?

4. What changes will you suggest can be made to reduce teenage pregnancy in the Western Cape?

APPENDIX 2

ONDERHOUD LEI VRAE:

1. Vertel my oor die inligting wat jy nodig het om tienerswangerskap te voorkom.

Probing vrae:

Kan jy my meer vertel oor die verskillende voor behoedmiddels?

• Watter inligting weet jy van in verband met die verskillende voor behoedmiddels van die voorkoming van tienerswangerskap?

• Verduidelik assesblief wat jy sal doen as jy nie genoeg informasie oor die voorkoming van tienerswangerskap het nie.

• Verduidelik asseblief wat doen jy as jy nie genoeg inligting oor tienerswangerskap het nie?

2. Kan jy asseblief verduidelik hoe gereeld jy inligting soek om te weet oor tienerswangerskap?

Probing vraag:

Brei asseblief op die gebiede wat jy gewoonlik soek SRH inligting om tienerswangerskap te voorkom?

3. Vertel my wat is die belangrikste hindernisse van gesondheid inligting moet jy ervaar om tienerswangerskap te voorkom?

Probing vrae:

Vertel my asseblief & n bietjie meer oor wat en/of wie verhoed dat jy toegang tot relevante inligting oor tienerswangerskap?

4. Watter veranderinge sal u voorstel dat u tienerswangerskap in die Wes-Kaap kan verminder?

APPENDIX 3

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INFORMATION SHEET FOR PARTICIPANTS

Project Title: Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

What is this study about?

This is a research project being conducted by Natheerah Holtman at School of nursing at the University of the Western Cape. We are inviting you to participate in this research project because you are between the ages of 16-17 years old and you are a female who has experienced teenage pregnancy either directly or indirectly. The purpose of this research project is to explore the sexual and reproductive health information needs, information seeking behaviour and access barriers of information needs among teenage girls at a high school in the Western Cape.

What will I be asked to do if I agree to participate?

You will be asked to complete a form that signifies that you are willingly to participate in the study and consent forms will be given to your parents/legal guardians to approve your participation in the study. You will be asked questions, in English or Afrikaans based on your preference, about your knowledge regarding your sexual and reproductive health and contraception and what information you may need regarding your sexual and reproductive health. You will also be asked questions about any barriers you may have experienced in getting information needed. A few questions will be posed to identify where you seek information. The study will not be done on school premises to avoid stigmatization and victimization however; the venue will be confirmed before data

collection begins. I will collect all the information required for the study by having one on one interviews with each participant and it will be approximately 30 minutes long.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, your name will not be included, instead a code will be placed on the collected data and through the use of an identification code, the researcher will be able to link your interview data to your identity. To ensure your confidentiality, the hard copy of the data and recorded audio data will be kept safe having locked filing cabinets and storage areas, and the soft data will be protected using password-protected computer files. Only the researcher will have access to these files. If we write a report or publish article on this research project, your identity will be protected. This research project involves making audiotapes during interview with you. This is done not to miss information and to increase credibility. All the collected data will be destroyed after five years of completion of the study.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities' information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks for e.g. feeling embarrassed or uncomfortable. We will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results can help the researcher learn more about the information needs, barriers to access information needs and the information seeking behaviour of teenage girls to reduce teenage pregnancy. We

hope that, in the future, other people can benefit from this study through improved understanding of the findings in this study.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Natheerah Holtman from The School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Mrs. Holtman at: cell: 082 968 2376 and email: nholtman@uwc.ac.za. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research was approved by the Humanities and social Sciences Research ethics REFERENCE NUMBER

APPENDIX 4

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INLIGTINGSBLAD VIR DEELNEMERS

Projek titel: Die verkenning van die seksuele en reproduktiewe gesondheid inligting behoeftes en hindernisse van tienermeisies by 'n Hoërskool in die Wes-Kaap

Wat is hierdie studie oor?

Dit is 'n navorsingsprojek wat deur Natheerah Holtman by die skool van verpleging aan die Universiteit van die Wes-Kaap uitgevoer word. Ons nooi jou uit om deel te neem in hierdie navorsing projek, want jy is tussen die ouderdomme van 16-17 jaar oud en jy is 'n vroulike wat tienerswangerskap óf direk of indirek ervaar. Die doel van hierdie navorsingsprojek is om die seksuele en reproduktiewe gesondheidsinligting te verken, inligting op soek na gedrag en toegang hindernisse van inligting behoeftes onder tienermeisies by 'n Hoërskool in die Wes-Kaap.

Wat sal ek gevra word om te doen as ek instem om deel te neem?

U sal gevra word om 'n vorm te voltooi wat beteken dat u gewillig is om deel te neem aan die studie en toestemming vorms sal gegee word aan u ouers/wettige voogde om u deelname in die studie goed te keur. Jy sal vrae, in Afrikaans of Engels op grond van jou voorkeur gevra word, oor jou kennis met betrekking tot jou seksuele en reproduktiewe gesondheid en voorbehoeding en watter inligting jy nodig het met betrekking tot jou seksuele en reproduktiewe gesondheid. Jy sal ook vrae oor enige struikelblokke wat jy kan ervaar het in die kry van inligting nodig het gevra. 'N paar vrae sal gestel word om te identifiseer waar jy inligting soek. Die studie sal nie gedoen word op skoolperseel om stigmatisasie en viktimisasie te vermy nie; die lokaal sal bevestig word voordat data-insameling begin. Ek sal al die inligting wat nodig is vir die

studie versamel deur die een op een onderhoude met elke deelnemer en dit sal ongeveer wees 30 minute lank.

Sou my deelname aan hierdie studie vertroulik gehou word?

Die navorsers onderneem om jou identiteit en die aard van jou bydrae te beskerm. Om jou anonimiteit te verseker, sal jou naam nie ingesluit word nie, in plaas daarvan sal 'n kode op die Versamelde data geplaas word en deur die gebruik van 'n identifikasie-kode sal die navorser jou onderhoudsdata aan jou identiteit kan koppel. Om jou vertroulikheid te verseker, sal die harde kopie van die data en aangeteken klank data veilig gehou word met geslote indiening kaste en stoor gebiede, en die sagte data sal beskerm word met behulp van wagwoord beskermde rekenaar lêers. Slegs die navorser sal toegang tot hierdie lêers hê. As ons 'n verslag skryf of ‘n artikel op hierdie navorsing projek publiseer, sal jou identiteit beskerm word. Hierdie navorsing projek behels die maak van audiotapes tydens onderhoud met jou. Dit word gedoen om nie inligting te mis en geloofwaardigheid te verhoog. Al die Versamelde data sal vernietig word na vyf jaar van voltooiing van die studie.

In ooreenstemming met wetlike vereistes en/of professionele standaarde, sal ons bekend te maak aan die toepaslike individue en/of owerhede se inligting wat kom by ons aandag met betrekking tot kindermishandeling of nalaat of potensiële skade aan jou of ander. In hierdie geval sal ons u inlig dat ons vertroulikheid moet breek om ons wettige verantwoordelikheid te vervul om aan die aangewese owerhede te rapporteer.

Wat is die risiko's van hierdie navorsing?

Daar kan 'n paar risiko's van deelname aan hierdie navorsing studie. Alle menslike interaksies en praat oor self of ander dra 'n aantal risiko's vir bv. voel skaam of ongemaklik. Ons sal nogtans sodanige risiko's verminder en dadelik optree om u te help indien u enige ongemak, sielkundige of andersins tydens die proses van u deelname aan hierdie studie ervaar. Waar nodig, sal 'n toepaslike verwysing aan 'n geskikte professionele vir verdere hulp of ingryping gedoen word.

Wat is die voordele van hierdie navorsing?

Hierdie navorsing is nie ontwerp om jou te help persoonlik, maar die resultate kan help om die navorser leer meer oor die inligting behoeftes, hindernisse tot toegang tot

inligting behoeftes en die inligting op soek na gedrag van tienermeisies tienerswangerskap te verminder. Ons hoop dat, in die toekoms, ander mense kan baat vind by hierdie studie deur verbeterde begrip van die bevindings in hierdie studie.

Moet ek in hierdie navorsing wees en kan ek ophou deelneem aan enige tyd?
Jou deelname aan hierdie navorsing is heeltemal vrywillig. Jy kan kies om nie deel te neem ten alle. As jy besluit om deel te neem aan hierdie navorsing, kan jy dalk ophou deelneem aan enige tyd. As jy besluit om nie deel te neem aan hierdie studie of as jy ophou deelneem aan enige tyd, jy sal nie gepenaliseer of verloor enige voordele wat jy anders kwalifiseer.

Wat as ek vrae het?
Hierdie navorsing word gedoen deur Natheerah Holtman van die skool vir verpleging aan die Universiteit van die Wes-Kaap. As jy enige vrae het oor die navorsing studie self, **kontak mev Holtman by: Cell: 082 968 2376 en e-pos: nholtman@uwc.ac.za.** Indien u enige vrae het oor hierdie studie en u regte as 'n navorsingsdeelnemer of indien u enige probleme wat u ervaar het, met betrekking tot die studie wil rapporteer, kontak asseblief:

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Hierdie navorsing is goedgekeur deur die Geesteswetenskappe en Sosiale Wetenskappe
Navorsing etiek verwysing Nommer:

APPENDIX 5

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 9346 Fax: 27 21-959 2679
E-mail: nholtman@uwc.ac.za
mbimerew@uwc.ac.za
kmthimunye@uwc.ac.za

INFORMATION SHEET FOR PARENTS/ LEGAL GUARDIANS

Project title: Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

What is this study about?

This is a research project conducted by Natheerah Holtman at the University of the Western Cape. We invite your child to participate in this research project, because she is between the ages of 16-17 years old and who has experienced teenage pregnancy either directly or indirectly. The purpose of this research project is to explore the sexual and reproductive health information needs, information seeking behaviour and barriers access to information needs among teenage girls at a high school in the Western Cape.

What will your child be asked to do if she agrees to participate?

She will be asked to sign a form that she is willing to participate in the study and consent forms will be given to you as her parent/legal guardian/s to approve her participation in the study. She will be asked questions in Afrikaans or English based on her preference, about her knowledge of sexual and reproductive health information and information needs regarding her sexual and reproduction health. She will also be asked questions about any obstacles she has experienced in accessing information related to sexual and reproductive health. The interview will be conducted on one on one with each participant and the interview will take approximately 30 minutes.

Would your child's participation in this study be kept confidential?

The researcher undertakes to protect her identity and the nature of her contribution. To ensure her anonymity, the answers she provides in this study will remain confidential and will not be viewed by or shared with any person or party not involved in this study. She is allowed to access the data and can ask for adaptations. Her name will not be included, instead a code will be placed on the collected data and by using an identification key, and the researcher will be able to make a connection between the data to her identity. Only the researcher will have access to the identification key. To ensure her confidentiality, the hard copy of the data and recorded audio data will be kept safe having locked filing cabinets and storage areas, and the soft data will be protected using password-protected computer files. Only the researcher will have access to these files. If we write a report or publish article on this research project, her identity will be protected. This research project involves making audiotapes during the interview with her. This is done not to miss information and to increase credibility. All the collected data will be destroyed after five years of completion of the study.

In accordance with legal requirements and/or professional standards, we will disclose to the applicable individuals and/or authorities ' information that comes to our attention in relation to child abuse or neglect or potential harm to her or others. In this case we will inform her that we must break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks of participating in this research study. All human interactions and talk about itself or others carry a number of risks for e.g. Feel embarrassed or uncomfortable. However, we will try to minimize such risks and promptly help you if you will have any discomfort, psychological or otherwise during the process of her participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help her personally, but the results can help the researcher learn more about the information needs, barriers to access information needs and the information seeking behaviour of teenage girls to reduce teenage pregnancy. We hope that, in the future, other people can benefit from this study through improved understanding of the findings in this study.

Does my child have to be in this research and can she stop participating at any time?

Your child participation in this research is completely voluntary. She can choose not to participate at all. If she decides to participate in this research, she can stop participating at any time. If she decides not to take part in this study or if she ceases to participate at any time, she will not be penalised.

What if my child and I (parent/legal guardian) have questions?

This research is done by Natheerah Holtman from the School of Nursing to the University of the Western Cape. If any questions about the research study itself, **contact Mrs. Holtman at: Cell: 082 968 2376 and e-mail: nholtman@uwc.ac.za.**

If any questions regarding this study and your child's rights as a research participant or if any of you wish to report any problems that your child may experience with the study, please contact:

Prof. J. Chipps
Head of Department: School of Nursing
University of the Western Cape
Private X17
Bellville 7535
jchipps@uwc.ac.za

Prof Anthea Rhoda
Dean of the Faculty of Community and Health sciences
University of the Western Cape
Private X17
Bellville 7535
chs-deansoffice@uwc.ac.za

HSSREC
Research Development
University of the Western Cape
Private Bag x17

Bellville, 7535
Tel: 021 959 4111
Email: research-ethics@uwc.ac.za

This research was approved by the Humanities and social Sciences Research ethics REFERENCE NUMBER

APPENDIX 6

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
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E-mail: nholtman@uwc.ac.za
mbimerew@uwc.ac.za
kmthimunye@uwc.ac.za

INLIGTINGSBLAD VIR OUERS/WETLIKE VOOGDE

Projek titel: die verkenning van die seksuele en reproduktiewe gesondheid inligting behoeftes en hindernisse van tienermeisies by 'n Hoërskool in die Wes-Kaap

Wat is hierdie studie oor?

Dit is 'n navorsingsprojek wat deur Natheerah Holtman aan die Universiteit van die Wes-Kaap gedoen is. Ons nooi jou kind uit om deel te neem aan hierdie navorsingsprojek, want sy is tussen die ouderdomme van 16-17 jaar oud en wat tienerswangerskap óf direk of indirek ervaar het. Die doel van hierdie navorsingsprojek is om die seksuele en reproduktiewe gesondheidsinligting te verken, inligting op soek na gedrag en struikelblokke toegang tot inligting behoeftes onder tienermeisies by 'n Hoërskool in die Wes-Kaap.

Wat sal jou kind gevra word om te doen as sy instem om deel te neem?

Sy sal gevra word om 'n vorm te teken dat sy bereid is om deel te neem in die studie en toestemming vorms sal aan u gegee word as haar ouer/wettige voog/s om haar deelname aan die studie goed te keur. Sy sal vrae in Afrikaans of Engels gevra word op grond van haar voorkeur, oor haar kennis van seksuele en reproduktiewe gesondheid inligting en inligting behoeftes met betrekking tot haar seksuele en reproduksie gesondheid. Sy sal ook vrae oor enige struikelblokke wat sy ervaar in die toegang tot inligting wat verband hou met seksuele en reproduktiewe gesondheid gevra word. Die onderhoud sal gedoen word op een van die een met elke deelnemer en die onderhoud sal ongeveer neem 30 minute.

Sou u kind se deelname in hierdie studie vertroulik gehou word?

Die navorser onderneem om haar identiteit en die aard van haar by drae te beskerm. Om haar anonimiteit te verseker, sal die antwoorde wat sy in hierdie studie bied, vertroulik bly en sal nie besigtig word of gedeel word met enige persoon of party wat nie betrokke is by hierdie studie nie. Sy word toegelaat om toegang op die data en kan vir aanpassings vra. Haar naam sal nie ingesluit word nie, in plaas daarvan sal 'n kode op die versamelde data geplaas word en deur 'n identifikasiesleutel te gebruik, en die navorser sal in staat wees om 'n verband tussen die data en haar identiteit te maak. Slegs die navorser sal toegang hê op die identifikasie sleutel. Om haar vertroulikheid te verseker, sal die harde kopie van die data en aangeteken klank data veilig gehou word met geslote indiening kaste en stoor gebiede, en die sagte data sal beskerm word met behulp van wagwoord beskermde rekenaar lêers. Slegs die navorser sal toegang op hierdie lêers hê. As ons 'n verslag skryf of ‘n artikel op hierdie navorsing projek publiseer, sal haar identiteit beskerm word. Hierdie navorsing projek behels die maak van audiotapes tydens die onderhoud met haar. Dit word gedoen om nie inligting te mis en geloofwaardigheid te verhoog. Al die versamelde data sal vernietig word na vyf jaar van voltooiing van die studie.

In ooreenstemming met wetlike vereistes en/of professionele standaarde, sal ons aan die toepaslike individule en/of owerhede se inligting wat kom by ons aandag ten opsigte van kindermishandeling of verwaarlosing of potensiële skade aan haar of ander te openbaar. In hierdie geval sal ons haar inlig dat ons vertroulikheid moet breek om ons wettige verantwoordelikheid te vervul om aan die aangewese owerhede te rapporteer.

Wat is die risiko's van hierdie navorsing?

Daar kan 'n paar risiko's van deelname aan hierdie navorsing studie. Alle menslike interaksies en praat oor homself of ander dra 'n aantal risiko's vir bv. voel skaam of ongemaklik. Ons sal egter probeer om sodanige risiko's te verminder en jou stiptelik te help as jy enige ongemak, sielkundige of andersins tydens die proses van haar deelname in hierdie studie sal hê. Waar nodig, sal 'n toepaslike verwysing aan 'n geskikte professionele vir verdere hulp of ingryping gedoen word.

Wat is die voordele van hierdie navorsing?

Hierdie navorsing is nie ontwerp om haar persoonlik help, maar die resultate kan help om die navorser leer meer oor die inligting behoeftes, hindernisse tot toegang tot inligting behoeftes en die inligting op soek na gedrag van tienermeisies tienerswangerskap te verminder. Ons hoop dat, in die toekoms, ander mense kan baat vind by hierdie studie deur verbeterde begrip van die bevindings in hierdie studie.

Het my kind te wees in hierdie navorsing en kan sy ophou deelneem aan enige tyd?

Jou kind deelname aan hierdie navorsing is heeltemal vrywillig. Sy kan kies om nie te deel nie. As sy besluit om deel te neem aan hierdie navorsing, kan sy ophou deelneem aan enige tyd. As sy besluit om nie deel te neem aan hierdie studie of as sy ophou om deel te neem te eniger tyd, sal sy nie gepenaliseer.

Wat as my kind en ek (ouer/wettige voog) vrae het?

Hierdie navorsing word gedoen deur Natheerah Holtman uit die skool vir verpleging aan die Universiteit van die Wes-Kaap. Indien enige vrae oor die navorsingstudie self, **kontak mev Holtman by: Cell: 082 968 2376 en e-pos: nholtman@uwc.ac.za.** Indien enige vrae met betrekking tot hierdie studie en jou kind se regte as 'n navorsingsdeelnemer of indien enige van u enige probleme wil rapporteer wat u kind met die studie mag ondervind, kontak asseblief:

Prof. J. Chipps (Hoof van Departement: Skool vir Verpleging)

Universiteit van die Wes-Kaapse

Privaatsak X17

Bellville 7535

jchipps@uwc.ac.za

Prof Anthea Rhoda

Dekaan van die Fakulteit Gemeenskap en Gesondheidswetenskappe

Universiteit van die Wes-Kaap

Privaatsak X17

Bellville 7535

chs-deansoffice@uwc.ac.za

HSSREC

Navorsings Ontwikkeling

Universiteit van die Wes-Kaap

Privaatsak x17

Bellville, 7535

Tel: 021 959 4111

Email: research-ethics@uwc.ac.za

Hierdie navorsing is goedgekeur deur die Geesteswetenskappe en sosiale Wetenskappe

Navorsing etiek verwysing Nommer:

APPENDIX 7

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel : +27 21-959 9346 Fax : 27 21-959 2679

E-mail : nholtman@uwc.ac.za

mbimerew@uwc.ac.za

kmthimunye@uwc.ac.za

ASSENT FORM FOR PARTICIPANTS

Title of Research Project: **Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape**

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Please tick in the box of one option below:

☐ I agree to be audiotaped during my participation in this study.

☐ I do not agree to be audiotaped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

APPENDIX 8

UNIVERSITY OF THE WESTERN CAPE

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mbimerew@uwc.ac.za
kmthimunye@uwc.ac.za

BEKRAGTIG VORM VIR DEELNEMERS

Titel van die navorsing projek: Die verkenning van die seksuele en reproduktiewe gesondheid inligting behoeftes en hindernisse van tienermeisies by 'n Hoërskool in die Wes-Kaap

Die studie is aan my beskryf in taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verstaan wat my deelname sal betrek en ek stem saam om deel te neem van my eie keuse en vrye wil. Ek verstaan dat my identiteit nie geopenbaar sal word aan enigiemand. Ek verstaan dat ek kan onttrek uit die studie te eniger tyd sonder om 'n rede en sonder vrees vir negatiewe gevolge of verlies van voordele.

Merk asseblief die boks van een opsie hieronder:

☐ Ek stem saam om oudiotaped tydens my deelname in hierdie studie.

☐ Ek stem nie saam om oudiotaped tydens my deelname in hierdie studie te wees nie.

Naam van die deelnemer se.....

Deelnemer se handtekening.....

Datum.....

APPENDIX 9

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mbimerew@uwc.ac.za
kmthimunye@uwc.ac.za

CONSENT FORM FOR PARENTS/ LEGAL GUARDIANS

Title of Research Project: ***Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape***

The study has been described to me in language that I understand. My questions about the study have been answered. I am granting permission for my child's involvement in the research study and understand what it involves and I agree to allow my child to participate. I allow my child to be audio-taped during the interview. I understand that my child's identity will not be disclosed to anyone. I understand that I may withdraw my child from the study at any time without giving a reason and without fear of negative consequences or loss of benefits to me or my child.

Parents/Legal Guardian of participant's name…….

Parents/Legal Guardian of participant's signature…….

Date……

APPENDIX 10

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel : +27 21-959 9346 Fax : 27 21-959 2679

E-mail : nholtman@uwc.ac.za

mbimerew@uwc.ac.za

kmthimunye@uwc.ac.za

TOESTEMMINGSVORM VIR OUERS/WETTIGE VOOGDE

Titel van die navorsing projek: Die verkenning van die seksuele en reproduktiewe gesondheidsinligting en-hindernisse van tienermeisies by 'n Hoërskool in die Wes-Kaap

Die studie is aan my beskryf in taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verleen toestemming vir my kind se betrokkenheid in die navorsingstudie en verstaan wat dit behels en ek stem in om my kind toe te laat om deel te neem. Ek laat my kind toe om oudio-opgeneem te wees tydens die onderhoud. Ek verstaan dat my kind se identiteit nie aan enigiemand geopenbaar sal word nie. Ek verstaan dat ek my kind kan onttrek uit die studie te eniger tyd sonder om 'n rede en sonder vrees vir negatiewe gevolge of verlies van voordele vir my of my kind.

Ouers/Wettige voog van die deelnemer se naam.....

Ouers/Wettige voog van die deelnemer se handtekening.....

Datum.....

APPENDIX 11

ETHICAL CLEARANCE LETTER

OFFICE OF THE DIRECTOR: RESEARCH AND INNOVATION DIVISION

NHREC REGISTRATION NUMBER - 130416-049

Private Bag X17,

Bellville 7535

South Africa

T: +27 21 959 4111/2948

F: +27 21 959 3170

E: research-ethics@uwc.ac.za www.uwc.ac.za

10 February 2020

Mrs N Holtman

School of Nursing

Faculty of Community and Health Sciences

Ethics Reference Number: HS19/9/22

Project Title: Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape.

Approval Period: 31 January 2020 – 31 January 2021

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias

Research Ethics Committee Officer

University of the Western Cape

NHREC REGISTRATION NUMBER - 130416-049

APPENDIX 12

RESEARCH APPROVAL LETTER

Western Cape Government
Education

Audrey.wyngaard@westerncape.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20200304-5290
ENQUIRIES: Dr A T Wyngaard

Mrs Natheerah Holtman
129 Taurus Road
Surrey Estate
Athlone
7764

Dear Mrs Natheerah Holtman

RESEARCH PROPOSAL: EXPLORING THE SEXUAL AND REPRODUCTIVE HEALTH INFORMATION NEEDS AND BARRIERS OF TEENAGE GIRLS AT A HIGH SCHOOL IN THE WESTERN CAPE

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **23 March 2020 till 20 September 2021**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

    The Director: Research Services
    Western Cape Education Department
    Private Bag X9114
    CAPE TOWN
    8000

We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
Directorate: Research
DATE: 05 March 2020

APPENDIX 13: PERMISSION LETTER

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel : +27 21-959 9346 Fax : 27 21-959 2679
E-mail : nholtman@uwc.ac.za
mbimerew@uwc.ac.za
kmthimunye@uwc.ac.za

PERMISSION REQUEST LETTER

To whom it may concern

I, Natheerah Holtman, a Masters student at the University of the Western Cape, hereby request permission to conduct a research study under the topic of *Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape*. The findings in this study will serve by informing healthcare providers as to what health education to promote to teenagers about their sexual and reproductive health and it is predicted that parents and communities will be made aware of their influence in a teenager's choices in lifestyle and the need for better communication with their teenage girls around this topic.

The study is aimed to take place as soon as permission is granted by the Department of Education and will occur over a period of 30 days. Interviews will be conducted with 17 girls between the ages of 16-17 years old across grade 11 through voluntary participation and consent from their parents / legal guardians. The interviews will be 30 minutes long and anonymity and confidentiality of each participant will be ensured. With permission of the school and the Department of Education the interviews will be held after school hours and each participant will be given a time slot to uphold confidentiality and safety of participants. Please indicate your permission below and return this form via email as communicated above.

PERMISSION GRANTED ☐
PERMISSION GRANTED WITH CERTAIN RESTRICTIONS, TO BE DISCUSSED ☐
PERMISSION DENIED ☐

Yours sincerely,

Natheerah Holtman - student number 2439654

APPENDIX 14: EDITORS LETTER

Leverne Gething, M.Phil. c*um laude*
PO Box 1155, Milnerton 7435; cell 072 212 5417
e-mail: leverne@eject.co.za

10 November 2022

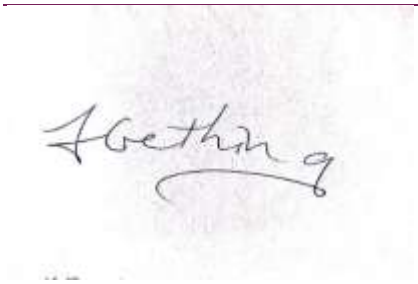
Declaration of editing of a Master's thesis

Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

I hereby declare that I carried out language editing of the above thesis on behalf of Natheerah Holtman.

I am a professional writer and editor with many years of experience (e.g. 5 years on *SA Medical Journal*, 10 years heading the corporate communication division at the SA Medical Research Council), who specializes in Science and Technology editing – but am adept at editing in many different subject areas. I have edited a great deal of work, including academic papers and theses, for various academic journals, universities and publishers.

I am a full member of the South African Freelancers' Association as well as of the Professional Editors' Association.



Yours sincerely

LEVERNE GETHING leverne@eject.co.za

APPENDIX 15: TURNITIN DIGITAL RECEIPT

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

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Submission author:	Million Bimerew
Assignment title:	Assignment 1_Ethical Dilemma
Submission title:	Exploring the sexual and reproductive health information ne…
File name:	Natheerah_FINAL_THESIS.docx
File size:	175.86K
Page count:	134
Word count:	39,773
Character count:	209,708
Submission date:	13-Nov-2022 09:56PM (UTC+0200)
Submission ID:	1952589594

CHAPTER ONE

OVERVIEW OF THE STUDY

1 Introduction

This chapter presents an overview of the background to the research, both from a global and a local perspective, background information on the study, the rationale, and the problem statement. The chapter also presents the aim, objectives, and significance of the study. Lastly, an outline is given of the subsequent chapters of the thesis.

1.1 Overview of the study

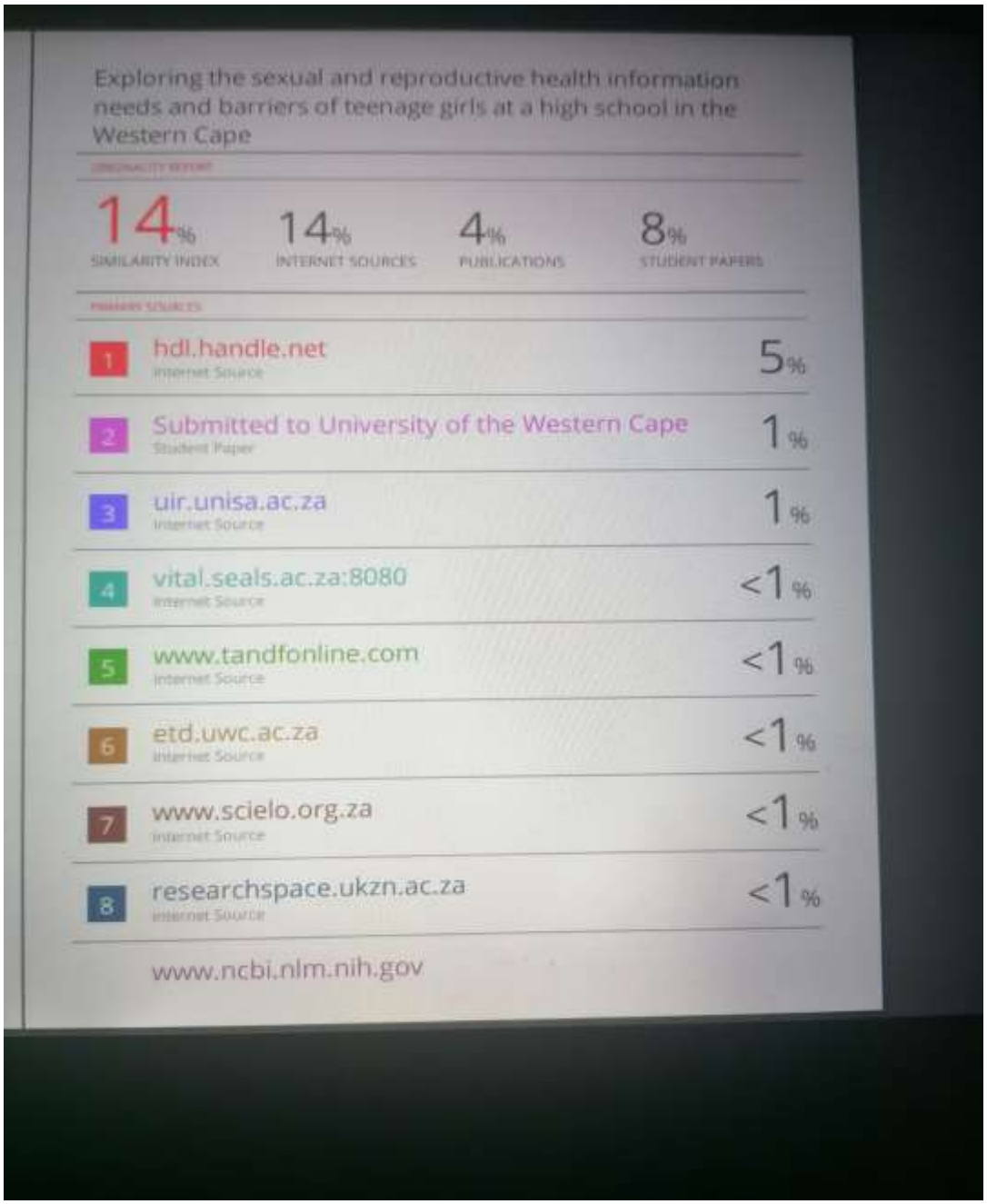
The health and social consequences of teenage pregnancy are serious and wide ranging, with pregnancy and childbirth complications being the second leading cause of death among teenage girls globally (World Health Organization, 2018).

Family Planning 2020 is a global initiative founded in London in 2012 with the aim of making modern contraceptives accessible to an additional 120 million women by 2020 (Linco Dorcicia et al., 2020). South Africa has retained and expanded its sexual and reproductive health and rights (SRHR) policies in the areas of abortion, contraception, youth and HIV treatment. However, persistent socio-economic inequities and gender inequality continue to affect South African women's SRHR (Essiaw et al., 2020). The Millennium Development Goals (MDGs) for 2000–2015 and Sustainable Development Goals (SDGs) of 2015 include universal access to SRH information and services. Both strategies were adopted by South Africa, but the country has struggled to make progress on health-related MDGs for various reasons (Linco Dorcicia et al., 2020). The National Contraceptive Policy Guidelines released in 2001 and updated in 2012

1

APPENDIX 16

TURNITIN RESULTS



Exploring the sexual and reproductive health information needs and barriers of teenage girls at a high school in the Western Cape

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