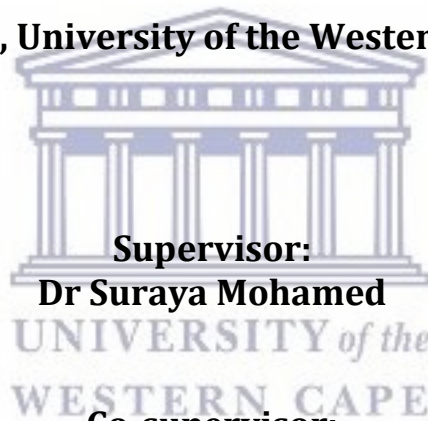


**FACTORS INFLUENCING TEENAGE PREGNANCY IN  
HEIDEDAL LOCATION, MANGAUNG DISTRICT**

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**A mini-thesis submitted in partial fulfillment of the requirements  
for the degree of Master in Public Health at the School of Public  
Health , University of the Western Cape**



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## **KEYWORDS**

Adolescent sexuality

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Teenager

Influencing factors

Individual level factors

Social factors

Structural factors

Mangaung District

South Africa

Qualitative Research



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## ABBREVIATIONS

DHP	District Health Plan
GDP	Gross Domestic Products
HIV	Human Immunodeficiency Virus
ISHP	Integrated School Health policy
SA	South Africa
STI	Sexual Transmitted Infection
UNICEF	United Nations Children’s Fund
WHO	World Health Organisation
YFS	Youth Friendly Services
YRBS	Youth Risk Behaviour Survey



## ABSTRACT

Teenage pregnancy remains a complex issue globally. According to the World Health Organisation (2014), the average global birth rate of girls aged 15-19 years was 49 per 1000 births reported globally. In South Africa, the general household survey conducted in 2014 revealed that 5.6% of females 14-19 years were reported to have been pregnant in 2013, with teenage pregnancy increasing by age from 0.8% for the age group of 14 years to 11.9% for teenagers aged 19 years.

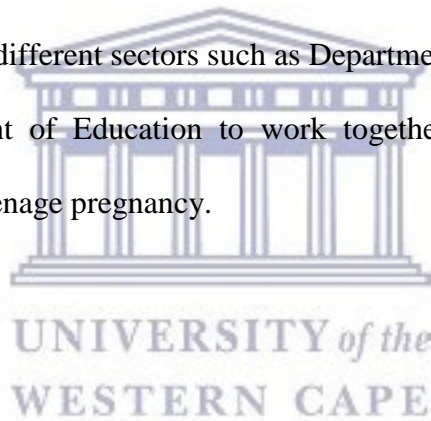
In South Africa, a range of health policies and programs exist to address teenage pregnancy, including school-based sex education, peer education programmes, adolescent friendly clinic initiatives and mass media interventions. Despite such initiatives, the number of teenagers becoming pregnant remains high. Teenage pregnancy reported in Mangaung district is 7%, which is three times more than the provincial target of 2% for teenage pregnancy. This research therefore aimed to explore the reasons behind teenage pregnancy in Heidedal, Mangaung District, Free State Province, South Africa.

Two in- depth interviews were conducted, one with twelve teenage mothers and the other with four key informants who were selected based on insight and experience they possess in working with teenagers. The key informants suitable for the study included a nurse, life orientation teacher, ward councillor and a counsellor working for a non-governmental organization that supports the implementation of youth programmes in the health facility. Thematic analysis was used to analyse data and key themes, afterwards concepts were interpreted so that explanations could be constructed to answer the research aim and objectives.

The study aimed to contribute to understanding reasons behind the high teenage pregnancy rates in Mangaung District. This information will be useful to policy makers in developing policies and strategies that will address factors identified to be influencing teenage pregnancy.

The study found that teenage pregnancy in Heidedal is influenced by many factors which are interrelated. The knowledge about contraceptives amongst the teenagers was sufficient to enable them to make informed decisions with regard to initiating sexual engagements. On the other hand, misconceptions about contraceptives influenced their decision not to use contraceptives. Various factors were identified from individual level, social level and structural level which contributed to early sexual initiation resulting in unplanned teenage pregnancy. These factors included risky sexual behaviour, peer influence, poor parent child communication, cultural beliefs and health system factors including the attitude of nurses towards the teenagers. The factors at the different levels also impacted on each other.

Due to its complex nature, teenage pregnancy needs a multi-faceted approach. Therefore the study recommends collaboration of different sectors such as Department of Health, Department of Social Development and Department of Education to work together to address the different levels identified to be influencing teenage pregnancy.



## DECLARATION

I declare that “Factors leading to teenage pregnancy in Heidedal location, Mangaung District, Free State Province”, is my own work. It has not been submitted for any degree or examination in any university. All the sources that I have quoted have been indicated and acknowledged by complete referencing.

A handwritten signature in black ink, appearing to read 'H. Stea.', is enclosed in a thin black rectangular box.

09 November 2017



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## **CHAPTER ONE**

### **BACKGROUND OF STUDY**

#### **1.1 Introduction**

Teenage pregnancy is defined as teenage girl, usually within the ages of 13 to 19 years becoming pregnant (UNICEF, 2008). Teenage pregnancy remains an important and complex issue around the world (Odejimi and Bellingham-Young, 2014). In low and middle- income countries about 16 million girls aged between 15 and 19 years and 1 million girls under 15 years give birth each year (World Health Organization, 2014). In South Africa, the 2014 General Household Survey revealed that the prevalence of teenage pregnancy increased progressively by age: 0.8%, 1.9%, 4.2%, 4.8%, 9.6% and 11.9% for age groups 14, 15, 16, 17, 18 and 19 years respectively (Stats SA, 2014).

The health and social consequences of teenage pregnancy are serious and wide ranging. Pregnancy and child birth complications are the second leading cause of death among 15 to 19 year old women globally (WHO, 2014). Teenage girls account for 14% of the estimated 20 million unsafe abortions performed globally each year, which results in 68 000 deaths (UNICEF, 2008).

Teenage pregnancy has been viewed as a social problem that has implications for the development and empowerment of women in South Africa (Mwaba, 2000). Jewkes, Morrell & Christofides (2009: 676) noted that ‘... teenage pregnancy is not just an issue of reproductive health and young women’s bodies but, rather one in its causes and consequences that is rooted in women’s gendered social environment.’ Teenagers who fall pregnant are less likely to complete their high school education, which seems to be one of the major obstacles in the educational development of young women in South Africa (Ncube, 2009). Despite the progressive legislation in South Africa allowing young women to return to school post-pregnancy only around a third actually re-enter the schooling system (Grant & Hallman, 2006).

## **1.2 Problem statement**

Approximately 30% of teenagers in South Africa report ‘ever having been pregnant’ with the majority of these pregnancies being unplanned (Willan, 2013). Whilst there has been a decrease in the number of teenage pregnancies reported over the past few decades, the rate is still inadmissibly high (Willan, 2013). This is despite a number of prevention interventions that have been instituted in South Africa which include school-based sexuality education, peer education programmes, adolescent friendly clinic initiatives, mass media interventions as well as community level programmes (Panday, Makiwane, Ranchod, & Letsoalo, 2009).

In the Free State Province, data of under 18 teenage deliveries reported for the 2013/14 period was 7.1% (District Health Barometer, 2015). This reported figure is slightly below the 7.8 % national teenage pregnancy target (Mangaung District Health Plan, 2015). Although the rate of under 18 deliveries in Mangaung is within the national target, it is however three times more than the provincial target of 2%. . Due to the rates being higher than the policy goals of the province, it is worth conducting a study in order to gain deeper understanding of factors that are influencing teenage pregnancy in this district.

## **1.3 Purpose of the study**

In order to address the problem of teenage pregnancies in Mangaung district, the aim of this research was to contribute towards an understanding of the factors that influence teenage pregnancy by exploring the individual, social and structural factors influencing teenage pregnancy. Furthermore, the information can be useful to policy makers in developing policies and strategies that will address factors identified to be influencing teenage pregnancy at a local level. It is also hoped that addressing factors influencing teenage pregnancy will enable teenagers to complete their schooling and become financially independent and productive citizens.

## **1.4 Aims and Objectives**

The aim of the study was to explore the reasons behind teenage pregnancy. Therefore the objectives of the study are:

- To explore perceptions and experiences of factors at the individual level that influence teenage pregnancy.

- To explore perceptions and experiences of social factors that influence teenage pregnancy.
- To explore perceptions and experiences of structural factors that influence teenage pregnancy.
- To explore the interrelatedness of the different factors that influence teenage pregnancy.

### **1.5 Study setting**

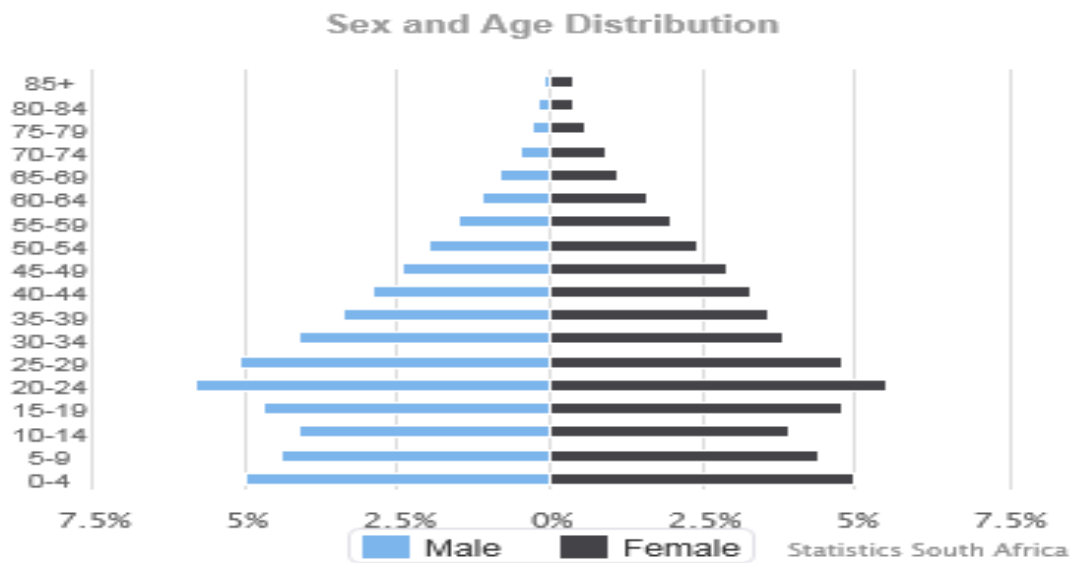
Mangaung District is located in the central interior of the Free State and comprises of three sub-districts, namely Bloemfontein, Botshabelo and Thaba - Nchu. The district has the largest population of 747 341 in Free State Province, with an unemployment rate of 27.7% (Stats SA, 2011). The youth population in Mangaung District aged between 10-19 years is 8.4% for females and 8.7% for the males (See Figure 1).

Heidedal location is situated near the regional Hospital called Pelonomi. Residents in this area access health services from Opkoms clinic which is one of the 42 Primary Health Care (PHC) facilities in Mangaung district, and is the health facility where the study was conducted. This clinic operates eight hours a day. The area is dominated by the Coloured ethnic group. The community in this area have access to water and sanitation. Residents of Heidedal live in bricked houses with most households having access to electricity. However the unemployment and crime rates are known to be high in this area.



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The graph below illustrates population in Mangaung segregated in sex and age.



**Figure 1: Population of Mangaung district.** (Source: Stats SA, 2011).

### 1.6 Outline of the thesis

This thesis is comprised of six chapters, Chapter one gives a background to the study including an introduction, problem statement, and purpose of the study, aim and objectives and a short description of the study setting. Chapter two presents the literature reviewed internationally and locally on various factors considered to be influencing teenage pregnancy. Chapter three outlines the methodology used in the study followed by presentation of findings in chapter four. In chapter five study findings are discussed, highlighting the major finding supported by literature. The final chapter six, draws conclusions from the findings and outlines recommendation that can assist in reducing teenage pregnancy in Mangaung district.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

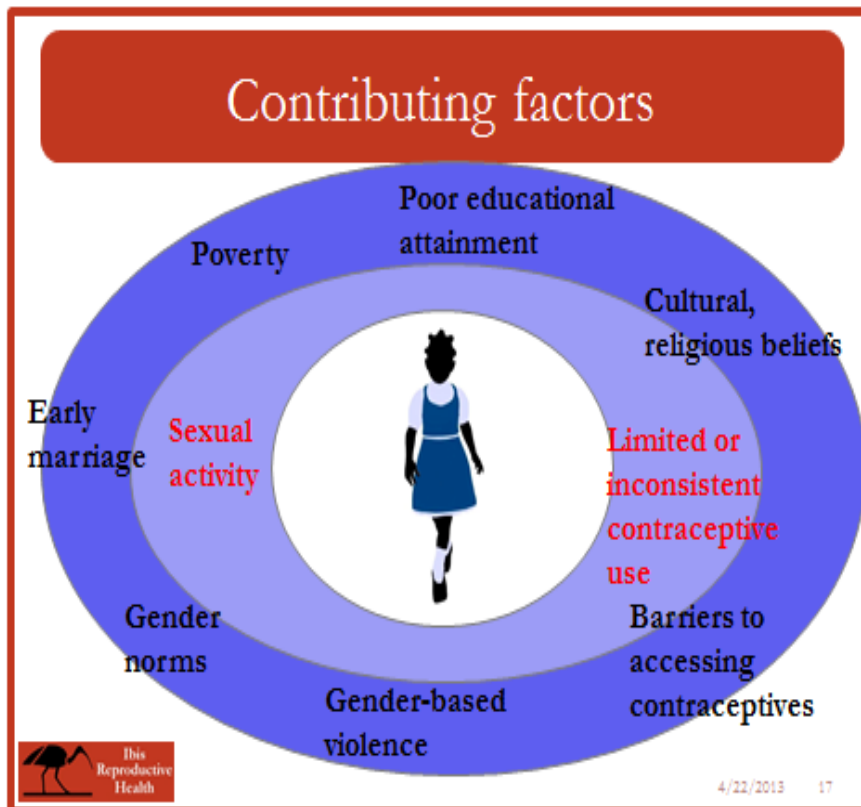
Teenage pregnancy is driven by many factors which are broad and complex. This chapter explores studies that have identified factors believed to be influencing teenage pregnancy in both developed and developing countries. The level of national wealth, the pace of economic development and the magnitude of income inequality within countries have been found to be associated with differences in teenage birth rates between countries (Santelli et al., 2015). A study conducted using data from 51 African countries on strategies and policies that can be implemented to reduce teenage pregnancy suggested that improving the female literacy rate, health care expenditure and the gross domestic product (GDP) per capita of the country will be practical approaches to addressing teenage pregnancy (Odejimi & Bellingham-Young, 2014).

In South Africa, there are a number of prevention programmes geared at reducing teenage pregnancy. Initiatives implemented in South Africa to prevent and reduce the rate of teenage pregnancy include amongst others, sex education as part of the Life Orientation Programme in schools, roll-out of Youth Friendly Services (YFS) in government clinics and funding programmes such as Love-life which combines highly visible sustained national multi-media sex education and HIV/AIDS awareness campaigns (Tsebe, 2012). Several policies were launched by the National Department of Health in 2012 that are related to teenage pregnancy. These policies include: Integrated School Health Policy (ISHP) which was jointly launched by the Department of Health and Department of Basic Education, the updated National Contraceptives Guideline Policy; and a booklet titled “Preventing teenage pregnancy” (Willan, 2013). In addition to the existing policies to combat teenage pregnancy, the National Department of Health launched the Adolescent Youth Health Policy in 2017 (Department of Health, 2017).

In order to have a comprehensive understanding of the reasons influencing teenage pregnancy, this study used the theoretical framework illustrated by Flaganan et al. (2013). This framework explicitly shows the interrelation of various factors considered to be influencing teenage pregnancy. According to Flanagan et al. (2013:10) “The contributing factors for teenage

pregnancy can be related to the individual herself, social, structural or environmental factors and the interaction between the individual and her social/structural/environmental situation.”

Figure 1 illustrates the framework of the inter-connectedness of factors influencing teenage pregnancy.



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**Figure 1: Factors contributing to teenage pregnancy** (Source: Flanagan et al., 2013:11)

The sequence of literature reviewed in this study starts with the individual factors influencing teenage pregnancy, followed by the social factors and lastly the structural factors influencing teenage pregnancy.

### 2.2 Individual level factors influencing teenage pregnancy

Individual level factors influencing teenage pregnancy are described as factors that are most proximal to sexual behaviours, and include the teenager’s attitude, values and actions that impinge on his or her sexual related choices (Farber, 2009). A quantitative study carried out in Nepal by Shrestha (2012) explored and analysed the factors contributing to teenage pregnancy. The study identified knowledge, risk perception on sexuality, attitudes, educational status, age at marriage, age at first sexual intercourse, sexual curiosity, substance abuse, health seeking



behaviour and number of sexual partners as individual level factors that influence teenager's sexual behaviour. Some of these factors are described in more detail next.

### ***2.2.1 Lack of Knowledge regarding contraceptives***

Knowledge plays a vital role in decision making that influences health and development (Shrestha, 2012). There is limited knowledge amongst adolescents about sex and family planning, and lack of skills to put that knowledge into practice because effective sexuality education is lacking in many countries (WHO, 2012). In married or unmarried adolescent girls, some pregnancy is accidental and results from experimenting with sexuality or lacking knowledge about how to prevent conception (Rowbottom, 2007). In addition, Adogu et al. (2014) claim that in Nigeria, of the adolescents who engaged in sexual activity, only a few used condoms during sex even those with multiple partners. Furthermore it was revealed that minimal condom usage during sex by adolescents is probably due to limited knowledge on safe sex, cultural norms, unfriendly environment for condom accessibility, thereby exposing themselves to the risk of contracting sexual transmitted infections including HIV and unwanted pregnancies (Adogu et al., 2014). Similar findings were discovered in a quantitative study carried out on adolescent pregnancy and associated factors in South Africa which revealed that not only is lack of knowledge a cause of risky sexual behaviour but poor decision making also results in unprotected sexual intercourse (Mchunu et al., 2012). On the other hand, a qualitative study conducted by Panday et al. (2009) found that in South Africa, while adolescents might have high levels of knowledge about contraceptive methods; gaps exist in the accuracy of their knowledge and skills regarding correct use of contraceptives.

### ***2. 2. 2. Risky sexual behaviours***

Adolescence is a time of rapid physical, psychological and social change (Kim, 2008). These multiple changes promote exposure to some new health risk behaviours such as physical inactivity, smoking, drinking alcohol, illegal drug use, and risky sexual activity (Kim, 2008). Problem or sensation-seeking behaviour may expose teenagers to sexual risk-taking or more desire to have unprotected sex (Kirby et al., 2007). A qualitative study that was conducted in London to identify factors that shape young people's sexual behaviour, revealed that adolescent girls may perceive agreeing to have sex as a way of holding on to their boyfriends (Marston and King, 2006). In Nepal, it was found that even though some young people are aware of the risks when practicing unprotected sex, they still continue with the sexual activity (Shrestha,

2012). Similarly, the findings of a quantitative study in Nepal conducted on adolescent pregnancy and associated factors in South Africa by Mchunu et al. (2012) indicated that adolescents do not think about the risks involved in engaging in unprotected sexual intercourse. Other findings from a quantitative study carried out on factors influencing teenage pregnancy rate in Giyani, Limpopo Province in South Africa, revealed that 72.8% of the study participants reported that when they engage in sexual activity they were aware of the risk of contracting STIs (Mushwana et al., 2015). According to the authors the high percentage showed that these teenagers had knowledge about the consequences of unsafe sex but still continued with risky sexual behaviour (Mushwana et al., 2015).

A quantitative study conducted in the United States of America revealed that most teenage pregnancies are unplanned and preconception substance use is a significant risk factor thereof. Both teenage pregnancy and substance use are national public health concerns in the United States of America and are targeted for improved health outcomes (Finer and Zolna, 2006). The findings of a qualitative study conducted in Cook Island in South Pacific targeting adolescents revealed that substance abuse was long recognised as one of the greatest health and social problems which resulted in teenage pregnancies since teenagers engaged in sexual intercourse without making calculated decisions due to the influence of alcohol (Van Eijk, 2007). Similarly, in South Africa unsafe sex practise among other consequences is associated with high alcohol use by youth (Seggie, 2012). For example, a Youth Risk Behaviour Survey (YRBS) conducted on Grade 8 – 11 learners in nine Provinces revealed that from the 38% of learners who had reported ever having sex, 16% had sex after consuming alcohol and 14% after taking drugs (Reddy et al., 2010).

### ***2.2.3 Educational status***

Another key factor that contributes to teenage pregnancy is lack of education. Recent research shows that adolescents enrolled in school are less likely to have ever had sex than those not enrolled (Lloyd, 2006). Female students who are sexually active are more likely to use contraception than non-students (Lloyd, 2006). A qualitative study carried out to assess factors contributing to teenage pregnancy in Tunduru, a district in Ruvuma Region of Tanzania, by Malisa (2015) revealed that teenagers who have low education levels are at a higher risk of becoming pregnant than those with a higher level of education.

#### **2.2.4 Early sexual debut**

Globally, adolescents have their sexual debut between age 15 and 19, with boys initiating sex earlier than girls (WHO, 2011). A qualitative study on sexual health, contraception and teenage pregnancy conducted in the United Kingdom revealed that having sex for the first time at an early age is often associated with unsafe sex, lack of knowledge, lack of access to contraception and lack of skills and self-efficacy to negotiate contraception (Tripp and Viner, 2005). In a study conducted in America, the findings revealed that early sexual debut is a factor that is highly associated with teenage pregnancy (Domenico and Jones, 2007). A qualitative study conducted in Tunduru, Tanzania revealed that many teenagers become sexually active while very young and this poses a risk to them because they become vulnerable to falling pregnant (Malisa, 2015). Similar findings were revealed from a quantitative study carried out in Nigeria, which revealed that engagement in sexual intercourse by teenagers happens at a very early age (Ogori, et al., 2013). In addition, a quantitative study carried out on factors contributing to teenage pregnancy in Capricorn district in Limpopo Province revealed that 62% of the study respondents reported to have started engaging in sexual activities between the age of 13 and 15 years. Fifty four percent of them reported to have engaged for the first time in sexual intercourse between the age of between 16 and 19 years whilst 4% started between the ages of 10 and 12 years (Mothiba and Maputle, 2012).



The above section reviewed literature mostly relevant to the individual level factors influencing teenage both locally and internationally. The section that follows focuses on the social/interpersonal factors influencing teenage pregnancy.

#### **2. 3 Social/Interpersonal factors influencing teenage pregnancy**

In this section cultural beliefs, parental influences and peer pressure will be the three aspects that will be discussed. The environment in which a child grows has been found to be an influence on his or her development as well as behaviour (Ncetakalo, 2011). According to Shrestha (2012), parental values and communication with children, peers pressure and teachers are interpersonal factors identified to be influencing teenage pregnancy.

### **2.3.1 Cultural beliefs**

According to Ncitakalo (2011:10) “Cultural beliefs are regarded as symbolic and learnt aspects of a society or community that in some way or the other prescribe behaviour, these beliefs are considered as the norms and values shared by a community.”

A qualitative study conducted in South Africa on socio-cultural influences in decision making among adolescent in Khayelitsha revealed that female adolescents are expected not to argue about the number of sexual partners their partner has nor argue about condom use (Ncitakalo, 2011). The study participants further revealed that tradition somehow privileged males and put females under male control (Ncitakalo, 2011). This may result in females being unable to negotiate for safe sexual practise such as condom use putting them at risk for pregnancy.

Mothiba and Maputle (2012) conducted a study in Capricorn district in Limpopo province and found that some parents were reluctant to make sex education and contraceptives available to their teenagers, as they were afraid that their teenagers might interpret this as permission to engage in sexual activities. In addition, a Tanzanian quantitative study revealed that despite comprehensive reproductive health services being provided in public, private and non-governmental organization outlets, these services were still surrounded by stigma from parents, community leaders, religious leaders, service providers and even programs for adolescent care (Philemon, 2007).

### **2.3.2 Parental values and communication with children**

A study conducted in California suggests that the values and behaviour demonstrated by family members regarding sexual risk-taking and early childbearing influence a teenager’s own attitudes and behaviour (Berglas et al., 2003). A report compiled in the United States by the policy analyst highlights that sexual conversations between parents and teenagers is helpful in delaying sexual initiation (Kim, 2008). A quantitative study carried out in Washington investigating parental involvement in teenagers first sexual experience, revealed that teenagers with higher levels of parental guidance were less likely to engage in sexual intercourse. On the other hand, teenagers with lowest levels of parental guidance were more likely to have had sex before the age of 16 (Ikramullah et al., 2009).

Interesting findings emerged from a quantitative study carried out to assess parental communication about sex and motherhood trends among students at Limpopo university which

revealed that parental communication about sex and related matters is not a common practice among many of the families in the population studied (Mafokane and Oyedimi, 2015).

In addition, the Mothiba and Maputle (2012) study revealed that many young people perceived it as a cultural taboo to discuss sex with their parents. Although sex topics were found to be a taboo by many participants, the discussion of the topic with parents was cited as being significant in influencing the sexual behaviour of teenagers that could lead to unwanted pregnancy. A qualitative study of peer pressure conducted in South Africa revealed that negative peer pressure to engage in risky sexual behaviour can be prevented by increased parent-child communication about sex (Selikow et al., 2009).

### ***2.3.3 Peer Pressure***

One of the most powerful psychosocial influences on an adolescent's sexual risk behaviour is their peers' perception about the behaviour (Pettifor et al., 2004). Furthermore, as children make the transition from childhood to adolescence and engage in the process of identity formation, their reliance on parents and siblings as the sole sources of influence and decision-making begins to change (Sieving et al., 2006). Adolescents spend more time with friends and peer groups than with their parents which can affect their choices and decisions (Gouws et al., 2008; Malisa, 2015). A quantitative study carried out to describe factors contributing to high rates of teenage pregnancy in Kinondoni municipality, Dar Es Salaam, revealed that peer pressure does lead to teenage pregnancy (Philemon, 2007). These findings were confirmed by the respondents of a quantitative study carried out in Tanzania acknowledging that their participation in sexual activities was encouraged by their peers in exchange for money, while others reported engaging in sexual activities in order for them not to look old fashioned to their peers (Malisa, 2015). Similarly in South Africa, a quantitative study conducted to explore secondary school girls' the knowledge, attitudes and behaviour regarding emergency contraception, teenage pregnancy and sexuality among secondary school, the girls confirmed peer pressure as one of the factors influencing teenage pregnancy (Ramathuba, 2013).

The above section has reviewed literature internationally and locally on various factors at the social level that influence teenage pregnancy. The next section focuses on the structural factors influencing teenage pregnancy.

## **2. 4 Structural factors influencing teenage pregnancy**

Structural factors are another level of factors influencing teenage pregnancy. Structural factors are defined as the economic, social, policy, and organizational environments that "structure" the context in which risk production occurs (Marshall et al., 2009:1).

### **2.4.1. Poverty**

Flanagan et al. (2013) describe poverty as a key structural factor that contributes to teenage pregnancy. Some of the consequences of poverty and economic inequality for adolescent women globally include an increased risk of inaccessible contraception, unwanted pregnancy, unsafe abortion, HIV/AIDS and other STIs and infant and maternal mortality (Shaw, 2009). According to Oke (2010), poverty has a dual dynamic in teenage pregnancy, presenting both as a determinant and a consequence of teenage pregnancy. A qualitative study conducted in South Africa by Nkwanyana (2011) revealed that teenage pregnancy is more common among young people brought up in poor families who have a low expectation of education or the job market.

### **2.4.2 Health system factors**

Reproductive health services is described as an organisational factor influencing teenage pregnancy (Shrestha, 2012). It is estimated that 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception; the reasons for this include reproductive health service issues such as limited choice and access to contraception, particularly among young people and poor quality of available services (WHO, 2015).

South Africa has the highest contraceptive prevalence rate for married women using a modern form of contraceptives in Africa which is reported to be at 59.8% (Department of Health et al., 2007). However, the high rates can be misleading as they vary according to religion and educational level and young women being largely left out of this statistic (Department of Health et al., 2007). It is also reported in South Africa that adolescents aged 15 to 19 years have a higher prevalence of unmet need for contraception (17.7%) when compared to older women (Department of Health et al., 2007). A qualitative study conducted to assess the service availability and health care workers opinions about young people's sexual and reproductive health in Soweto revealed that availability, accessibility and acceptability of health care services for young women significantly impact their

use of prevention methods which in turn influence their risk of becoming pregnant and contracting HIV (Holt et al., 2012).

A quantitative study conducted in South Africa on contraception use and pregnancy among 15 to 24 year old South African women identified barriers to accessing contraceptives and attitudes of health workers to be influencing teenage pregnancy (MacPhail, Pettifor, Pascoe & Rees, 2007). In addition, a qualitative study conducted to explore factors contributing to teenage pregnancy in Mpolokang High school, North West Province by Tsebe (2012), revealed that health care workers have not accepted that learners also should have access to reproductive health services so that they can make informed decisions. Tsebe (2012) concluded that the implication here is that this attitude makes the health care system unfriendly to the learners, who then rather seek information from their peers which may sometimes be incorrect.

According to MacPhail and Campbell (2001), although parental permission is not required for adolescents to access sexual and reproductive services and use contraception, nursing staff violate the privacy and confidentiality of teenagers by threatening to report condom use to their parents. Similarly a study conducted by Lesch & Kruger (2005) among Coloured adolescents in the Western Cape, revealed that adolescents do not have confidence in the local clinics and as a result they choose not to access contraceptive services.

## **2.5 Conclusion**

Teenage pregnancy is driven by many factors occurring at different levels including the individual, social and structural levels. This chapter has provided an overview of teenage pregnancy by comparing and contrasting factors influencing teenage pregnancy across a range of countries.

From the literature, lack of knowledge, risky sexual behaviour, educational status early sexual debut were discussed as individual level factors influencing teenage pregnancy. Cultural beliefs, parental values and communication with children and peer influence were discussed as social level factors influencing teenage pregnancy and lastly the structural factors reviewed included poverty and health system factors.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter discusses the research design and research setting. It also describes the study population, sampling, data collection, data analysis and ethics considerations for the study. Finally the chapter addresses issues of rigour in this study.

#### **3.2 Research design**

Qualitative research involves research methods that concerns itself with the systematic collection, ordering, description and interpretation of data that is generated from talks, observations or documentation (Kitto et al., 2008; Malterud, 2001). Qualitative research also focuses on seeking to understand phenomena from the perspectives of those involved in their setting, as experienced by them (Malterud, 2001; Robson and McCarthan, 2016). An exploratory study design was used for this study, as the aim was to explore the factors influencing teenage pregnancy. An exploratory study design attempts to identify new knowledge, new insights, new understandings, and new meanings in addition to what was previously studied (Brink, 2006). The phenomenon under study was teenage pregnancy and the study participants were teenage mothers and key informants were carefully selected as those people with the ability to give their perspectives from first-hand experience and knowledge regarding teenage pregnancy in their own context.

#### **3.3 Research setting**

The research setting used was Opkoms clinic in the Heidedal location, Mangaung. Opkoms clinic operates from Monday to Friday between 07:00 to 16:00. Services offered in Opkoms clinic include primary health care services, HIV care and treatment, tuberculosis screening and treatment, antenatal and postnatal care and immunisation services. A research setting is described as an environment in which the research study takes place and can be a natural or controlled environment. A natural setting is the real life environment without any changes made for the purpose of the study (Burns & Grove, 2005) and was used for this study as no changes were made in the clinic to manipulate the environment and which could affect the findings.



### 3.4 Study population

A study population refers to all the members that have the attributes of what is being studied (Babbie, 2005). The study population comprised of teenage girls attending Opkoms antenatal and post natal clinic who were either pregnant or were already teenage mothers aged between 13 and 19 years old. Hereafter referred to as teenage participants

### 3.5 Sample and sampling process

Purposive sampling was used in selecting the participants. Purposive sampling is a selection method commonly used to select a sample based on the in-depth knowledge and/or experience of the phenomenon being studied (Babbie, 2005). After obtaining permission to conduct the study, the researcher contacted the facility manager requesting to be assigned a clinic sister who will assist in recruitment of the study participants. The role of the clinic sister was to identify potential participants from the registers who met the inclusion criteria and to provide their telephone details to the researcher to contact them for interviews.

The selection of the sample of teenage participants was guided by the following inclusion criteria:

- Currently attending Opkoms clinic for antenatal or postnatal care
- Aged between 13-19 years
- Residents of Heidedal location (to understand the specific context).

The exclusion criteria included:

- Visiting teenage mothers from other areas since the study was limited to teenagers residing in Heidedal location
- Those who did not give consent or did not have consent from their parent/guardian

The recruitment process took place over a period of five weeks prior to the researcher commencing with data collection. Data collection was conducted from the 2<sup>nd</sup> to the 5<sup>th</sup> May 2017 with previously identified pregnant and teenage mothers whose follow up visit fell within the week of the data collection.

During the recruitment process, a list of 14 teenaged participants who met the inclusion criteria was obtained from the clinic sister. All the teenaged participants were contacted by the researcher telephonically and only 12 confirmed their availability to attend the interviews. The final sample size was 12 teenage participants. During the telephonic recruitment discussion the researcher explained to the participants that interviews will take between 30 to 45 minutes and during that time

they will be provided with a light snack. The age of the participants at the time of the interview ranged between 16 to 19 years.

In addition, four key informants were recruited to give their unique perspectives on factors influencing teenage pregnancy in Heidedal based on their experiences with or knowledge of young people. The key informants included:

- A nurse who provided antenatal and postnatal services to the teenagers in Opkoms clinic
- A representative from Lovelife which is a non-governmental organization working with youth in the community. The Love Life representative provided insight regarding the youth behaviours, interests and perspectives about life
- A ward councillor provided insight on social and structural factors believed to be influencing teenage pregnancy in the community

A life skills teacher from the secondary school near the clinic provided her unique perspectives on factors influencing teenage pregnancy in Heidedal.

### **3.6 Data collection methods and tools**

Individual in depth interviews were conducted with the teenage participants. This qualitative method of data collection is appropriate for exploring sensitive topics, where participants may not want to discuss such issues in a group environment (Gill, Steward, Treasure & Chadwick, 2008). Interviews for teenaged participants were held at the clinic, an environment they were familiar with. The participants were asked to choose a suitable time for the interviews which were conducted between 10.00 and 16.00 daily during the period of the data collection. The interviews conducted lasted between 25 – 45 minutes.

Key informant interviews were conducted with individuals who were selected because of their expertise, experience or position within the society, and who were able to provide more information and a deeper insight into the issue at hand (Marshall, 1996). Interviews for the key informants took place where it was most convenient for them: the ward counsellor and the nurse were interviewed in Opkoms Clinic; the school teacher was interviewed at the secondary school situated in Heidedal location near the clinic; and the Lovelife representative was interviewed at a youth event he was attending in Heidedal location. Interviews with key informants lasted between 40 – 50 minutes each.

Semi structured interview schedules were used to guide both the teenage participants and the key informant interviews (Appendices IV & V respectively). The interview questions were designed to initially ask simple, more general and non-sensitive questions and transitioned to asking more

sensitive questions. The interview schedules were prepared in English, Afrikaans and South - Sotho as these are the commonly spoken languages in Heidedal location. Before commencing with the interviews, the researcher asked the participants in which language they preferred to be interviewed; all preferred to be interviewed in English. The researcher therefore conducted all the interviews in English. The researcher was accompanied by a translator who was conversant in Afrikaans and South- Sotho to assist when needed. The translator also doubled up as note-taker during the interviews. All interviews were audio-taped and transcribed verbatim by an independent transcriber.

### **3.7 Rigour**

According to Kitto, Chesters & Grbich (2008: 243) “Procedural or methodological rigour is concerned with transparency or explicitness of the description of the way the research was conducted.” The following strategies were used to ensure rigour:

#### **3.7.1 Data verification**

Checks relating to the accuracy of data may take place during the course and at the end of a data collection period (Shenton, 2004). In this study the researcher used communication techniques like summarizing and clarification to verify the accuracy of data captured.

#### **3.7.2 Audit trail**

According to Robson and McCartan (2011), an audit trail involves keeping record of data from transcripts and notes, researcher’s journal and details of data analysis conducted by the researcher. The researcher used the voice recorder to record key steps and decisions throughout the study to ensure effortless tracking of information in the future if the study is replicated elsewhere. The voice recorder has been safely stored and will be availed should the need arise. A note book has been kept which contains information of activities carried out during the interviews such as documentation of the recruitment process. In addition, the transcripts and all soft copies of study documents have been securely stored on a hard drive only accessible to the researcher.

#### **3.7.3 Reflexivity**

According to Cresswell and Miller (2000: 127), reflexivity “... is the process whereby the researcher reports on personal beliefs, values and biases that may shape the inquiry”. The researcher reflected what she might bring into the study which might influence the inquiry. Therefore the researcher ensured that her thoughts regarding teenage pregnancy as a professional nurse did not interfere with

the research process. As a nurse, the researcher acknowledged the importance of youth friendly services. A reflective diary was kept during the research process to record the researcher's own perspectives and feelings regarding teenage pregnancy in order to be acutely aware of how this might influence the data collection and her analysis of the data.

### **3.7.4 Triangulation**

Triangulation is described as a rigour procedure where the researcher seeks conjunction from various and different sources (Creswell and Miller, 2000). In ensuring triangulation, the researcher collected data from two different sources. Information regarding factors influencing teenage pregnancy was obtained from teenage participants affected by pregnancy and key informants.

### **3.8. Data analysis**

Thematic analysis was used to analyse the data for this study. According to Clarke and Braun (2006), thematic analysis is a data analysis method used for identifying, analysing and reporting patterns (themes) within data. All six steps of thematic data analysis were:

1. Familiarisation: the researcher familiarised herself with the data by listening and re-listening to the audio tape recording and reading the transcribed information exactly the same way it was verbalised by the participants. At the same time the researcher used the notes that were captured during the interviews to supplement the transcripts. All this was undertaken by the researcher so as to have a full understanding of data
2. Generating initial codes: after completion of the transcript, the researcher together with a colleague started coding the transcripts. The colleague was experienced in qualitative research and recently graduated with an Honours degree in Psychology. The researcher together with the colleague discussed all the codes and interrogated the relevance of codes generated.
3. Searching for themes: after coding, the researcher categorised all the codes with similar meaning and brainstormed the themes that represented the codes well.
4. Reviewing themes: many themes were identified. The themes were checked against the relevant data to check for suitability and relevance. Some were combined to form new themes and those that were found to be irrelevant were left out.
5. Defining and naming the themes: literature reviewed in Chapter 2 of this thesis assisted in defining and naming the themes.

6. Producing the report: chapter 4 of this thesis bears relevance to the report that was produced after data analysis.

### **3.9. Ethics considerations**

Ethics approval was sought from the Biomedical Research Ethics Committee at the University of Western Cape and ethics clearance was obtained from the Free State Provincial Health Department. Following this the proposal and ethical clearance certificate was submitted to the Opkoms clinic to obtain their permission to conduct the data collection at the facility.

The teenage participants and key informants were provided with the necessary information from the information sheet concerning the study (see, Appendices III A & III F respectively). All participants were told about the purpose of the study, were informed that their participation was voluntary and that they could withdraw whenever they wanted to without any negative consequences for them. Eight participants were under 18 years and therefore assent to participate in the study was obtained from them and consent from their parent or caregiver (see, Appendices IIA). The caregivers were requested to accompany the under 18 participants on the day of interview in order to give consent. Consent was obtained from participants older than 18 years and key informants (see Appendices IA & IC respectively).

To protect the identity of the participants, they were informed that their names would be replaced with study identification numbers. Data collection was conducted in a private, comfortable and safe environment and a DO NOT DISTURB sign placed on the door to minimise movement.

Knowing that teenage pregnancy is a sensitive topic and teenage mothers might have felt emotional or depressed, the researcher had liaised with a social worker from the Department of Health for possible psychosocial management. However no referrals were needed or requested.

This chapter has provided an overview of the research design and methods that were followed. Data collection methods and strategies to ensure rigour were employed and a brief summary of issues relevant to ethics consideration were also discussed. The next chapter discussed in full the data analysis and the results thereof.

## CHAPTER FOUR

### FINDINGS

#### 4.1 Introduction

The preceding chapter gave a detailed explanation of the research methodology and design employed to gather data in this study. This chapter presents the findings that emerged during data collection process.

The main themes that are discussed in this chapter are: lack of parent-child communication regarding sexuality, peer influence on teenager's behaviour, knowledge of contraceptive methods used to prevent pregnancy, clinic environment and teenagers' risky behaviours. Thereafter, the participants' recommendations of how sexual and reproductive health services in clinics can be improved and also strategies that can be implemented in schools and community to prevent teenage pregnancy are presented.

Key informant interviews were conducted with four key informants. The participants were selected based on their extensive experience in working with teenagers, only two of the four key informants were residents of Heidedal location (Table 4.1.1)

**Table 4.1.1: Key informants information**

Key informant	Key informants identifier	Years of experience in current role	Residing in Heidedal
Ward counsellor	KI 1	20 years	Yes
Nurse	KI 2	10 years	No
Love life counsellor	KI 3	3 years	Yes
Life orientation teacher	KI 4	8 years	No

**Table 4.1.2: Teenage participant's information**

<b>Participant</b>	<b>Age</b>	<b>Ethnicity</b>	<b>School Grade before pregnancy</b>	<b>Resides with</b>
P 1	17	Coloured	Grade 11	Grandmother & Aunt
P 2	16	Coloured	Grade 10	Both parents
P 3	19	Sotho	Grade 10	Father (mother deceased)
P 4	19	Sotho	Grade 10	Both parents
P 5	17	Sotho	Grade 11	Father, Mother & 2 siblings
P 6	17	Coloured	Grade 11	Both parents
P 7	18	Coloured	Grade 11	Grandmother, Mother & 5 siblings
P 8	17	Coloured	Grade 10	Father & 1 sibling
P 9	17	Coloured	Grade 10	Mother & 2 siblings
P 10	19	Coloured	Grade 11	Both parents
P 11	16	Sotho	Grade 10	Mother, Step father & 2 siblings
P 12	17	Coloured	Repeated Grade 11	Parents & 3 siblings

Individual interviews were conducted with 12 participants. All the participants were selected from the antenatal care records. At the time of the interviews, 11 of the 12 participants were attending school except for one participant who was due for delivery in a week's time. Two of the 11 participants who were attending school were pregnant and the rest of the participants were teenage mothers. The age of the participants at the time of the interview ranged from 16 to 19 years. At the time of the interview, the levels of the participant's education ranged between Grade 10 and Grade 11 with only one participant repeating a grade. Despite the differences in ethnicity (eight coloured and three Sotho), all participants were fluent in English. All participants reported to having been pregnant only once and none of the participants planned their pregnancy, they all reported that becoming pregnant was something that just happened. Although not all the participants' households were headed by both parents, the participants had at least one adult heading the household and more than half of the 12 participants had at least one resident sibling. Parents or grandparents were responsible for taking care of the family's financial needs, with only one participant also being dependant on her boyfriend for financial support. All the participants were residents of Heidedal since childhood except one participant who moved to Heidedal three years back from another town in the Northern Cape (Table 4.1.2)

The participants' responses are now presented according to the main themes that emerged from the interviews.

#### **4.2 Poor parent – child relationships and communication**

This theme describes communication within households between teenage mothers and their parents. It was clear that in most families the parent-child relationships were not always amicable:

One participant related the autocratic relationship she had with her mother which served as a barrier for open discussions between them:

*“.....Me and my mother in our relationship we did not discuss any boyfriends it was strictly daughter and mother relationship, where there were no discussions except stop doing this and that, so I could only trust my friend with anything not my mother.” (P 6)*

Another participant who lived with an aunt and grandmother confirmed that tensions within the household created an uncomfortable home environment which then exacerbated the communication negatively. She had to go outside the household if she wanted to discuss issues:



*“I used to fight a lot with my aunt; she will pretend when my grandmother is around that we were okay and pretended to like me, but it was all an act, I was really uncomfortable around her; I only had discussions with my [other] aunt in Cape Town since I could open up to her with everything.” (P 1)*

Although all the households were headed by an adult and the majority of them were headed by both parents, some participants confirmed that there was no communication around sex with them.

*“We never talked about sex at home at all.” (P 4)*

On the other hand, one participant who was willing to discuss sex with her mother was not given the opportunity to do so by her mother as it was regarded as taboo:

*“I tried to speak to my mother the first time I was having sex but she said I am not even allowed to talk about it and she wanted to hear nothing about sex.” (P 8)*

However most participants acknowledged that communication between them and their mothers improved after they became pregnant.

*“It is now only after being pregnant that we became really close where I also became more comfortable in discussing whatever with my mother; so I would say it has changed from bad to good. She is the mother I have always wanted; we are now able to have discussions.”(P 10)*

The extent of poor parent-child communication is evident from responses by participants when asked who they disclosed their pregnancy to. They preferred to disclose to friends rather than their parents:

*“I spoke to my friend since she is the only person I can be open with because me and my mother in our relationship we did not discuss any boyfriends ... so I could only trust my friend with anything not my mother.” (P 6)*

*“I told my best friend who was then in Matric, she is also one year old older than me. So I trusted her to tell me what to do with pregnancy and who to tell. The thing is she knew everything about me and I trusted her.” (P 8)*

One participant did not disclose her pregnancy to a friend like others, instead she chose to speak to her boyfriend about her pregnancy:

*“I told my boyfriend and he was excited the thing I chose him I needed to know first how will he react to the news before going to my parents at least I will know if he was supportive or not then.....” (P 8)*

This participant’s responses above reflect poor parent – child communication especially on sexuality matters as one of the reasons that influence teenage pregnancy. Sexuality talks in many homes seem to be a forbidden topic.

#### **4. 3. Peer influence on teenagers’ behaviour**

Peer influence on teenager’s behaviours emerged as a theme and it is related to decisions made by teenagers based on their peers’ actions and opinions. The majority of participants mentioned that they spent quite a bit of time with their peers talking about sex. Decisions to experiment sexually were informed by what they heard from their friends:

*“As learners we talked a lot about sex, other learners will say sex is nice and when you have sex then you make your partner happy; that is then when I decided to also go and have sex with my partner; I wanted to have experience because I have always heard from other learners that it feels good to have sex.” (P 9)*

Another participant confessed that the discussions held with peers about sex to some extent influence the decision to want to have sex because of peer perceptions of reasons to have sex:

*“As learners when we are sitting together we used to say that when you love someone you will have to do this so that the person loves you and yes because you hear others say ‘you are stupid you don’t know how to do this’ and sometimes there is a feeling of doing something just to prove to friends that you can do it.” (P 11)*

Even though the above responses are related to peer pressure, none of the participants claimed sexual coercion from their partners but was rather a joint decision:

*“Ma’am having sex was a joint decision no one pressured any one; although pregnancy was not an agreement really it just happened.” (P 2)*

*“It was actually something that we [participant and boyfriend] planned, we have been talking about sex so we decided to take it to another level and have sex.” (P3)*

One participant differed from the responses above and cited material needs in the desire to fit in with peers, which alluded to unprotected transactional sex:

*“School girls want to be bought things like pads and be given money ... something that they do not always get from home because at home we struggle and we want to be like other kids; so when they get older partners who buy them things then they do not talk about using condoms, they just have sex without a condom.”(P 9)*

One key informant was certain that transactional sex happens due to peer pressure:

*“Teenagers somehow have a desire to be recognised and also want to fit in and not to look like they are old fashioned, therefore even when they do not have affordability they opt for transactional sex.” (KI 4)*

Another factor related to peers that likely influenced teenage pregnancy was the fact that the decisions taken by teenagers were based on friends imitating one another:

*“I do not know honestly but here in Heidedal it is as if teenagers just want to get pregnant because their friends are pregnant; so it sometimes becomes a trend (giggle) it is an issue of my friend is pregnant and also me I want to have a baby.” (P8)*

It is evident that teenage pregnancy can be influenced by what teenagers see and hear from their peers. The curiosity of wanting to experiment what is said and done by peers about sexual engagement and the pressure to fit in puts teenagers at the risk of teenage pregnancy.

#### **4. 4. Teenagers’ risky behaviours**

Teenager’s risky behaviours emerged as a theme. The behaviour of teenagers was described aptly by one participant as risky:

*“Our minds work 24/7 and to us everything is possible, mostly we do not always think about the consequences of the things that we do.” (P 10)*

Another participant claimed that there was no sense of responsibility for actions taken by teenagers especially when are under the influence of alcohol:

*“The thing is us the youth when we go out we drink and when we are drunk we do not take responsible actions, we are controlled by alcohol and we lack self-control.” (P 3)*

One key informant interviewed confirmed that teenagers were prone to make mistakes when they were under the influence of alcohol and the worst part was that teenagers had access to alcohol because their parents abused alcohol:

*“Most young people are exposed to alcohol abuse and they are like this because of what they see their parents do; their parents are also the victims of alcohol abuse, there is no difference between a child and an adult when coming to alcohol abuse and unfortunately for the young people they do a lot of mistakes under the influence of alcohol.”* (KI 3)

One of the participants confirmed that many parents were bad role models for their children with regard to alcohol use:

*Most parents do not lead by example, they drink alcohol in front of their kids; what example are they setting and you must know kids copy behaviours from their parents.”* (P 6)

Most participants confessed to alcohol abuse by disclosing that their leisure time was spent with friends drinking alcohol:

*“.....we used to go to taverns and drink a lot....”* (P 9)

*“I love to chill with my friends and we like drinking ..... we drink alcohol jaaaaa we like doing that when we are out chilling.”* (P 7)

Participants acknowledged the vulnerability that girls can be exposed to when under the influence of alcohol with regard to unprotected sex:

*“When you are drunk you are most of the time unable to control yourself as a girl and boys take advantage of that by having sex with you without protection.”* (P 11)

One key informant confirmed that alcohol and drug use was causing many problems in the community including teenage pregnancy:

*“I have a big problem with the drugs and alcohol use here; these young girls have affairs with older guys and they give them money to buy drugs and alcohol and then they use them and that is why they get pregnant. At this moment the drug use and alcohol use in Heidedal is very high.”* (KI 1)

The key informant further revealed that although Heidedal has sites where teenagers can entertain themselves, these sites were not maintained and therefore they remained unattractive to the teenagers. One participant expressed her frustration at the absence of recreational activities highlighting the related negative consequences such as risky sexual behaviour:

*“Here in Heidedal, there are no activities to entertain young people and keep them away from being naughty... at least if we had a well taken care of soccer grounds then boys will drink less and stop chasing girls to have sex with them.” (P 5)*

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 also resultant teenage pregnancy.

#### **4. 5. Knowledge of contraceptive methods**

All participants knew about the contraceptive methods that can be used to protect themselves from becoming pregnant. The methods they mentioned included contraceptive pills, condoms, Depo Provera and implants. Although many of the participants were aware of these protective methods, utilisation was minimal as they had the perception that contraception was harmful to the body:

*“Well as for Depo I was afraid of it because some girls said they did not get periods and periods are designed for your body to clean itself; so if my body doesn’t clean itself then that can affect me when I want to have babies.”(P 1)*

One participant confidently confirmed her knowledge of methods used to prevent pregnancy. However from what she had heard and also seen from her mother’s experiences, she blatantly had no intention to use contraceptives as she felt they were not safe:

*“Yes I know you get them from the clinic and what they are used for, but I was not going to use them for my body since I heard people say Depo makes them gain weight so for me is a big no, I have also noticed that people become moody and dizzy..... that is what I see from my mother.” (P 4)*

When asked to specify which methods she felt were not safe the response was:

*“I know about injection [Depo] and condoms and I also know that condoms cannot always be reliable because it can break.”(P 4)*

The majority of participants, when asked what they knew about contraceptives before becoming pregnant, confirmed that they knew of the consequences that sex without contraceptives can lead to pregnancy:

*“I knew that when you have sex without protection you obviously get pregnant.”* (P 12)

It was clear that although participants knew about the methods available, this information was obtained elsewhere other than from the health care workers:

*“.....I got this information from friends and internet.”* (P3)

*“..... I got information from people they talked about injections and condoms mostly they will talk about condoms that it prevents pregnancy; I knew that condoms cannot always be reliable because it can break.”* (P 4)

Although the participants had knowledge about the different types of contraceptive methods available, there were certain misconceptions that influenced their decision not to use contraceptives which then put them at risk for teenage pregnancy.

#### **4.6. Attitude of others towards contraceptive use**

This theme is related to the attitude displayed by families and community members towards contraceptive use:

*“Yes I knew where to get family planning but then again my mother when she was still alive never wanted to hear a thing about family planning, that is why I never went anyway.”* (P 8)

It seems there was stigma attached to contraceptive use by teenagers:

*“I was scared of being laughed at by older people and also people will start talking about me saying as young as I am I am having sex when they see me come for condoms and going for injections.”* (P 9)

*“Getting to the clinic at such an age and asking about methods to prevent pregnancy - imagine the way nurses will look at me and how people will react.....”* (P 12)

It is clear that the teenagers knew about contraceptives but they refrained from accessing and using these preventative methods because of the negative attitude of others.

*how am I supposed to tell my parents what I was just a mess.”* (P 6)

#### 4. 7. Sexuality education

All participants confirmed that they were provided sexuality education at school by the life orientation teacher. Although they reported to have knowledge about sexuality from other sources, they confirmed that the knowledge they had about contraceptives and teenage pregnancy was obtained from the life orientation classes which they found to be interesting and informative.

The sexuality education provided by the life orientation teacher included teenage pregnancy, contraceptives, sexual harassment and sexually transmitted diseases. The life orientation teacher remarked that learners became more participative during these classes:

*“In our school we have life orientation classes that take place every day, they take up to 45 minutes and I get 40 – 45 learners attending these classes. Sexuality education is one of the topics that learners enjoy, they ask a lot of questions in reference to what they did. For example they will ask ‘If I slept with a boy without protection, what signs of STI will I have?’” (KI 4)*

The participants confirmed that they found life orientation classes to be interesting and informative:

*“Yes we were taught life orientation at school although we used to joke about it as friends at school but it was an interesting class; information about sexuality I learned from LO at school.” (P 5)*

It is evident from the responses that learners were provided information about sexuality at school and the setting seemed conducive to enable active learner participation.

#### 4. 8. Clinic environment

The Opkoms clinic operates 8 hours per day and 5 days per week clinic and renders adolescent health services among other services:

*“Here in Opkoms even though the clinic is small for such a big population we see all people and have services for all population including the teenagers. When they come to our clinic we offer them health education, we provide them with contraceptives and there are days that the Love Life counsellors have interactions with them in our clinic. Even those who come here and are pregnant we see them.” (KI 2)*

However, most of the participants said that they were reluctant to access reproductive health service from the clinic. One of the reasons for being reluctant to visit the clinic included the long waiting times:

*“I never liked going to the clinic, you always wait long before you get help, so I never liked being in the clinic.” (P 7)*

*The thing is we do not want to wait long, people always leave because nurses take long to help people. You see people have left whilst I was waiting.... To sit there so long for just an injection, I can do that myself mos....” (P 7)*

The participants also expressed dissatisfaction regarding the manner in which the facility staff addressed them. The attitude and behaviour of the staff members towards the teenagers who sought assistance from the clinic was described as being unfriendly, hostile, rude and judgemental:

*“Like I said, nothing is attractive in wanting to go to the clinic (pause) just the way nurse’s talk to us they just shout... I do not understand why are they not polite to people; clinic people are not friendly when they see teenagers. They just become rude towards us, it will be nice if they can treat us in a respectable manner.” (P 6)*

Another participant reflected on the judgemental attitude and inefficiency of the staff when asked about the treatment they received at the clinic:

*“We were put in the wrong line when we just wanted information and the other nurse even said we were too young for asking such questions.... Nurses should stop criticising people, stop with their judgement because you can see by the look in people’s faces of what they think about you; and stop this thing of directing people to the wrong places you end up spending the whole day at the clinic for nothing.” (P 12)*

Despite the reproductive health services being available, participants felt that the request for identity documents when visiting the clinic or otherwise wanting to see their parents created barriers towards accessing health services:

*“You know what, most of the time they want an ID or birth certificate and if you do not have them then they want your parents and it is not always easy to say to parents you want family planning.” (P 6)*



Although Opkoms clinic is supported by Love life as partners to implement youth friendly services for the adolescents, this process has not been easy due to human resource challenges experienced by these partners:

*“We have people called the Mpintshi who are deployed in our facilities. However because they are not receiving any stipend and have to volunteer they do not stick around for long so even though the positions are there, they are not filled because people want money.” (KI 3)*

Despite the long waiting times mentioned by participants and challenges experienced by the developmental supporting partners to support the provision of adolescent and youth friendly services, the nurse interviewed confirmed that the clinic is fast tracking the adolescents and tried by all means to offer them a speedy service although they were also experiencing shortage of staff:

*“Here in Opkoms we try by all means to make our services youth friendly, but limited resources do not make it easy, such that when we are short staffed. We are unable to see adolescents as quickly as we would like to especially those who come only for the reproductive health services.” (KI 2)*

Systems within the clinic environment which teenagers find unnecessary and inappropriate creates a barrier for teenagers to freely access services related to prevention of pregnancies.

#### **4. 9. Recommendations to improve sexual and reproductive health services for the teenagers at the clinic**

When asked about what could be done to improve sexual and reproductive services for teenagers at the clinic, most of the participants yearned for private informative conversations led by the nurses:

*“I think that (sigh) like they should have private sessions with girls here in the clinic and talk about... the stuff important for us to know.” (P 3)*

Another participant preferred speedy clinic services to avoid long waiting times:

*“It will be nice to go there after school and get quick help you see I am not sick when I go for contraceptives I just need an injection, it should be as quick as possible. (P 7)*

Most participants felt that there was a need for collaborative efforts between schools and clinics. One participant expressed her wish to have reproductive health services made available at schools by nurses:

*“I wish for clinic people to come to school and be open to learners, they should not just wait for them to go to the clinic but they should make efforts to come to school and give us information and contraceptives.” (P 6)*

#### **4. 10. Recommendations on what can be done in the community to reduce teenage pregnancy**

The ward counsellor noted that parents can play a big role in reducing teenage pregnancy. This can be achieved by parents making time to talk to their children and to show interest in community meetings in which such topics are discussed:

*“Parents in this community do not attend meetings when they are called and it is in these meetings where we discuss teenage pregnancy and other topics such as drugs that are concerning teenagers. Parents need to play a role in their houses to avoid all this but they do not come to community meetings.”*

Most participants also expressed the need for a strong open communication within families regarding sexuality topics to equip them with the relevant information:

*“It should start at home first, parents should continue to provide information to their children and there should be consistency on what is given at home otherwise the teenagers will feel like they are thrown into the adult world to take care of themselves and that is dangerous.” (P 1)*

The life orientation teacher also felt that it was important that parents should play a role in discussing sex issues with their children and not leave the responsibility to others to do:

*“.....I sometimes also ask learners whether they talk about things like teenage pregnancy and sex at home they say they are not allowed at all, but then again I feel parents have a role to play in ensuring that their children are informed. Us only as teachers and nurses talking can never be enough...”*

One participant suggested giving information on sexual and reproductive health in the community:

*“Community events can be made that reach out to young people where they can be told about teenage pregnancy.”* (P 3)

Another recommendation was about making the services more accessible. One participant suggested the rendering of mobile services in the community:

*“The mobile clinic can also go into the community and give contraceptives into the community.”* (P 9)

#### **4. 11. Recommendations about what can be done at schools to reduce teenage pregnancy.**

Most participants wished to have contraceptives offered to them as well as sexuality education by nurses at schools.

The life orientation teacher commented that, it is important for learners to engage with their teachers proactively. She commented that it is the appropriate subject that these learners can be informed about sexuality matters:

*“Here in school during LO classes we talk about sexuality including sex, pregnancy and contraceptives. It is just that learners are not upfront in class which can be benefit to all; nevertheless information is sufficiently provided to them.”* (KI 4)

From the findings, the decision to use contraceptives by teenagers is influenced by many factors. Although teenagers have knowledge about contraceptives, utilisation of these protective methods remains poor due to several interrelated factors.

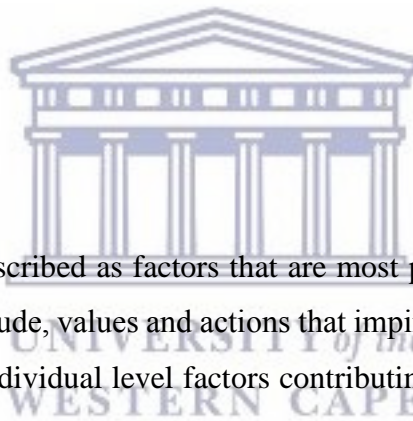
In the next chapter the researcher discusses the findings in accordance to individual level, social level and health system factors.

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.1 Introduction**

This chapter discuss the findings that were presented in Chapter 4. The findings are discussed using the Flanagan et al. (2013) framework of the inter-connected factors, which place girls at risk of unplanned pregnancy. According to Flanagan et al. (2013:10) “The contributing factors for teenage pregnancy can be related to the individual herself, social, structural or environmental factors and the interaction between the individual and her social/structural/environmental situation.” The discussion in this chapter is categorised into individual, social and structural factors influencing teenage pregnancy. These findings are discussed by also drawing on the findings of other studies that have been conducted on the topic of teenage pregnancy.



#### **5.2 Individual level factors**

Individual level factors are described as factors that are most proximal to sexual behaviours, and include the teenager’s attitude, values and actions that impinge on his or her sexual related choices (Farber, 2009). The individual level factors contributing to teenage pregnancy in this study are discussed in this section and are categorised as follows: risky sexual behaviour and perceptions about contraceptives and it’s inter relatedness to knowledge about contraceptives and stigma.

##### ***5.2.1 Risky sexual behaviour***

This study established that teenagers spent their leisure time drinking alcohol with friends and admitted that being under the influence of alcohol made them vulnerable to engaging in risky sexual behaviours through lack of self-control. A study conducted to investigate the effects of alcohol consumption and alcohol policies on youth risky sexual behaviours by Markowitz et al. (2005) concluded that teenagers like to spend time in shebeens drinking alcohol which is well known for its ability to impair judgement with regard to safe sex.

The current study's findings also revealed that teenagers continued with repeated sexual engagements assuming that they would not become pregnant. It is possibly for this reason that the participants declared pregnancy as something that "just happened" which means that it was unplanned. Although the teenagers knew about the dangers of unprotected sex they ignored the consequences of their risky sexual behaviour. Similarly, a concern was raised by Mchunu et al. (2012) that adolescents do not take into consideration the risks involved in engaging in unprotected sexual intercourse which could lead to teenage pregnancy.

### ***5.2.2 Knowledge and perceptions about contraceptives***

Teenagers in this study had knowledge about contraceptives which they obtained from peers, family, media and the internet, although they concentrated more on the side effects caused by contraceptives than it preventing pregnancy. As a result the use of contraceptives by participants in the current study was low despite being aware of the various contraceptive methods. The findings of this study concur with the study by Undie et al. (2007) on conceptualization of sex among young people in Malawi. The authors confirmed that information received from friends, families and media influenced the adolescents' perceptions about contraceptive use. The current study established that participants were more concerned about the side effects of contraceptives than the benefits. This negative perception of contraceptives was influenced by misinformation received from their various sources highlighting the influence others can have in decision making around contraceptive use. Tabane and Peu (2015) confirmed that perceived side effects of contraceptive use discouraged teenagers from using or continue using contraceptives. Similarly in Bangladesh, a study on what influences adolescent girl's decision making regarding contraceptive methods and child bearing found that adolescents perceived that contraceptives were harmful to their bodies and they regarded contraceptives as the cause of infertility (Shahabuddin et al., 2016).

This study's findings also revealed that although teenagers had sufficient information about contraceptives, they were more concerned about people's reaction towards them should it be known that they were using contraceptives. Opinions from friends, family and community members about contraceptives to some extent had influenced low uptake of contraceptives. It is therefore evident from this study that teenager's decision making is influenced by other people's opinions. The findings of this study concur with the study by Israel et al. (2016)

conducted on the attitude and knowledge of teenagers in the Pietermaritzburg area towards contraception. The authors concluded that although teenagers had sufficient knowledge about contraceptives, there is still a gap between knowledge and the use of contraceptives which they attributed to fear of parents and teachers knowing that they were using contraceptives. This fear is related to the stigma surrounding teenage pregnancy and teenagers being sexually active, and is influenced by social and cultural norms which are discussed in the next section.

### **5.3 Social level factors**

The social environment in which a child grows up has an influence on his or her development as well as behaviour (Ncetakalo, 2011). Factors that are discussed in this section include: cultural beliefs with its inter-relatedness to poor parent-communication and peer influence.

#### **5.3.1 Cultural beliefs**

From the responses of participants of not having open communication about sex with parents it is evident that this topic was regarded as a taboo in many households nothing related to sexuality was ever discussed in most households as the participants felt uncomfortable discussing such topics with their parents. The participants associated initiating sex talks with parents as being disrespectful. Furthermore there was no platform created by parents for teenagers to freely talk about sex.

It is evident that the parents were not comfortable discussing sex and contraception with their children. Participants revealed that their parents admitted to them that they were afraid to talk about sex because it would have seemed as if they were promoting promiscuity. This finding concurs with a study by Wamoyi et al. (2010) conducted in Tanzania on parent-child communication about sexual reproductive health. The study found that parents believed that it was culturally unacceptable to have discussions about contraceptive use with their children as they believed this would be an encouragement for teenagers to have sex.

Many studies are suggesting that good communication between parents and teenagers may delay early sexual initiation. For example, Kirby and Lepore (2007) suggested that teenagers who have conversations with their parents about sex and contraceptives delay sex initiation. In a study conducted by Ncetakalo (2011) on socio-cultural influences in decision making

involving sexual behaviour among adolescents in Khayelitsha, Cape Town, the importance of the parental role and the need for parents to provide their children with relevant information on sexual behaviour was highlighted. Although the findings from a study on parental communication about sex and motherhood trends concurred with these findings, the author's also argue that parental communication alone is unlikely to reduce teenage pregnancy. They posit that the decision to engage in pre-marital sex or safe sex is not only dependent on parental communication but is also influenced by other factors such as the attitude of teenagers towards safe sex (Mafokane and Oyedimi, 2015).

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 friend's opinions more than their parents' which can put them at risk for teenage pregnancy because of the lack of correct information

### ***5.3.2 Peer influence***

This study established that the decision to initiate sexual engagements was influenced by peers. Participants confessed that the decision to have sexual engagements was informed by what friends said about sex. Although the teenagers had knowledge about sex from other sources and could decide to delay initiation of sex, the negative influence from friends seemed compelling. This finding concurs with those from a study conducted on factors contributing to teenage pregnancy by Malisa (2015) revealing that the teenagers' participation in sexual activities was encouraged by their peers in exchange for money, while others reported engaging in sexual activities in order for them not to look old fashioned to their peers. Although in this study teenagers seemed to have less interest in transactional sex the decision to have sex could have been influenced by the desire to fit in and not to be labelled as being old fashioned. This feeling of wanting to fit in is not uncommon in the adolescent phase of development. It is evident that peer pressure can have a negative effect on teenagers, which disempowers them from becoming assertive and resilient in their decision making. For example, the study by Kirby and Lepore (2007) highlighted that the teenagers' sexual behaviour was influenced by their friends, especially if their best friends and peers were older, and were using alcohol and drugs.

## 5.4 Structural factors

Apart from individual and social level factors, the structural factor that is comprehensively discussed in this section is the health system level factors.

### 5.4.1. Health system factors

Reproductive health services are described as an organisational factor influencing teenage pregnancy (Shrestha, 2012). The health service barriers that are discussed in this section are related to staff attitude and long waiting times which were the main health system concerns raised by the participants in this study.

The teenage participants confirmed that the negative staff attitude was a barrier to accessing reproductive health services at the health facilities. They claimed that they stayed away from the health facilities fearing judgmental and negative attitudes and being reprimanded by the nurses. The findings from this study confirmed that of other studies that have identified the negative attitude of health professionals as a barrier to contraceptive use by teenagers. For example, a study conducted by Ramathuba et al. (2012) on knowledge, attitude and practices of secondary school girls towards contraception in Limpopo Province, revealed that 60% of the study participants were not visiting the health facilities in order to avoid being judged on account of their young age for being sexually active. Similarly, a study conducted in Kenya on the perceptions and barriers to contraceptive use among adolescents found that adolescents were discouraged to visit the health facilities as they experienced discrimination on account of their age from the health professionals (Kinaro et al., 2014).

The implications of the nurses' judgemental attitude can deprive the teenagers of obtaining quality information which they can use to make informed decisions. It has been established from this study that teenagers rather seek information from other sources. Tsebe (2008) found that nurses' attitude made the health care system unfriendly to the learners, who then rather sought information from their fellow peers - which may sometimes be incorrect and can result in negative perceptions as discussed earlier. Forty two percent of participants in a study conducted by Ramathuba et al. (2012) on knowledge, attitude and practices of secondary school girls towards contraceptives in Limpopo felt that nurses needed to display a positive attitude such as being caring, polite, friendly and improve the way they communicate. The authors



concluded that needed to be tailored according to the needs of teenagers. Suggestions of how this can be achieved was made in a study conducted by Chilinda et al. (2014) on attitudes of health care providers towards sexual reproductive health in developing countries, proposing that training of nurses to meet sexual reproductive health needs of the youth is necessary.

Another health system factor that this study suggests is that long waiting times contributed to low utilisation of sexual and reproductive health services. Teenagers visiting the health facility after school felt the 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. It is for this reason that they might feel that the health system is failing to meet their needs as teenagers resulting in them becoming reluctant to visit the health facility. In an attempt to address the sexual reproductive health needs of teenagers, the South African National Department of Health launched the Adolescent Youth Health Policy (DoH, 2017). This policy is aimed at ensuring the provision of comprehensive sexual reproductive health services that is tailored to the needs of adolescents and youth, based on recognition of the specific challenges that they face.

Although the nurse key informant in this study said that they provided a youth friendly service, there still seems to be a need for improvement in rendering these services as the teenage participants did not seem to have this opinion. A study conducted by Carai et al. (2015) assessing youth friendly services in the Republic of Moldova, argued that designating health facilities to be made youth friendly and assigning health workers to manage them can be achieved. However, improving performance is time consuming and requires a lot of effort. The authors suggested that there is a need for approaches that go further than training of health workers such as collaborative learning and job shadowing which may create an opportunity to improve the knowledge, understanding and motivation of health workers to address the problem of poor quality of adolescent health services.

## **5.5 Limitations**

One limitation of this study was that it focussed on only collecting data from teenagers who were residents of Heidedal location, excluding teenagers who were not residents of Heidedal. Therefore the findings of the study cannot be generalised as the sample was not representative of the entire

teenage population. Only 12 participants were interviewed from that location. However, the aim of qualitative research is not to generalize but rather have an in-depth understanding of the phenomenon which a small sample can still achieve. Recruiting participants through the clinic could have been a limitation as teenage mothers not attending the clinic were not accessed. Their perceptions and experiences might have been different to those who had attended the clinic and therefore could have enriched the study further.

Another limitation could have been conducting the interviews at the clinic which could influence their participation because of the assumption that they would be kept longer at the clinic. This was overcome by explaining to the participants that there will be no waiting period, they were immediately attended to by the clinic sister assigned to assist the researcher. The interviews were conducted between 30- 45 minutes in a private room and a snack was offered to avoid loss of interest during the interviews and irritability that may be caused by long interviews and hunger.

Furthermore, teenage pregnancy is a very sensitive issue and therefore another limitation could have been that discussions could have resulted in participants withholding useful information from the researcher or even withdrawal from interviews. The participants could also have shared information they thought the researcher might want to hear which might not necessarily have been the truth. These limitations were overcome by explaining to participants that their openness would be instrumental in recommending targeted interventions to reduce teenage pregnancy and again ensuring them of anonymity.

This chapter shows the inter relatedness of different factors influencing teenage pregnancy making it a complex public health problem to address. From the discussion it is evident that teenage pregnancy needs a multi-faceted approach.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATIONS**

This chapter outlines the overall conclusion and recommendations for this study, taking into account what needs to be done at school, health facility and the community level to address the identified factors influencing teenage pregnancy.

#### **6.1 Conclusion**

The aim of the study was to explore individual, social and structural factors influencing teenage pregnancy in Heidedal location, Mangaung district and also to provide recommendations aimed at addressing these factors.

The study revealed that although teenagers were knowledgeable about different contraceptive methods they still had negative perceptions with regard to the use of contraceptives. These perceptions resulted from misinformation provided by peers. It is clear that the negative perceptions outweigh the known benefits of contraceptives, which in this case is prevention of pregnancy. It is however important to note that knowledge alone is not enough to make informed decisions; the attitude towards what is known influence the decision to utilise contraceptives. It can then be concluded that negative attitude towards contraceptives results in poor uptake of these preventative methods which consequently lead to unplanned teenage pregnancy.

The study also revealed that apart from misinformation and negative perceptions influencing the decision to use contraceptives, peer pressure played a major role in these teenager's decisions regarding risky sexual behaviour. The risky sexual behaviour is also influenced by alcohol use amongst teenagers, which they confessed to. It is worth noting that alcohol use impairs teenager's judgement and makes them vulnerable to risky sexual behaviour. It can then be concluded that alcohol use is a driver to risky sexual behaviour such as having unprotected sex which consequently can lead to unwanted teenage pregnancy.

The study revealed cultural norms as a factor that influenced teenage pregnancy. Open communication regarding sex topic within homes was not happening; as a result most of the information they had about sex was obtained from friends and school. The cultural norms of not discussing sex issues within homes left teenagers with no choice but to seek guidance and

information elsewhere. However the quality and accuracy of information obtained from friends remain questionable. It is worth noting that although information from parents alone cannot prevent teenage pregnancy, it can influence the decision to initiate sex to some extent. Therefore, it can be concluded that the lack of guidance and communication from parents impacts negatively on teenagers' decision making around sex initiation.

Although the nurse in this study claimed that a youth friendly service was implemented, this was in contrast to what the teenagers said. This means that there is a need for improvement of these services. Poor utilisation of reproductive health services was also related to the negative attitude presented by the nurses. The nurses' attitude towards the teenagers impacted negatively on their utilisation of sexual reproductive services. Consequently, poor utilization of sexual reproductive health dispossesses the teenagers from obtaining quality reproductive health services. As a result teenagers are at a risk to unplanned pregnancy

In conclusion, the factors influencing teenage pregnancy are multiple and at different levels of influence including the individual, social and structural level and are interrelated which adds to the complexity of teenage pregnancy; therefore a multipronged approach is needed to address this complexity.

## **6.2 Recommendations**

The recommendations are derived from a combination of what the teenage participants and key informants thought could be helpful to address teenage pregnancy in Heidedal location.

### ***6.2.1 Identify and train Adolescent and Youth Friendly champions***

There is a need to train and appoint at least one adolescent and youth friendly champion in the health facility for implementation of youth friendly service. The facility manager should conduct a skills audit and liaise with the district regional training centre for consideration of adolescent and youth friendly training. The trained champion needs to ensure that the services are tailored according to the needs of the teenagers.

### ***6.2.2 Ensure the implementation of the Adolescent and Youth Health Policy***

The National Department of Health launched the Adolescent and Youth Health Policy in 2017. The aim of the policy is to integrate the needs of young people with the latest high quality evidence regarding effective strategies and services for health promotion. In this policy one of the six priority objectives is providing comprehensive integrated sexual and reproductive health

services. It will benefit the facility staff to have knowledge, through in-service trainings, of the policy and implementation of interventions aimed at improving adolescent and youth utilisation and access to sexual and reproductive health services. For example, an emphasis of the policy is creating an adolescent friendly space that upholds privacy and employs non-judgemental staff attitude.

### ***6.2.3. Promote teenagers' access to accurate information***

B-Wise is an interactive cellphone health platform that is available for use by young people. The aim of B-Wise is to empower youth both in and out of school to make the right choices based on accurate information. The school health nurse and nurses in the health facility can promote signing up of B – Wise both in schools and the health facility to enable adolescent and youth to have access to accurate health information including sexual and reproductive health.

### ***6.2.4 Involve youth representative in governance of the facility***

In the existing facility committee, there is a need to have two youth representation to provide advocacy for the needs of the adolescent. The representatives will be mediators between the teenagers and the facility staff which will benefit and possibly increase utilization of the health service.

### ***6.2.5 Create awareness of teenage pregnancy in the community***

There is a need to utilise the local radio station to reach out to the community at large to raise awareness about the causes and consequences of teenage pregnancy. An afternoon slot can be sourced from the local radio station aimed at reaching parents and children; raising such awareness may be a way to increase their awareness of health and social challenges that teenagers are faced with and how as a community they can step in to assist in addressing these challenges.

### ***6.2.6 Initiate Parent-child communication workshops***

There is a great need to improve parent-child communication; therefore workshops can be arranged through schools. The workshops can be facilitated by the Department of Health, Department of Social Development and the Department of Education. The aim of this intersectoral approach will be to motivate and empower parents and their children to develop effective communications strategies so that together they can address the issues that teenagers face including sexual and reproductive health.

### ***6.2.7 Advocate for renovation of the recreation centre***

The Departments of Health and Social Development can advocate for the local municipality to renovate the existing recreation centre. Renovating and maintaining a well-resourced recreation centre will provide the teenagers with an appealing place for leisure as opposed to frequenting shebeens and taverns which they currently do.

### ***6.2.8 Multi-pronged approach to address teenage pregnancy***

Many of the above recommendations can be achieved through the “She Conquers” campaign which was launched by the Department of Health in 2016 and is aimed at the prevention of HIV and teenage pregnancy. The core package of interventions includes biomedical interventions which seek to increase access to sexual reproductive health information and services through adolescent and youth friendly services and integrated school health programmes. There are also socio-behavioural interventions which seek to increase community mobilization and support, access to peer groups and clubs, opportunities for awareness and information on gender, and access to parenting programmes for parents of teenagers, pregnant teenagers and teenage parents. In addition, there are structural interventions included that seek to increase access to economic opportunities such as grants and other forms of social assistance, bursaries and funding to increase access to post school education, and increase post-schooling options including employment, mentorship and internships for youth. The “She Conquers” campaign therefore has the potential to address the complexity related to teenage pregnancy.

### ***6.2.9 Recommendations for further studies***

The complexity of factors influencing teenage pregnancy requires implementation of downstream interventions and this can be achieved by more research, including quantitative research, being conducted to further explore the factors which impact influence teenage pregnancy at the different socio-ecological levels. This should be done in Heidedal as well as other similar locations in the Free State so that a comprehensive plan of action can be planned to address the problem of teenage pregnancy in Heidedal and Free State broadly.

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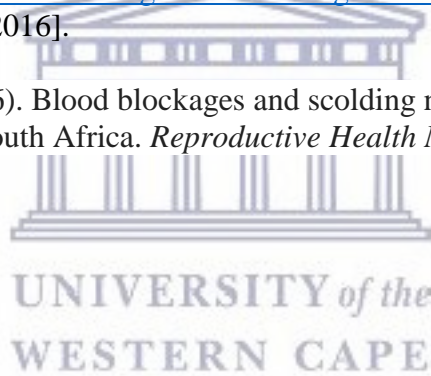
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## APPENDICES

**Appendices IA: Consent form for key informants**



**UNIVERSITY OF THE WESTERN CAPE**

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**CONSENT FORM FOR KEY INFORMANTS**

**Title of Research Project:** Factors leading to teenage pregnancy in Heidedal location, Mangaung District, Free State Province

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.

Participant's name.....

Participant's signature.....

Date.....

**Appendices 1B (Afrikaans): Toestemmingsvorm vir sleutel informants**



# UNIVERSITY OF THE WESTERN CAPE

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## TOESTEMMINGSVORM VIR SLEUTEL INFORMANT

**Titel van navorsingsprojek:** Faktore wat lei tot tienerswangerskap in Heidedal ligging, Mangaung distrik, Vrystaat Provinsie.

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

Deelnemer se naam.....

Deelnemer handtekening.....

Datum.....

se

UNIVERSITY of the  
WESTERN CAPE

**Appendices I C: Consent form for teenage mothers**



**UNIVERSITY OF THE WESTERN CAPE**

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**CONSENT FORM FOR TEENAGE MOTHERS**

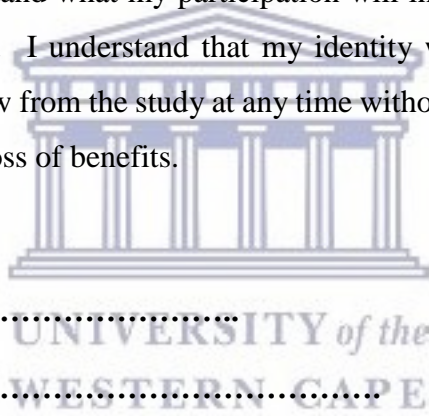
**Title of Research Project:** Factors leading to teenage pregnancy in Heidedal location, Mangaung District, Free State Province.

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.

Teenage mother's name.....

Teenage mother's signature.....

Date.....





**Appendices 1 D (South Sotho): Consent form for teenage mothers**



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**LENGOLO LA TUMELLANO HO BOMME BA BATJHA**

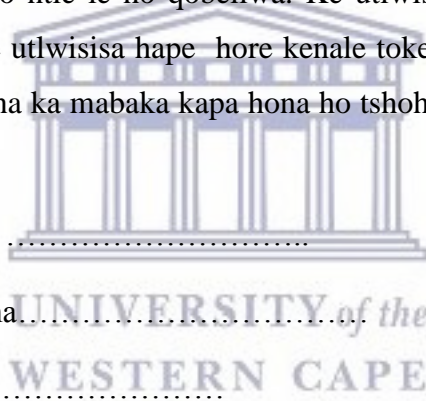
**Sehloho sa thuto :** Mabaka a lebisang ho boimana ba lilemong tsa bocha, Heidedal, seterekeng ya Mangaung, Free State.

Thuto e, e hlositswe ka puo eo ke e utlwisang. Lipotso tsa ka kaofela mabapi le thuto ena li arabiwe. Ke utlwisa seo tshebelisano mmoho ya ka e se kenyeletsang, ebile ke lumela ho sebelisana - mmoho ka khetho ntle le ho qobellwa. Ke utlwisa hore boitsibiso baka bo ka se tsibiswe mang kapa mang. Ke utlwisa hape hore kenale tokelo ya ho ikhula thutong ena nako efeng kapa efeng ntle le ho fana ka mabaka kapa hona ho tshoha ditlamoraho kapa yona tahlehelo ya eng kapa eng.

Lebitso la moimana ya motjha .....

Tshaeno ya moimana ya motjha.....

Lehla.....



**Appendices I E (Afrikaans): Consent form for teenage mothers**



**UNIVERSITY OF THE WESTERN CAPE**

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**TOESTEMMINGSVORM VIR TIENERMOEDER**

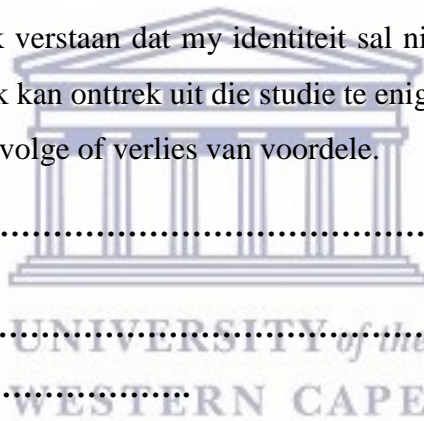
**Titel van navorsingsprojek:** Faktore wat lei tot tienerswangerskap in Heidedal ligging, Mangaung distrik, Vrystaat Provinsie.

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

**Tienerma se naam**.....

**Tienerma handtekening**..... **se**

**Datum**.....



**Appendices I F: Consent form for parents of teenage mothers**



**UNIVERSITY OF THE WESTERN CAPE**

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**CONSENT FORM FOR PARENTS OF TEENAGE MOTHERS**

**Title of Research Project:** Factors leading to teenage pregnancy in Heidedal location, Mangaung District, Free State Province.

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

**Parent of teenage mothers name**.....

**Parent of teenage mothers signature**.....

**Date**.....

**Appendices I G (Afrikaans): Consent form for parents of teenage mothers**



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**TOESTEMMINGSVORM VIR OUERS VAN TIENERMOEDERS**

**Titel van navorsingsprojek:** Faktore wat lei tot tienerswangerskap in Heidedal ligging ,  
Mangaung distrik, Vrystaat Provinsie.

Die studie is om my kind in taal wat sy verstaan beskryf. My kind se vrae oor die studie is beantwoord. My kind verstaan wat haar deelname behels en ek stem in om te laat deelneem aan die studie. Ek verstaan dat my kind se identiteit sal nie openbaar gemaak word aan enigiemand. Ek verstaan dat sy kan onttrek uit die studie te eniger tyd sonder 'n rede te gee en sonder vrees van negatiewe gevolge of verlies van voordele.

Ouer van tienerma se naam.....

Ouers van tienerma se handtekening.....

Datum.....

**Appendices II A: Assent form for teenage mothers under 18 years**



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**ASSENT FORM FOR TEENAGE MOTHERS UNDER 18 YEARS**

**Title of Research Project:** Factors leading to teenage pregnancy in Heidedal location, Mangaung District, Free State Province.

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 assent 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.

Teenage mother's name.....

Teenage mother's signature.....

Date.....

**Appendices 1I B (Afrikaans): Assent form for teenage mothers under 18 years**



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**BEKRAGTIG VORM VIR TIENERMOEDER ONDER 18 JARE**

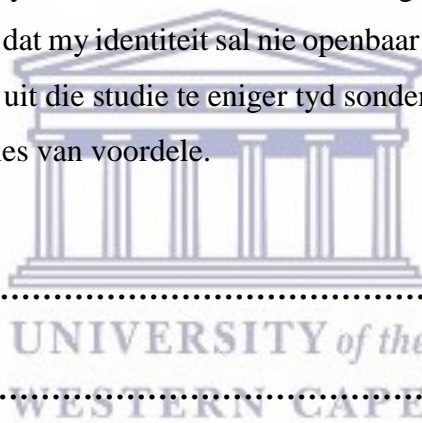
**Titel van navorsingsprojek:** Faktore wat lei tot tienswangerskap in Heidedal ligging ,  
Mangaung distrik, Vrystaat Provinsie.

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

**Tienerma se naam**.....

**Tienerma handtekening**.....

**Datum**.....



## Appendices III A: Information sheet for teenage mothers



# UNIVERSITY OF THE WESTERN CAPE

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Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: [soph-comm@uwc.ac.za](mailto:soph-comm@uwc.ac.za)

## INFORMATION SHEET FOR TEENAGE MOTHERS

**Project Title:** Factors leading to teenage pregnancy in Heidedal location, Mangaung district, Free State Province.

### What is this study about?

This is a research project being conducted by Sandra Qolesa at the University of the Western Cape. I am inviting you to participate in this research project because you are a teenager who is or was pregnant. Your input to the study will be highly appreciated and can change the lives of other teenagers because it will give us an understanding of the issues affecting teenage pregnancy. The information gathered during interviews is also hoped to be shared with policy makers, in order to develop policies that will address factors identified to be influencing teenage pregnancy.

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

You will be asked to attend an in depth interview that will take 45-60 minutes per individual, the study is intended to take 3 days at most, however you as an individual will be interviewed only once. The sessions are intended to take place between 12: 00 noon until 16:00pm and during these sessions light refreshments will be provided.

### Would my participation in this study be kept confidential?

To ensure your anonymity, you shall not be requested to identify yourself using your name and surname, numeric tags will be issued and you shall be referred only by the number on your tag. To ensure your confidentiality, all information collected will be kept strictly confidential, no health professional in the health facility will have access to the information.

If a report is written or article produced about this research project, your identity will be protected.

**What are the risks of this research?**

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise 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 may help the investigator learn more about factors leading to teenage pregnancy. We hope that, in the future, other people might benefit from this study through improved understanding of the reasons that cause teenagers to become pregnant.

**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 for which you otherwise qualify.

**What if I have questions?**

This research is being conducted by *Sandra Qolesa* at the University of the Western Cape. If you have any questions about the research study itself, please contact Sandra Qolesa at: 47 Kellner Street, Westdene, Bloemfontein, telephone number 0835877723.

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:

Prof Helen Schneider  
School of Public Health  
Head of Department  
University of the Western Cape  
Private Bag X17  
Bellville 7535  
[soph-comm@uwc.ac.za](mailto:soph-comm@uwc.ac.za)



Prof José Frantz  
Dean of the Faculty of Community and Health Sciences  
University of the Western Cape  
Private Bag X17  
Bellville 7535  
[chs-deansoffice@uwc.ac.za](mailto:chs-deansoffice@uwc.ac.za)

This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION  
Research Office  
New Arts Building,  
C-Block, Top Floor, Room 28  
University of the Western Cape  
Private bag17  
Bellville  
7535



**Appendices III B (South Sotho): information sheet teenage mothers**



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## LENGOLO LA KITSO HO BOMME BA BATJHA

**Sehloho sa lipatlisiso :** Mabaka a lebisang ho boimana ba lilemong tsa bocha, Heidedal, seterekeng ya Mangaung, Free State

### **Ke thuto e e mabapi le eng?**

Ena ke projeke ea ho etsa lipatlisiso e khannoa ke Sandra Qolesa Univesithing ea Western Cape. Ke ho memelang ho kenela mosebetsi ona etsa lipatlisiso hobane o sa le mocha eo a imileng kapa o ne e le moimana. Linhla tsa hao mo thutong ena li tla nkeloa holimo ebile li ka fetola maphelo batho ba bacha hobane e tla re fa kutloisiso e amang bokhachane lilemong tsa bocha. Boitsebiso nakong ya lipuisano ho tšepiwa hore bo kopane le baetsi pholisi, e le hore ho ba le maano a tla rarolla mabaka a susumetsa bokhachane lilemong tsa bocha.

### **Ke tla koptjoa ho etsang haeba ke lumellana ho kopanela?**

O tla kōptjoa hore o be teng puisanong e keneletseng e tla nka metsotso e 45-60 ka motho ka mong, ho ithuta e reretsoe ho nka matsatsi a 3 ka ho fetisisa leha ho le joalo uena joaloka motho o tla nna le puisano e le nngoe feela. mananeo a reretsoe ho etsahala pakeng tsa 12: 00 motšhare ho fihlela ka 16:00 thapama le nakong ya mananeo ana o tla fuwa sengwe sa ho ja.

### **E kaba tshebedisano-mmoho ya ka mo thutong ena e tla etswa sephiri?**

Ho netefetsa ho sa tsetjwe ha hao, ha hona mohlang o ka kopiwang ho fana ka boitsibiso pakeng tsa ho sebidisa lebitso la hao le sefane, o tla fuwa nomoro eo o tla bitswang ka yona nakong ya dipatlisiso tsena.

Ho netefatsa polokeho, dinhla ka ofela li tla nkilwa sephiring, ha ho mosebetsi ope wa tsa maphelo a ka nna le monyetla wa ho fuwa kapa ho fumana dinhla tsa dipatlisiso ena. Ha e kaba ho ka nna le padi e etsiwanng pakeng tsa dipatlisiso ena, boitsibiso ba hao bo tla bolokiwa wa se tshebahale.

### **Matshosetsi a ho nka karolo mo thutong ena ke afe ?**

Likamano le lipuisano kaofela le batho li nale matshosetsi, re tla leka ka hohle hohle ho isa tlase matsosetsi ana, ebe re ho fana ka thuso e maleba mohlang o nnang le maikutlo a ferekanang nakong ya patlisiso ena. Ha ho hlokeha, o ka kopannwa le moitseanapetho pakeng tsa maikutlo ho ka ho thusa.

### **E kaba melemo ha lipatlisiso tsena ke efe?**

Thuto ena ha li a lebana le ho ho thusa wena ka bong empa se tla fumanwang ho tswa ho tsona li tla thusa mmatlisisi ho ithuta ho feta ka linhla tseo li bakang boimana jwa batjha. Tsholofelo ke hore ho tla nna le tsebo e fetisisang ya mabaka boimana jwa batjha.

### **A ke hapeletswa ho nka karolo mo dipatlisisong tsena, ebile a ke nale tokelo ya ho emisa ho nka karolo nako efeng kapa efeng?**

Ho nka karolo ha hao mo thutong ena ke kgetho ya hao, o na le tokelo ya ho sa nke karolo. Le ha o nka qheto ya ho nka karolo thutong ena o ka emisa nako efeng kapa efeng e o batlang. Mohlang o nkang qheto ya o se tsee karolo kapa o emisa ho nka karolo ha hona mohlang o ka fumanang kotlo kapa o lahlehelwe ke eng kapa eng.

### **Ho tla etsahala eng ha ke nale dipotso?**

Thuto ena e etswa ke Sandra Qolesa moithuti University ya Kapa Bophirima. Ha o nale potso e fe kapa efe hoyu ka thuto ena o ka ikamana le Sandra Qolesa mo : 47 Kellner street, Westdene, Bloemfontein, nomoro ya mogala ke 0835877723.

Ha e kaba o nale ditlalebo mabapi le thuto ena kapa o batla ho itse ka ditshwanelo tsa hao o ka ikamana le:

Prof Helen Schneider  
School of Public Health  
Head of Department  
University of the Western Cape  
Private Bag X17  
Bellville 7535  
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Private Bag X17  
Bellville 7535  
[chs-deansoffice@uwc.ac.za](mailto:chs-deansoffice@uwc.ac.za)

Thuto ena e lumelletswa ho tswella pele ke University of the Western Cape's Biomedical Research Ethics Committee.

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION  
Research Office  
New Arts Building,  
C-Block, Top Floor, Room 28  
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**Appendices III C (Afrikaans): Information sheet for teenage mothers**



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## INLIGTING BLADSY VIR TIENERMOEDER

**Projek titel :** Faktore wat lei tot tienerswangerskap in Heidedal liggings, Mangaung distrik, Vrystaat Provinsie.

### Wat behels hierdie studie?

Dit is 'n navorsingsprojek gedoen deur Sandra Qolesa by die Universiteit van die Wes-Kaap. Ek nooi jy hierdie navorsingsprojek deelneem omdat jy is 'n tiener wat is of was swanger. Jou insette aan die studie sal hoogs waardeur word en kan die lewens van ander tieners verander want dit gee ons 'n begrip van die kwessies wat tienerswangerskap beïnvloed. Die inligting ingesamel tydens onderhoud is ook gehoop om gedeel te word met beleidmakers, ten einde te ontwikkel beleide wat sal spreek faktore geïdentifiseer te word wat tienerswangerskap.

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

Jy sal gevra word om by te woon 'n in diepte onderhoud wat 45-60 minute per individu, sal in die studie is daarop gemik om te neem 3 dae by die meeste, maar jy as individu sal slegs een keer ondervra word. Die sessies is bedoel om plaasvind tussen 12:00 middag tot 16:00 saans en gedurende hierdie sessies ligte verversings sal voorsien word.

### Sou my deelname in hierdie studie word vertroulik gehou?

Om te verseker jou anonimiteit, jy mag nie versoek word om jouself te identifiseer met jou naam en van, numeriese merkers sal uitgereik word en jy mag net deur die nommer op jou merker verwys word.

Om te verseker jou vertroulikheid, alle inligting ingesamel sal streng vertroulik gehou word, geen gesondheid professionele in die gesondheid fasiliteit sal toegang tot die inligting. Indien 'n verslag geskryf of artikel geproduseer oor hierdie navorsingsprojek, jou identiteit beskerm sal word.

### Wat is die risiko's van hierdie navorsing?

Alle menslike interaksie en praat self of ander dra 'n sekere bedrag van risiko's. Ons sal nogtans sulke risiko's te minimaliseer en onmiddellik optree om jou te help as jy ervaar ongemak, sielkundige of andersins gedurende die proses van jou deelname in hierdie studie. Waar nodig, 'n toepaslike verwysing gemaak sal word om 'n geskikte professionele vir verdere bystand of ingryping.

### **Wat is die voordele van hierdie navorsing?**

Hierdie navorsing is nie ontwerp om te help jy persoonlik, maar die resultate kan help om die ondersoeker leer meer oor faktore wat lei tot tienerswangerskap. Ons hoop dat, in die toekoms ander mense kan voordeel trek uit hierdie studie deur verbeterde begrip van die redes wat veroorsaak dat tieners raak swangerskap.

### **Het ek in hierdie navorsing wees en kan ek ophou deelneem op enige tydstip?**

Jou deelname in hierdie navorsing is heeltemal vrywillig. Jy kan kies om nie deel te neem op alle. As jy besluit om deel te neem in hierdie navorsing, kan jy ophou deelneem op enige tyd. As jy besluit om nie deel te neem aan hierdie studie as jy ophou deelneem op enige tyd, jy sal nie benadeel word of verloor enige voordele waarvoor jy andersins kwalifiseer.

### **Wat gebeur as ek vrae het?**

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Hierdie navorsing is goedgekeur deur die Universiteit van Wes- Kaap se Biomediese navorsings etiese komitee.

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

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UNIVERSITY *of the*  
WESTERN CAPE

**Appendices III D: Information sheet for parents of teenage mothers**



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## INFORMATION SHEET FOR PARENTS OF TEENAGE MOTHERS

**Project Title:** Factors leading to pregnancy in Heidedal location, Mangaung district, Free State Province

### What is this study about?

This is a research project being conducted by Sandra Qolesa at the University of the Western Cape. I am inviting your child to participate in this research project because she is a teenager who is or was pregnant. Her input to the study will be highly appreciated and can change the lives of other teenagers because it will give us an understanding of the issues affecting teenage pregnancy. The information gathered during interviews is also hoped to be shared with policy makers, in order to develop policies that will address factors identified to be influencing teenage pregnancy.

### What will my child be asked to do if I agree to participate?

She will be asked to attend an in depth interview that will take 45-60 minutes per individual, the study is intended to take 3 days at most, however as an individual she will be interviewed only once. The sessions are intended to take place between 12: 00 noon until 16:00pm and during these sessions light refreshments will be provided.

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

To ensure your child's anonymity, she shall not be requested to identify herself using her name and surname, numeric tags will be issued and your child shall be referred only by the number on her tag.

To ensure your child's confidentiality, all information collected will be kept strictly confidential, no health professional in the health facility will have access to the information.

If a report is written or article produced about this research project, her identity will be protected.



**What are the risks of this research?**

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist your child if she experience 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 your child personally, but the results may help the investigator learn more about factors influencing teenage pregnancy. We hope that, in the future, other people might benefit from this study through improved understanding of the reasons that cause teenagers to become pregnancy.

**Does your Child have to be in this research and may she stop participating at any time?**

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

**What if your child has questions?**

This research is being conducted by *Sandra Qolesa* at the University of the Western Cape. If your child have any questions about the research study itself, please contact Sandra Qolesa at: 47 Kellner Street, Westdene, Bloemfontein, telephone number 0835877723.

Should she have any questions regarding this study and her rights as a research participant or if she wish to report any problems she have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee

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## Appendices III E ( Afrikaans): Information sheet for parents of teenage mothers



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### INLIGTING BLADSY VIR OUERS VAN TIENERMA

**Projek titel :** Faktore wat lei tot tienerswangerskap in Heidedal ligging, Mangaung distrik, Vrystaat Provinsie.

#### **Wat behels hierdie studie?**

Dit is 'n navorsingsprojek gedoen deur Sandra Qolesa by die Universiteit van die Wes-Kaap. Ek is uit te nooi jou kind aan hierdie navorsingsprojek deelneem want sy is 'n tiener wat is of was swanger. Haar insette aan die studie sal hoogs waardeur word en kan die lewens van ander tieners verander want dit gee ons 'n begrip van die kwessies wat tienerswangerskap beïnvloed. Die inligting ingesamel tydens onderhoude is ook gehoop om gedeel te word met beleidmakers, ten einde te ontwikkel beleide wat sal spreek faktore geïdentifiseer te word wat tienerswangerskap.

#### **Wat sal my kind gevra word om te doen as ek instem om deel te neem?**

Sy sal gevra word om by te woon 'n in diepte onderhoud wat 45-60 minute per individu, neem die studie bedoel is om te neem 3 dae by die meeste, maar as 'n individu sy sal onderhoude te voer net een keer. Die sessies is bedoel om plaasvind tussen 12:00 middag tot 16:00 saans en gedurende hierdie sessies ligte verversings sal voorsien word.

#### **Sou my kind se deelname in hierdie studie word vertroulik gehou?**

Om te verseker jou kind se anonimiteit, sy sal nie word versoek om haarself te identifiseer met behulp van haar naam en van, numeriese merkers sal uitgereik word en jou kind mag slegs deur die nommer op haar merker verwys word.

Om te verseker jou kind se vertroulikheid, alle inligting ingesamel sal streng vertroulik gehou word, geen gesondheid professionele in die gesondheid fasiliteit sal toegang tot die inligting.

Indien 'n verslag geskryf of artikel geproduseer oor hierdie navorsingsprojek, sal haar identiteit beskerm word.

### **Wat is die risiko's van hierdie navorsing?**

Alle menslike interaksie en praat self of ander dra 'n sekere bedrag van risiko's. Ons sal nogtans sulke risiko's te minimaliseer en tree dadelik te help jou kind as sy ongemak te ervaar, sielkundige of andersins gedurende die proses van haar deelname aan hierdie studie. Waar nodig, 'n toepaslike verwysing gemaak sal word om 'n geskikte professionele vir verdere bystand of ingryping.

### **Wat is die voordele van hierdie navorsing?**

Hierdie navorsing is nie ontwerp om jou kind persoonlik te help, maar die resultate kan help om die ondersoeker leer meer oor faktore wat tienerswangerskap. Ons hoop dat, in die toekoms ander mense kan voordeel trek uit hierdie studie deur verbeterde begrip van die redes wat veroorsaak dat tieners raak swangerskap.

### **Jou kind hoef te word in hierdie navorsing en mag sy ophou deelneem op enige tydstip?**

Jou kind se deelname in hierdie navorsing is heeltemal vrywillig. Sy kan kies om nie deel te neem nie. As jou kind besluit stop deelneem in hierdie navorsing, sy kan ophou deelneem op enige tyd. As sy besluit om nie deel te neem aan hierdie studie as sy ophou deelneem op enige tyd, sy sal nie benadeel word of verloor enige voordele waarvoor sy andersins kwalifiseer.

### **Wat as jou kind het vrae?**

Hierdie navorsing is gedoen deur Sandra Qolesa by die Universiteit van die Wes-Kaap. As jou kind enige vrae het oor die navorsing studie self, asseblief kontak Sandra Qolesa by: 47 Kellner straat, Westdene, Bloemfontein, telefoon nommer 0835877723. Moet sy enige vrae het met betrekking tot hierdie studie en haar regte as 'n navorsing deelnemer of as sy wil rapporteer enige probleme wat sy ervaar het met betrekking tot die studie, asseblief kontak:

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Hierdie navorsing is goedgekeur deur die Universiteit van Wes- Kaap se Biomediese navorsings etiese komitee

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## Appendices III F: Information sheet for Key Informants



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E-mail: [soph-comm@uwc.ac.za](mailto:soph-comm@uwc.ac.za)

## INFORMATION SHEET FOR KEY INFORMANTS

**Project Title:** Factors leading to teenage pregnancy in Heidedal location, Mangaung district, Free state Province.

### What is this study about?

This is a research project being conducted by Sandra Qolesa at the University of the Western Cape. I am inviting you to participate in this research project because of your experience and knowledge towards teenage pregnancy. Your input to the study will be highly appreciated and can change the lives of other teenagers because it will give us an understanding of the issues affecting teenage pregnancy. The information gathered during interviews is also hoped to be shared with policy makers, in order to develop policies that will address factors identified to be influencing teenage pregnancy.

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

You will be asked to attend an in depth interview that will take 45-60 minutes per individual, the study is intended to take 3 days at most, however you as an individual will be interviewed only once. The sessions are intended to take place between 12: 00 noon until 16:00pm and during these sessions light refreshments will be provided.

### Would my participation in this study be kept confidential?

To ensure your anonymity, you shall not be requested to identify yourself using your name and surname, numeric tags will be issued and you shall be referred only by the number on your tag. To ensure your confidentiality, all information collected will be kept strictly confidential, no health professional in the health facility will have access to the information.

If a report is written or article produced about this research project, your identity will be protected.

### **What are the risks of this research?**

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise 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 may help the investigator learn more about factors influencing teenage pregnancy. We hope that, in the future, other people might benefit from this study through improved understanding of the reasons that cause teenagers to become pregnancy.

### **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 for which you otherwise qualify.

### **What if I have questions?**

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## Appendices III G (Afrikaans): Information sheet for Key Informants



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### INLIGTINGSBLAD VIR SLEUTEL INFORMANTS

**Projek titel:** Faktore wat lei tot tienerswangerskap in Heidedal liggings, Mangaung distrik, Vrystaat Provinsie.

#### **Wat behels hierdie studie?**

Dit is 'n navorsingsprojek gedoen deur Sandra Qolesa by die Universiteit van die Wes-Kaap. Ek is nooit jou uit om deel te neem in hierdie navorsingsprojek as gevolg van jou ervaring en kennis tot tienerswangerskap. Jou insette aan die studie sal hoogs waardeer word en kan die lewens van ander tieners verander want dit gee ons 'n begrip van die kwessies wat tienerswangerskap beïnvloed. Die inligting ingesamel tydens onderhoude is ook gehoop om gedeel te word met beleidmakers, ten einde te ontwikkel beleide wat faktore geïdentifiseer om tienerswangerskap wees wat sal spreek.

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

Jy sal gevra word om by te woon 'n in diepte onderhoud wat 45-60 minute per individu, sal in die studie is daarop gemik om te neem 3 dae by die meeste, maar jy as individu sal slegs een keer ondervra word. Die sessies is bedoel om plaasvind tussen 12:00 middag tot 16:00 saans en gedurende hierdie sessies ligte verversings sal voorsien word.

#### **Sou my deelname in hierdie studie word vertroulik gehou?**

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### **Het ek in hierdie navorsing wees en kan ek ophou deelneem op enige tyd?**

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### **Wat gebeur as ek vrae het?**

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## **Appendices IV: Interview guide for teenaged participants**

### **Interview guide for the teenage mothers on factors leading to teenage pregnancy**

#### **BACKGROUND INFORMATION**

I would like to begin by you telling me a little about yourself:

1. How old are you at the moment?
2. Can you please tell me about where you live, how long you have lived there and who do you live with?
3. Can you tell me about whether you are at school at the moment or not and if not if you are working or staying at home and how you are finding this?
4. Can you tell me a bit about what kind of things you do for fun/when you have time off.

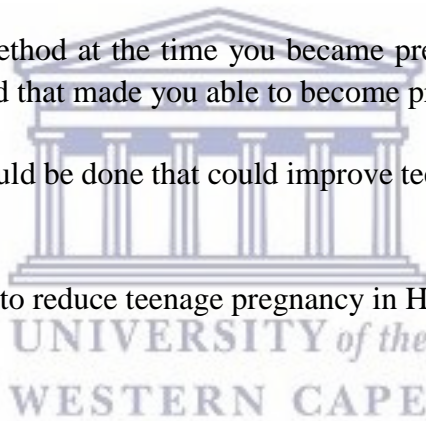
#### **PREGNANCY**

I would now like to ask you some questions about your pregnancy:

5. How old were you when you became pregnant for the first time? How many times altogether have you been pregnant?
6. How many children are you now planning to have/would you like to have?
7. Can we speak about your experiences of your pregnancy? Could you tell me about your situation at the time and how you felt? (*Probe: what was type of intimate relationship she was in with the father of the baby; whether it was her own decision to become pregnant or a joint one; did she/they feel pressurized by someone to become pregnant; did it just 'happen' without thinking it would- i.e was it planned or unplanned; did she have feelings of happiness about being pregnant and why; did she have concerns or fears and why?*)
8. Who did you speak to about being pregnant? Can you talk about why you decided on this person/people? How did speaking to them about it turn out?
9. What was your personal and family life like before you became pregnant?
10. What was the economic situation before you became pregnant?
11. What was your social life (with friends etc.) before you became pregnant? (*probe: what do you do for recreation etc.*)
12. How were things at school before you became pregnant?

#### **INTIMATE RELATIONS AND PREGNANCY PREVENTION**

13. Thinking about when you had sex on the occasion that led to your first pregnancy, was this the first time? If not could you tell me a bit about the first time you had sex – what were the circumstances in which it happened? *(Probe with this was her choice or whether someone else for e.g. person she has sex with, peers or something else persuaded her to have sex at that time; did it just happen on the spur of the moment or was it planned?)*
14. When you became pregnant, did you know about any methods that could prevent a pregnancy? If yes, what methods did you know about? What did you know about these methods and what they do in offering protection?
15. If you knew about methods to prevent a pregnancy, were there any things that made/or would have made it easier or more difficult for you to decide to use a method? Can you talk more about this? *[Probe as to where they got information from; did she know where to go for contraception? Where did she go? if they did use contraception: how easy or difficult this was; how was she treated by the health service providers?]*
16. If you were using a method at the time you became pregnant what happened (if you know) with this method that made you able to become pregnant?
17. What do you think should be done that could improve teenage sexual and reproductive health service
18. What else can be done to reduce teenage pregnancy in Heidedal?



Thank you for your time. Much appreciated

## **Appendices V: Interview guide for key informants**

### **Key informant Interview guide for the nurse**

I would like you to tell me a little bit about yourself and your work)

1. Can you please tell me about your role in the facility?
2. Can you tell me whether you work with teenagers if so how long have you worked with them in this facility?
3. What has your experience been like in working with teenagers? (*Do teenagers visit the facility more often and if so what kind of information are they interested in? who do they speak to when they come in to the health facility? what trainings do health workers who provided services to the teenagers have? What other services are provided to teenagers in this health facility? Kindly describe the utilization of the services you mentioned by teenagers).*)
4. Based on your experiences, what do you think about the general atmosphere at the health facilities for the teenagers (*Do they have access to any information at any given time* )
5. Based on your interactions with teenagers would you say teenagers are well informed about their sexuality and reproductive health issues?

### **TEENAGE PREGNANCY**

I would like to ask you about teenage pregnancy:

6. Can you please tell me about your perception broadly regarding teenage pregnancy?
7. What do you think are the reasons that teenagers in Heidedal are becoming pregnant
8. What would you think in your area of expertise will be a strategy to be used to reduce teenage pregnancy in Heidedal?

### **Key Interview guide for the ward councilor**

I would like you to tell me a little bit about yourself and Heidedal location

1. Can you tell about your role in Heidedal location?
2. How long have you been occupying this role and what are the challenges in this location? (*Probe: What services are available to the community in Heidedal, can you tell me about the socio economic status of Heidedal/*)
3. In your role I take it you have engaged with teenagers one way or another, what interactions have you had with them, if there has been **any** what concerns did they have as teenagers?

4. Can you tell me what do you think teenagers in Heidedal like to spend their time on?  
(Probe: *What recreational activities are available for the teenagers in Heidedal, if any are these teenagers making use of these activities if NOT what would you think are the reason for them not to use the recreational services.*)

**TEENAGE PREGNANCY:**

5. Can you please tell me about your perception broadly regarding teenage pregnancy?
6. In Heidedal, what would you say are the reasons teenagers are becoming pregnant?
7. What would you think in your area of expertise will be a strategy to be used to reduce teenage pregnancy in Heidedal.

**Key informant Interview guide for the Life skills teacher.**

I would like to you to tell me a bit about yourself

1. Can you tell me about your role in this school?
2. How long have you occupied this role?
3. What has your experience been like in working with teenagers (*What do you talk about when you are with teenagers? In your conversation with teenagers what topics do they seem more interested in? if there are any How do you address these topics?*)
4. As a life skills teacher can you please tell me about the contents of the curriculum that is meant for the teenagers in school? (*probe for sexual and reproductive health content?*)

**TEENAGE PREGNANCY:**

5. Can you please tell me about your perception broadly regarding teenage pregnancy?
6. In Heidedal, what would you say are the reasons teenagers are becoming pregnant?
7. What would you think in your area of expertise will be a strategy to be used to reduce teenage pregnancy in Heidedal location.

### **Key informant Interview guide for someone working with youth in “New Start”**

1. Can you tell me your role in this organization and how long you have occupied this role
2. What has your experience in working with teenagers been like
3. What services are you providing for teenagers and how often are you servicing them?  
*(Probes Would you say they appreciate these services, if so what makes you think so?  
Can you share with me when you are with teenagers what do they like to talk about the most and how do you handle these topics, do they come voluntarily for services?)*

### **TEENAGE PREGNANCY**

4. Can you please tell me about your perception broadly regarding teenage pregnancy?
5. In Heidedal, what would you say are the reasons teenagers are becoming pregnant?
6. What would you think in your area of expertise will be a strategy to be used to reduce teenage pregnancy in Heidedal location.

Thank you for your time. Much appreciated

